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TO SUE OR NOT TO SUE:
THE DECISIONAL PROCESS OF A LAWYER

BY

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SYNOPSIS

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[1]Adapted from NURSING HOME LITIGATION GUIDE by David Marks, with the permission of the publisher, Butterworth Publications (Stoneham, Mass.), a division of Reed Publishing (U.S.A.), Inc.

§1.01 -- Introduction

The most important decision made on a recurrent basis by the personal injury practitioner is the decision to accept a case and invest time, experience and money towards its resolution. The lawyer prone to accept a number of speculative or marginal cases is destined to drain his or her office of the substantial energy and resources needed to pursue meritorious cases. Perhaps nowhere is this more true than in the evaluation of cases arising out of the alleged negligent conduct of health care professionals and long term care institutions. The cost of development, in terms of time and money, is so demanding that the initial determination as to whether a case is meritorious is of primary importance.

As a general rule, the screening of this type of case involves two fundamental decisions: 1) Is the evidence sufficiently aggravating to support a substantial damage award? and 2) Can the resident's injury be causally linked to a breach of duty on the part of defendant?

A proper evaluation of the facts and understanding of the complex issues involved is essential to the drafting of pleadings and discovery in the nursing home case. Accordingly as a predicate to pleading and discovery strategies, the following topics will be considered: 1) common evaluation concerns; 2) causation problems; 3)key damage elements and appraisal questions; 4) comparative verdicts and settlements; and 5) factors influencing the size of a verdict or settlement. This discussion is followed by an examination of: 1) the causes of action that are generally available to plaintiff in a nursing home case; and 2) the pleadings and initial discovery in such case.

§ 1.02 -- Common Evaluation Concerns

Evaluation of the nursing home malpractice treatment case begins with the proposition that the criteria traditionally utilized to assess the potential and quantity of recovery in a personal injury case (and for that matter, in a medical malpractice case) are simply not applicable to litigation arising out of neglect and injury of a long term care resident. Characteristically, in a significant personal injury case, plaintiff's health status at the time of the injury (made the basis of the lawsuit) makes him or her eligible for the full spectrum of traditional tort damages. In such a case, plaintiff's capacity for life and earnings, measured from that point in time when the injury is sustained, is sufficient enough to allow recovery for: 1) lost earning potential; and 2) future health care expenses. From a quantitative value perspective, the huge discrepancy between

plaintiff's "before injury picture" and "after injury picture" constitutes the lifeblood of the significant personal injury case.

In a lawsuit filed on behalf of a nursing home resident for injuries or death allegedly caused by the wrongful conduct of a health care facility, the gap separating plaintiff's "before injury picture" and "after injury picture" is substantially smaller and arguably indistinguishable in many cases. Typically, plaintiff in a nursing home case is 67 to 95 years of age; frail and dependant upon the nursing staff for assistance with such basic activities of daily living as toileting, bathing, and ambulation[2]; and a recipient of Medicaid assistance.[3] Furthermore, plaintiff in such a case characteristically suffers from a cluster of maladies and diseases; commonly resembles a living chemistry set due to the large number of medications required to control pre-existing conditions; and universally has a very limited life expectancy. As a consequence thereof, plaintiff is not a candidate for damages based upon lost earning potential. The potential to earn wage or salary in most instances was impaired long before the resident entered the nursing home in question. In all likelihood, plaintiff's only source of income is a monthly Social Security check, the majority of which is paid to the nursing home.[4] Moreover, the ability of a nursing home victim to recover residual damages based upon continuing health care expenses; future pain, suffering and mental anguish; and diminished capacity to enjoy life in the future is severely limited by reason of the reduced and questionable length of plaintiff's life expectancy.

The foregoing case realities translate into the following significant liability and damage hurdles:

- How can plaintiff unravel the sequelae (effect) of neglect from the sequelae of underlying disease processes?

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[2]See Butler, *Nursing Home Quality of Care Enforcement, Part I -- Litigation by Private Parties*, 14 CLEARINGHOUSE REV.. 622, 641 (1980).

[3]Eighty-three percent of all single residents entering a nursing home are impoverished within 12 months of admissions. Fifty-eight percent of the married residents are impoverished within 12 months of admission. Of those individuals who enter a convalescent facility as private pay patients, 92% of the single residents and 80% of the married residents will "spend down" their income and resources to a poverty level within 104 weeks. Such spend down suggest that private patients are inevitably transformed into Medicaid recipients. BARRON'S MAGAZINE, June 2, 1986, and U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *Technical Work Group on Private Financing at Long-Term Care for the Elderly*, p. 2-21.

[4]Such maintenance deductions can result in a net income of $25-$30 per month for the resident.

- As a practical matter, given the deteriorated health status and limited life expectancy of the resident upon admission to the nursing home, how has the conduct of the facility altered the resident's future?
- Given these same realities, what is the likelihood of establishing a residual injury which will support a substantial award for future medical expense?
- Can a causal link between the alleged nursing home neglect and the destruction of capacity to earn wage or enjoy life be established?
- Have the statutory beneficiaries of the resident suffered any 1) pecuniary loss, 2) mental anguish, 3) impairment of familial interests or 4) loss of inheritances as a result of said resident's wrongful death?

In the past, the inability of attorneys to overcome these obstacles has caused the plaintiff's bar to be unenthusiastic about nursing home maltreatment cases. However, since 1984 a growing number of litigators have consistently obtained six- and seven-figure verdicts and settlements ranging up to $15 million[5] for personal injury, wrongful death and survival actions arising out of the neglect of nursing home residents. Their efforts not only have established the principle that the quantitative value of a nursing home case cannot be accurately measured by traditional personal injury discriminators (such as those questions posed herein above) but also have given rise to clear fact patterns customarily associated with high verdict and settlement value. These patterns, as well as the legal and factual issues occasioned by such litigation are explored throughout the remainder of this article.

§1.03 Causation: The Determinant Variable

Before accepting a case founded upon allegations of nursing home neglect, the attorney for the injured resident must be satisfied that the omissions or acts of the defendant can be causally linked to the injury of the plaintiff. The injury suffered by the

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[5]*See for example, e.g.*, Paasch and Manson, *Nursing Home Chain to Pay $4.5 Million for Gross Neglect*, HOUSTON POST, Apr. 19, 1986 at 1A.

resident must be a natural and continuous product of the defendant's conduct, without which such injuries would not have occurred.[6]

It is a fundamental principle of the law of torts that a person who suffers injury is entitled to recover damages only if a connection between such damages and the wrongful conduct of the defendant can be established. There can be no recovery of damages if: 1) plaintiff's injury merely coincides with the proscribed activities of the defendant but is not causally related to plaintiff's condition; 2) plaintiff's injury was the condition of existing disease processes not caused by defendant's conduct; or 3) the expense, pain, suffering and mental anguish suffered by plaintiff would have occurred even in the absence of the injury which serves as the basis for the cause of action.

[A] Pre-Existing Condition

It is well settled that an injured person is entitled to recover full compensation for all damage proximately resulting from the defendant's acts, even though his injuries may have been aggravated by reason of his pre-existing physical or mental condition, rendered more difficult to cure by reason of his state of health, or more serious because

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[6]The traditional test of causation is the "but for" or "sine qua non" test. Under this test, causation exists when the injury would not have occurred "but for" the defendant's tortious conduct. In recent years, the "substantial factor" test has been advocated as a replacement for the "but for" test. A force or condition is deemed a cause of a victim's harm when it was a "substantial factor" in bringing about that result, *id. at p. 1356.*

of a disease[7], than they would have been had he been in robust health. Pre-existing

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[7]King, *Causation, Valuation, and Chance in Personal Injury Torts Involving Preexisting Conditions and Future Consequences*, 90 YALE L J 1353 (1981)

Complaint, petition, or declaration -- Allegations of aggravation of pre-existing physical condition. 8 AM JUR PL & PR FORMS (Rev), DAMAGES, Forms 16, 17.

Instructions to jury -- Liability for aggravation of pre-existing condition. 8 AM JUR PL & PR FORMS (Rev), DAMAGES, Form 225.

VALDEZ V. LYMAN ROBERTS HOSP. INC. 638 swzd 111 (Tex. App.--Corpus Christi, 1982, writ ref'd n-r-e); STOLESON V. UNITED STATES (CA7 Wis) 708 F2d 1217 (fact that the plaintiff's vulnerability because of a pre-existing condition is psychological (predisposition to hypochondria) rather than physical is irrelevant); MAURER V. UNITED STATES (CA2 NY) 668 F2d 98; HENDERSON V. UNITED STATES (CA5 Ala) 328 F2d502 (action under Federal Tort Claims Act; stating law of Alabama); BOWLES V. ZIMMER MFG. Co. (CA7 Ind) 277 F2d 868, 76 ALR2d 120; CENTRAL DISPENSARY & EMERGENCY HOSPITAL, INC. V. HARBAUGH, 84 App DC 371, 174 F2d 507; OLIVER V. YELLOW CAB CO. (CA7 Ill) 98 F2d 192; UNDERWOOD V. SMITH, 261 Ala 181, 73 So 2d 717 (prior injury); INTERMILL V. HEUMESSER, 154 Colo 496, 391 P2d 684; TURNER V. SCANLON, 146 Conn 149, 148 A2d 334; FLOOD V. SMITH, 126 Conn 644, 13 A2d 677; C.F. HAMBLEN, INC. V. OWENS, 127 Fla 91, 172 So 694; WISE V. CARTER (Fla App D1) 119 So 2d 40; DZURIK V. TAMURA, 44 Hawaii 327, 359 P2d 164; REED V. HARVEY, 253 Iowa 10, 110 NW2d 442; KNOBLOCK V. MORRIS, 169 Kan 540, 220 P2d 171; LOUISVILLE TAXICAB & TRANSFER CO. V. HILL, 304 Ky 565, 201 SW2d 731; LAPLEINE V. MORGAN'S L. & T. R. & S. S. CO., 40 La Ann 661, 4 So 875; WALTERS V. SMITH, 222 Md 62, 158 A2d 619, 2 ALR3d 482; COCA COLA BOTTLING WORKS, INC. V. CATRON, 186 Md 156, 46 A2d 303; Royer v. Eskovitz, 358 Mich 279, 100 NW2d 306, 2 ALR3d 286; NELSON V. TWIN CITY MOTOR BUS CO., 239 Minn276, 58 NW2d 561; SMART V. KANSAS CITY, 208 Mo 162, 105 SW 709; RAWSON V. BRADSHAW, 125 NH 94, 480 A2d 37 (instruction that plaintiff was entitled to damages even though some of the injuries may have been rendered more difficult to cure by reason of plaintiff's existing state of health conveyed idea that his injuries might have been aggravated or precipitated by reason of his pre-existing condition); HEBENSTREIT V. ATCHISON, T. & s. F. R. Co., 65 NM 301, 336 P2d 1057; REEG V. HODGSON (Scioto Co) 1 Ohio App 2d 272, 30 Ohio Ops 2d 293, 95 Ohio L Abs 148, 202 NE2d 310 (aggravated or accelerated); MAYNARD V. OREGON R. & N. CO., 46 Or 15, 78 P 983 (ovrld on other grounds) FEHELY V. SENDERS, 170 Or 457, 135 P2d 283, 145 ALR 1092); WATSON V. WILKINSON TRUCKING CO., 244 SC 217,136 SE2d 286; COBB V. WADDELL, 51 Tenn App 458, 369 SW2d 743, 2 ALR3d 457; WATFORD V. MORSE, 202 Va 605, 118 SE2d 681; GREGORY V. SHANNON, 59 Wash 2d 201, 367 P2d 152, 2 ALR3d 397; FRENCH V. CHASE, 48 Wash 2d 825, 297 P2d 235.

Instructions to jury -- Effect of Plaintiff's susceptibility to injury because of previous infirm condition. 8 AM JUR PL & PR FORMS (Rev), DAMAGES, Form257.

Proof, by testimony of plaintiff, of good health or disability prior to injury. 3 AM JUR POF 491, DAMAGES, Proofs 24, 25.

HOLEMAN V. T. I. M. E. FREIGHT, INC. (WD Ark) 236 F Supp 462; OWEN V. DIX, 210 Ark 562, 196 SW2d 913; BRUNEAU V. QUICK, 187 Conn 617, 447 A2d 742; POZZIE V. MIKE SMITH, INC. (1st Dist) 33 Ill App3d 343, 337 NE2d 450; GALLARDO V. NEW ORLEANS S.B. CO. (La App 4th Cir) 459 So 2d 1215; OWENS V. KANSAS C., S. J. &

weakness which results in the plaintiff suffering a worse injury than a normal person would suffer from the defendant's negligence is not in itself a grounds for defeating causation.[8] Thus, one who violates the duty, imposed by law, of exercising due care not to injure others may be compelled to respond in damages for all the injuries which he inflicts by reason of the violation of such duty, even if a particular injury may have been aggravated by or might not have happened at all except for the peculiar physical condition of the injured person. This is the maxim that "the defendant takes the plaintiff as he finds him," or the "thin skull" or "eggshell skull" rule.[9] Phrases such as pre-dispositions, latent illnesses, dormant conditions and "the defendant takes the plaintiff as he finds him," all illustrate the attempt of the rules to deal with the fact that most people are not perfect specimens and a defendant may not avoid a claim of damages by pointing out this self-evident circumstance.[10]

The foregoing rules are of particular importance in a nursing home maltreatment case, given the susceptibility and vulnerability of residents to injury. Rare indeed is the case where the pre-existing condition, weakness and frailty of the victim does not form the nucleus of the nursing home's defense, with the thrust of the facility's argument being: the injury sustained by the nursing home resident was the inevitable product of

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[8]22 AM JUR 2d, DAMAGES, §281.

[9]A person injured by the negligence of another is entitled to recover to the full extent of the injury so caused without regard to whether, owing to his previous condition of heath, he is more or less liable to injury. Purcell v. St. Paul C. R. Co., 48 Minn 134, 50 NW 1034.

Recovery for frostbite was allowed even though plaintiff's poor blood circulation rendered her more susceptible to frostbite than a person in normal health. OWEN V. ROCHESTER-PENFIELD BUS CO., 304 NY 457, 108 NE2d 606, 33 ALR 2d 1354.

UNDERWOOD V. SMITH, 261 Ala 181, 73 So 2d 717; MOURISON V. HANSEN, 128 Conn 62, 20 A2d 84, 136 ALR 413; SQUIRES V. REYNOLDS, 125 Conn 366, f A2d 877; SANSONNI V. JEFFERSON PARISH SCHOOL BD. (La App 4th Cir) 344 So 2d 42, cert den (La) 346 So 2d 209 (plaintiff who suffered from congenital defect rendering his bones unusually brittle and susceptible to fracture with a minimum of force was entitled to substantial damages even though a normal child would have sustained only a bruise from the type of slip and fall accident that occurred); OWEN V. ROCHESTER-PENFIELD BUS CO., 304 NY 457, 108 NE2d 606, 33 ALR2d 1354; LOCKWOOD V. MCCASKILL, 262 NC 663, 138 SE2d 541; FLORIG V. SEARS, ROEBUCK & CO., 388 Pa 419, 130 A2d 445.

Bahr and Graham, *Thick Skull Plaintiff Concept*: *Evasive or Persuasive*, 15 LOYOLA L REV (Los Angeles) 409 (1982).

[10]Stein, Damages and Recovery, §123.

his or her compromised health status/physical weakness (which was present at time of admission to the facility in question) rather than the result of any neglect by defendant. The argument advanced by the defense revolves around the question of "cause in fact" as opposed to "foreseeability," thereby obligating plaintiff to show that the injury was more probably the result of external forces for which defendant is responsible rather than the internal pre-existing weaknesses of plaintiff.

The relationship between any injury and a pre-existing condition depends principally upon: 1) the status of underlying disease process present at the time of infliction of the alleged neglect; and 2) the severity and extent of the alleged neglect. In most nursing home maltreatment cases, the pre-existing conditions of plaintiff have been known and treated for many years prior to admission into defendant's facility. Accordingly, the key question relating to the status of plaintiff's pre-existing condition necessarily focuses upon the stability or rate of deterioration of any *relevant* disease processes affecting plaintiff's health. Frequently, the nursing home resident suffers from a pre-existing condition which, it may be supposed, would eventually cause further disability and death. The rate of expected deterioration is then subsequently altered by reason of the negligent conduct of defendant nursing home, causing the adverse condition to occur at a precise time. In other words, absent the wrongful conduct, the adverse condition would not have manifested at this particular time. Such a result is often referred to as "accelerating" or "hastening" the condition in question. It is generally held in such a case that the defendant has *caused in fact* the result. If a defendant accelerates a decedent's death by even an hour, minutes or seconds, said defendant is liable for such death.[11] Therefore, the plaintiff in a nursing home death case is not required to prove that the decedent, more likely than not, would have ultimately survived if it had not been for the defendant's wrongful acts and omissions.[12] Rather, plaintiff can recover if he is able to show that the decedent's chances of survival would have been greater if it had not been for the nursing home's wrongful acts or omissions. As stated by one Court:

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[11] Valdez v. Lyman-Roberts Hosp., Inc., 638 S.W.2d 111 (Tex. App. -- Corpus Christi 1982, writ ref'd n.r.e.)

[12] Ibid.

"The burning candle of life is such a precious light in anyone's existence that no one has a right to extinguish it before it flickers out into perpetual darkness and oblivion."[13]

[B] Red Flag Injuries: Clinical Outcomes Frequently Linked With Nursing Home Neglect

In screening a potential nursing home maltreatment case, one of the threshold questions the lawyer must address is whether the resident's injury is generally regarded as being linked to deficient care and nursing home neglect. In other words, is the outcome in question commonly recognized as being an indicator of poor care? Such determination is primarily derived from a review of the resident's clinical record coupled with interviews of witnesses who observed the resident's condition; and secondarily, from a review of the teachings, literature and experience of two distinct professional communities -- 1) the health care community, which includes the medical, nursing, pharmaceutical and nursing home professional, and 2) the legal community. As to the former, the pertinent inquiry is: What injuries are generally recognized by the health care community as being caused by a failure to render adequate care? As to the latter, the relevant question is: What types of injuries have been identified by the United States Congress, state regulators, courts, juries, and/or insurance carriers as being associated with a valid claim of nursing home neglect? Answers to these questions are compiled in the illustrative list below.

[C] Injuries Precipitated by Progressive Failures and Omissions of Care

The injuries listed in this category generally result from a prolonged form of neglect, as contrasted with an event which immediately produces an injury, such as a scalding. At the outset, it is important that plaintiff's counsel understand whether the injury in question was caused by recurrent neglect over an extended period of time, or was simply the result of a single event which effectively produced injury to the nursing home resident. The injuries listed below not only have been recognized by the medical and nursing communities as being preventable in nearly all nursing home residents through implementation of ordinary nursing care, but also have been the subject of successful litigation.

- ☒ Decubitus ulcers -- Stage III or IV.
- ☒ Infected decubitus ulcers.

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[13]Ibid. at p. 116.

- Gram negative septicemia, secondary to decubitus ulcer or wound sepsis.
- Severe dehydration.
- Severe protein-calorie malnutrition.
- Septic shock.
- Gangrene.
- Osteomyelitis secondary to Stage IV decubitus ulcer.
- Gram negative septicemia, secondary to long term failures regarding urinary catheter (e.g., failure to appropriately monitor and change urinary catheter).
- Gram negative septicemia, secondary to urinary tract infection or other localized sepsis.
- Aspiration/pneumonia.
- Gram negative or positive septicemia, secondary to pneumonia.
- Emotional trauma and distress arising out of inhumane conditions and care of a persistent and long-standing nature.[14]

[D] Injuries Precipitated by Medication Prescription and Administration Failures

Approximately 95 percent of all nursing home patients receive medication on a regular basis. The typical nursing home patient takes five to six medications daily. The over-use or under-use of certain medications can result in serious injury or death.

Drug-related injuries in a nursing home case are usually the result of: 1) inappropriate prescribing by the physician; 2) failure of the nursing home staff to follow physician's instructions by properly monitoring a specific aspect of the patient's condition prior to administering the medication in question; 3) administering medications to the resident despite the presence of adverse symptoms which require immediate physician notification; 4) over- or under-medicating the resident by the nursing home staff; or 5) administering Patient A's medication to Patient B. The

[14]The list of progressive-failure injuries set forth above is not intended to be all-inclusive. There are surely other injuries that might qualify for inclusion herein. This listing is intended only to identify the most common types of progressive injuries.

following list consists of drug-related injuries that commonly occur in a nursing home setting and are the subject of litigation.[15]

- Mental or physical deterioration secondary to inappropriate psychotropic medication administration.[16]
- Digoxin toxicity.
- Untreated congestive heart failure (such condition may be recognized by the following symptomology: edema, difficulty in breathing - especially in a prone position, chronic cough, swollen ankles, and/or bloated abdomen).
- Dilantin toxicity.
- Insulin shock/coma resulting from inappropriate administration of insulin.
- Improper antibiotic therapy resulting from: 1) the inappropriate prescription and continuation of a broad spectrum antibiotic coupled with the failure to obtain culture and sensitivity or the failure to track the effectiveness of the antibiotic; or 2) the failure to adjust the antibiotic therapy in response to the sensitivity report.
- Severe fall resulting from the failure to monitor the effects of any hypertensives and anti-arrhythmia drugs or from negligent use of psychotropic drugs.
- Hyperkalemia resulting from dehydration coupled with the use of any hypertensives, diuretics and/or potassium supplements.
- Any adverse drug reaction identified in the Physician's Desk Reference or product literature of the drug manufacturer.

[E] Injuries Precipitated by Untoward Incidents

A third category of injuries exists for the purposes of nursing home litigation. This category consists of injuries which can be causally linked to a singular event. In such cases, an efficient cause is said to exist. For example, in a case where a resident has

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[15]This listing is intended only to identify the most common types of drug-related injuries and is not intended to be an all-inclusive list.

[16]Examples of drugs which are sometimes inappropriately prescribed and administered are: Thorazine, Haldol, Valium, Librium, Lithium, Stelazine, Sinequan, Mellaril, Miltown and Serentil.

drowned in a whirlpool bath, the cause of death is clearly connected to a singular occurrence at a specific time. The time between the negligent behavior and the appearance of the full-blown injury is minimum. In contrast, in the case of a progressive injury such as a decubitus ulcer, the wound gradually evolves, and cannot be pinned down to a specific time.

In the former, the defense often asserts that the resident was psychologically dysfunctional to the point that he/she was impossible to monitor and control. Defense example:

> Patient John Doe was out of sight of nursing personnel for a mere 15 minutes, and subsequently was discovered floating face-down in the whirlpool bath. Defendant contends that it cannot assign a staff member to monitor each and every resident every second of the day. Consequently, the injury was not the fault of the nursing home staff, but rather resulted from the resident's unfortunate mental condition. John Doe was simply a time bomb waiting to go off.

In the latter progressive injury case, the defense often asserts that the complex medical history of the elderly resident, coupled with his/her age and deteriorating health status, was the true cause of the injury in question. The defense seizes upon the frail physical condition of the resident (as opposed to the mental condition), arguing that such condition preordained the occurrence, e.g. the Stage IV sore(s).

Thus the distinction between injuries identified hereinbelow from those contained in *[C] -- the progressive failure injury* -- stems not only from the the amount of time between the negligent behavior and the presence of the full-blown injury, but also the excuse typically offered by the defense to explain away liability.

Nursing home injuries precipitated by untoward incidents which are frequently the subject of litigation are as follows:

- Strangulation (e.g., strangulation resulting from the failure to either monitor restraints or the improper use or application of restraints such as posey restraints)
- Drowning
- Scalding
- "Wander-off" cases, wherein death or serious injury occurs after the resident has wandered away from the facility

- Falls and fractures resulting from the failure of nursing home staff to follow accepted protocols and implement necessary preventive measures[17]
- Rape and/or sexual assault
- Physical abuse and assault resulting in wounds, bruising or disfigurement[18]

§1.04 Key Damage Elements and Appraisal Questions

To restate the obvious, the damage elements which in large degree make up the bulk of the verdict in a significant personal injury case seldom contribute to the award for damages in a nursing home maltreatment case. Rare indeed, is the nursing home case where damages of a meaningful nature are recovered on the basis of future harm and pecuniary detriments occurring over the remainder of the resident's life.[19] Even more rare is the case where plaintiff resident has the capacity to generate earnings subsequent to admission to defendant facility. And of course, the most unusual case of all is one factually capable of supporting claims for both future medicals and lost income.

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[17]The occurrence of a fracture and subsequent failure to timely assess and recognize it may give rise to a *progressive failure* injury such as the case where patient Doe falls, sustains a fracture therefrom but is not X-rayed nor treated for the fracture, despite the presence of classic symptoms for eight days suggesting the occurrence of the same.

[18]It should be noted that the occurrence of one or more of the injuries contained in the above checklist does not absolutely guarantee the existence of a solid causal link. Counsel must not fail to factor into the evaluation the pre-existing condition defenses discussed below in Section 1.04C.

[19]The disease process and other debilitating factors underlying the condition of the nursing home residents, coupled with documentation in the patients nursing home chart stating "provide comfort as she prepares for death" or "unable to rehabilitate" severely weakens the probative value of any life expectancy estimate necessary to compute future damages.

See. BANDAZIAN V. CONVALESCENT SERVICES, INC., Richmond Circuit Court (VA) No. LJ742, where plaintiff, a 39-year-old brain-damaged man, received $802,000 after sustaining a broken leg (fall from bed). The settlement was designed to offset cost of full-time nursing care in the future.

Less than one-half of the twenty-nine damage elements presently recognized in most jurisdictions as being applicable to either a personal injury case, survival action or wrongful death action are *realistically* available to the nursing home resident injured as a result of the wrongful conduct of a long term care institution. [See below checklist.]

CHECKLIST OF DAMAGE ELEMENTS:[20]

A. Personal Injury or Survival Action[21]

☐ Lost Earnings
☐ Lost Earnings Capacity
☐ Past Loss of Value of Household Services
☐ Future Loss of Value of Household Services
☒x Past Medical Expenses
☐ Future Medical Expenses
☒x Past Physical Pain and Suffering
☐ Future Physical Pain and Suffering
☒x Past Mental Anguish
☐ Future Mental Anguish
☒x Past Disfigurement/Embarrassment
☐ Future Disfigurement/Embarrassment
☒x Past Physical Impairment
☐ Future Physical Impairment
☐ Past Loss of Consortium
☐ Future Loss of Consortium

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[20]Generally, the elements listed herein contain a a reference to "past" or "future" detriment. "Past" damage connotates the pre-trial timeframe which runs from the occurrence of the event made the basis of the lawsuit until the trial date. "Future" damage refers to the post-trial timeframe, which runs from the date of verdict to a future point in time. The maximum length of the future time frame is a function of the life expectancy of the victim.

[21]In a personal injury action, the injured nursing home resident may potentially recover all damages set forth hereinbelow except bystander damages which are awarded to a bystander as a consequence of the emotional trauma suffered from viewing the incident. In a survival action, the action arising out of a personal injury to the victim survives for the benefit of the estate. The estate may seek recovery for all damages hereinbelow set forth with the exception of: 1) bystander damages; and 2) in some jurisdictions punitive and damages for mental anguish. See generally, 1 AM JUR. 2D *Abatement, Survival, and Revival* .

☒x Loss of Mental or Intellectual Function[22]

☒ Bystander Mental Anguish for Personal Injury and Death

☒x Punitive/Exemplary

☒ Property Damages/Cost of Repairs

☒ WRONGFUL DEATH ACTION[23]

☒ Loss of care, support, services and contributions having a pecuniary value that would, in reasonable probability, have been provided by the deceased in the past.

☒ Loss of care, support, services and contributions having a pecuniary value that would, in reasonable probability, have been provided by the deceased in the future.

☒x Loss of love, affection, solace, comfort, companionship and society suffered in the past by surviving spouse or child.

☒x Loss of love, affection, solace, comfort, companionship and society to have been expected in the future by surviving spouse or child.

☒x Past mental anguish suffered by surviving spouse or child as a result of the death.

☒x Future mental anguish suffered by surviving spouse or child as a result of the death.

☒ Loss of inheritance: the amount that probably would have been added to the estate and probably left to spouse or child.

☒x Funeral expense.

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[22]In a case where plaintiff sustains brain damage which gives rise to the question of whether plaintiff could perceive pain and experience mental anguish, several courts have held that the loss of mental and intellectual function which precludes such "appreciation" is itself a separate element of damages. See, for example, WESTERN UNION TELEGRAPH CO. V. TWEED, 138 S.W.2d 1155, 1156, (Tex. Civ. App. - Dallas, 1911) rev'd on other grounds, 166 S.W. 2d 696 (Texas 1914).

[23]The items set forth hereinbelow constitute damages recoverable by the surviving spouse or descendant children under a wrongful death action. See generally, Sty, Damages and Recovery, §263-264; Smedley, *Order Out of Chaos in Wrongful Death Law*, 37 VAND. L. REV. 273; *Wrongful Death*, 22A AM JUR. 2D §1-542(1988).

Note that in addition to the above elements of recovery, punitive damages are recoverable in wrongful death actions in the following states: Alabama, Arizona, Arkansas, Florida, Idaho, Iowa, Kentucky, Massachusetts, Mississippi, Missouri, Montana, Nevada, New Mexico, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Texas, West Virginia, and Wyoming. See Ghiardi and Kircher, PUNITIVE DAMAGES L. P. PRAC. §5.19.

☒ Property Damage/Cost of Repair.

Those items checked above represent the relatively small subset of damages which are *commonly* recoverable[24] in an action arising out of personal injury or death of a nursing home resident. As a practical matter, however, only five of the twelve designated elements consistently bear substantial economic fruit: 1) claims for punitive damages; 2) claims for past mental anguish; 3) claims for past pain and suffering; 4) claims for past loss of love, affection, solace and companionship[25] on the part of statutory beneficiary of decedent resident; and 5) past medical expenses.

Due to the fact that the relationship between the deceased resident and the statutory beneficiaries is often at best tenuous, claims by the relatives of a nursing home victim for mental anguish and loss of society are frequently rendered suspect and inconsequential. Predictably, juries look with disdain on the claims of relatives who, for whatever reason, rarely visit the deceased.[26] Although there are exceptions to this general rule, such as the devoted wife or daughter who regularly attended to needs of a loved one in the convalescent facility,[27] attorney for plaintiff must be extremely cautious in projecting the damages that realistically are recoverable by reason of the emotional trauma inflicted upon beneficiaries of the deceased resident.

Furthermore, litigators must be cognizant of the fact that medical expenses subsequently occasioned by the wrongful conduct of the nursing home are often limited

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[24]Certain other damage elements may be available, depending on the facts of the case. This subset is intended to represent only those elements most frequently associated with substantial recovery by plaintiff against the long-term care facility.

[25]In a case where the life expectancy of the nursing home victim prior to the injury made the basis of the lawsuit is more than a few years, the damage elements consistently bearing economic fruit are expanded to include compensation for future losses and emotional and economic detriments.

[26]McMath, *The Nursing Home Maltreatment Case*, 21 TRIAL 52, (September 1985).

[27]See F. CAMPBELL V. PAYTON HEALTH CARE FACILITIES, Polk County Circuit Court, Florida, No. GCG-84,1170, (where jury awarded $500,000 for mental anguish suffered by wife of decedent in wrongful death action; and DSF, INC., V. MARY SUE SAGER, Los Angeles County Superior Court, California, Dept. No. 31, No. C449288, January 27, 1988 (where jury in a wrongful death action awarded daughter of decedent $185,000 for loss of her father's love, comfort, companionship, society and moral support and $5,800 for emotional distress resulting from her contemporaneous observations of defendant's negligent conduct.)

in scope. The failure of the nursing home to transfer an injured resident in need of medical attention to a hospital, coupled with the relatively short life expectancy of said resident frequently restrict the quantum of medical expenses.

As a consequence of these limitations, potential nursing home litigators should approach the issue of damage appraisal with the general view that claims[28] for punitive damages, mental anguish,[29] and pain and suffering represent the center of gravity of the case. Although other specific damages[30] may be available to plaintiff, in most cases, the final award will hinge upon this small core of elements. Accordingly, it follows that the key questions confronting one who seeks to determine the quantitative value of a nursing home maltreatment case are:

1. Based on the underlying facts, what is the probability that a jury will award punitive damages?
2. What sum of money is a jury likely to award to plaintiff resident against defendant nursing home as punitive damages?
3. Based on the underlying facts, what is the probability that a jury will award damages for the damages listed below?
   (a) Physical pain and suffering of the resident?
   (b) Mental anguish of the resident?[31]
4. What sum of money is a jury likely to award to plaintiff resident as fair and reasonable compensation for:

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[28]For reasons discussed above, claims brought by the injured resident or on behalf of said resident's estate are sometimes favored over wrongful death actions where statutory beneficiaries of decedent rarely visited decedent at the convalescent facility. See McMath, *The Nursing Home Maltreatment Case*, 21 TRIAL 52, (September 1985).

However, as stated previously, n. 17, in appraising the potential damages, counsel should be mindful that a close relationship between the decedent and the beneficiary may give rise to substantial damages for mental anguish and loss of familial relationship suffered by said beneficiary.

[29]For reasons discussed above, claims for mental anguish, pain and suffering by the resident are generally better received than those claims by relatives or beneficiaries for mental anguish.

[30]The elements of damages available to plaintiff are always a function of the underlying facts.

[31]Of course, if factually applicable, a third element should be included -- "(c) Medical Expenses."

(a) Pain and suffering of the resident?

(b) Mental anguish of the resident?[32]

5. Based on the underlying facts, what is the probability that a jury will award damages arising out of the wrongful death of the resident for elements listed below:

   (a) Loss of love, companionship, comfort, society and moral support suffered by statutory beneficiary?

   (b) Mental anguish suffered by statutory beneficiary?

6. What sum of money is a jury likely to award to the statutory beneficiary as fair and reasonable compensation for his/her:

   (a) Loss of love, companionship, comfort, society and moral support suffered by statutory beneficiary?

   (b) Mental anguish suffered by statutory beneficiary?

§1.05 Comparable Verdicts and Settlements

After having established the various elements of damages applicable in a nursing home maltreatment case, it is necessary to consider the amount of damages that can reasonably be expected for the type of injury suffered by the resident. One proven and frequently employed method in personal injury litigation for predicting the amount of damages a jury will likely award involves the use of comparable verdicts. By collecting and analyzing the damage awards rendered in comparable cases, i.e., cases where the injuries and facts giving rise thereto are similar in nature, litigators can substantially enhance their ability to calculate the probable verdict size. It has been shown through comprehensive studies that verdicts in personal injury cases generally follow patterns. Presented with similar injuries and supporting facts, juries tend to render remarkably consistent awards; significant deviations are infrequent, and for actuarial purposes, verdicts that deviate upward from the pattern tend to offset those that deviate downward.[33] There is no reason to believe that this tendency would be less

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[32]Ibid.

[33]6 AM JUR. TRIALS 984 citing *Liability Recovery Probabilities, Personal Injury Evaluation Handbook*, Jury Verdict Research Inc., (Cleveland, Ohio) v. 3, page 355.

pronounced in causes of action arising out of the neglect of a nursing home resident.[34] Accordingly, the verdict size in factually similar nursing home cases would appear to constitute a valuable yardstick for measuring the level of damages reasonably recoverable. Due to the limited amount of verdict data currently available in nursing home cases, it is readily conceded that the verdicts and settlements data will not support defendable statistical conclusions or actuarial inferences. Nonetheless, the reaction of both juries and insurance carriers to these distinguishable fact patterns provides the lawyer not only with an important indice for appraising the significance of a set of facts, but also a starting point for quantitatively assessing the value of a case.

§ 1.06 -- Causes of Action

[A] Negligence

The most common basis for imposing liability on a nursing home for the injury of its resident is the common law concept of negligence. Although a facility may be held liable under a variety of other theories,[35] negligence serves as the primary cause of action for plaintiffs in the majority of cases yielding large damage awards or settlements. To recover under this theory, plaintiff must establish: 1) that the nursing home and its employees were legally obligated to conform to a certain standard of conduct in caring for residents; 2) the applicable standard of conduct and its breach; 3) actual injury to the plaintiff; and 4) a causal connection between the breached standard of care and the complained-of harm.

1. FACT ISSUES

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[34]The applicability of this hypothesis is restricted in jurisdictions where: 1) punitive damages are not recoverable in wrongful death/survival actions; and 2) damages for pain and suffering/mental anguish are either capped by statute or limited by a ratio based upon the amount of pecuniary losses.

[35]See Neemore, *Applying Racketeering Laws to Nursing Homes*, 19 Clearinghouse Rev. 1306 (March, 1986); Johnson, Terry and Wolff, *Nursing Homes and the Law: State Regulation and Private Litigation,* §3-4, (Breach of Contract), and §3-9, (Assault and Battery); Neemore and Horvath, *Nursing Home Abuses as Unfair Trade Practices*, 20 Clearinghouse Rev. 801, (November 1986)

Under a theory of common law negligence, the critical issues for case appraisal purposes are as follows:

a. Did the nursing home fail to use ordinary care in providing for the needs of plaintiff/resident; that is, did it fail to do that which a nursing home of ordinary prudence would have done under the same or similar circumstances, or did it do that which a nursing home of ordinary prudence would not have done under the same or similar circumstances?

b. Was such negligence the proximate cause of the occurrence in question?

More specifically, the attorney must determine if: 1) the negligent conduct of the nursing home produced the complained-of event in a natural and continuous sequence, and without such conduct, such event would not have occurred; and 2) the act or omission complained of must be such that a nursing home exercising ordinary care would have foreseen that the event or some similar event might reasonably result therefrom. As is true in any case founded in negligence, the pivotal issue in a nursing home neglect case is the applicable standard of care by which the facility's conduct is to be measured. The law requires a nursing home to exercise that degree of skill and care which is expected of a reasonably competent nursing home in the same or similar circumstances.[36] In other words, a nursing home must provide reasonably competent health care to its patients.

2. VICARIOUS AND DIRECT CORPORATE LIABILITY FOR NEGLIGENCE

Generally speaking, the responsibility for a resident's injury or death arising out of the negligent conduct of an agent may be ascribed to the corporate nursing home owner or operator by way of two distinct but overlapping theories: 1) direct corporate liability; and 2) vicarious liability. Direct corporate nursing home liability is predicated on the idea that the long term care facility, as a separate entity, owes a direct non-delegable duty of care to its residents. If a breach of this duty proximately causes a patient's injury, the facility will be held directly liable, even though an employee within

[36]Alexander's Jury Instructions on Medical Issues (2nd ed.) INST8-1, 8-2, and 8-3; May v. Triple C Convalescent Centers, 19 WA App 794, 578 p. 2nd 541.

the facility's purview caused the actual injury.[37] At its most fundamental level, imposition of direct corporate nursing home liability depends upon two interrelated prerequisites: 1) definition of the duty owed by the facility to the patient; and 2) determination of the forms of evidence acceptable to define that duty.[38] Vicarious liability, on the other hand, does not presuppose that the nursing home owes its resident any independent duty of care. Under this theory, the facility may be held liable for injuries that others cause if a certain relationship is established between the institution and the person whose negligence proximately caused the injury.

The threshold question under this theory revolves around 1) the duty owed by the person whose substandard conduct caused the injury; and 2) such person's relationship to the facility.[39]

As a practical matter, the distinction between these two theories becomes blurred when plaintiff, as a part of his cause of action, draws a connection between the resultant harm and the failures of administrative personnel of the corporate entity and the high managerial agents to adequately discharge their supervisory responsibility (e.g., the failure of the Director of Nurses to adequately monitor nurses and nurse assistants; enforce patient care policies; and assure that sufficient nursing care was provided in quantity and amount to meet the needs of patients).

3. CHECKLIST OF MINISTERIAL OMISSIONS

The following ministerial omissions may serve as the basis for imposing liability on the corporate nursing home for negligence, regardless of whether the concept of direct corporate liability or the more prevalent theory of vicarious responsibility is employed.

- ☒ Failure to provide sufficient numbers of licensed nurses to meet the minimum requirement for licensed nurses established by law.

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[37]Hacker, Expansion of Health Care Provider's Liability: An Application of Darling to Long-Term Care Facilities 9 Connecticut Law Review, 462 (1977); Johnson, Terry and Wolff, Nursing Homes and the Law, Section 3-18 (Corporate Liability); Stogsdill v. Manor Convalescent Home, Inc., 35 Il App 3d 634, 343 NE 2d 589, (1976); Capital City Manor, Inc. v. Culberson, 613 S. W. 2d 835 (Ark. Ct. App - 1981).

[38]Purdue, *The Law of Texas Medical Malpractice*. 22 Hous.L.Rev.1, 280 (2nd ed., 1985) at pages 10-12 and 80.

[39]Id. at p. 154.

☒ The failure to provide nurses and nurse's assistants sufficient in number to provide 24-hour nursing service to the residents so as to assure that said resident received treatment, medication and diet as prescribed by his or her attending physician.

☒ Failure to provide nurses and nurse's assistants sufficient in number to provide proper care to said resident so as to keep him/her clean and comfortable and to prevent the formation of decubitus ulcers, lesions and sores on the body of said resident.

☒ The failure to provide sufficient non-attendant personnel, to wit: laundry personnel on duty to keep an adequate supply of clean linens for the care of said residents.

☒ Failure to provide 24-hour nursing service seven days a week, adequate in quality and amount, to assure that the resident receives, in accordance with the mandate set forth in federal law, state law, and the nursing home policy and procedure manual, the following care:

- Adequate water, fluids, nutrition and therapeutic diet.
- Adequate skin care, turning and repositioning so as to prevent the formation of decubitus ulcers, lesions and sores on the body of said resident.
- Adequate sanitary care, cleansing after each incontinent episode and changing of said resident's bed linen as needed so as to prevent urine and fecal contact with his or her skin for unsafe periods of time.
- Adequate examination and assessment by nursing home personnel for skin breaks and decubiti so as to timely and adequately intervene in order to prevent the formation of ulcerated, pus-infiltrated, festering and necrotic lesions on the body of said resident.
- Adequate examination and assessment by nursing home personnel of decubitus and open sores so as to timely and adequately intervene to prevent the systemic invasion of bacteria into the bloodstream of said resident.

- Adequate nursing care for decubitus after development.
- Observation and examination of the responses, systems and progress of the physical condition of said resident.
- Notification of the attending physician of said resident of significant changes concerning resident's physical condition and concerning persistent unresolved problems relating to the care and physical condition of said resident.
- Adequate and sanitary catheter care so as to prevent urinary tract infections.
- Timely and adequate nursing intervention to alleviate pain and suffering of the resident.
- Timely and adequate nursing intervention to alleviate edema, swelling and accumulation of excessive fluids developed by the resident.
- Adequately trained and qualified nurses and nurses assistants to administer to the nursing needs of said resident and to protect said resident from injury.
- Objective evaluation by nursing home personnel of the health status of said resident by frequent monitoring of temperature, pulse, respiration, blood pressure and weight.
- Objective evaluation of the health status of said resident through acquisition and submission of laboratory specimens obtained from said resident as ordered by his or her attending physician.
- Nursing plan of care as required by state and federal law, based on the needs of said resident at the time of admission to the facility.
- Nursing plan of care revisions and modifications as the need of said resident changed.

- The failure to provide sufficient quantities and quality of food, nutrition, medications, nursing supplies, linen, bandages, catheters, catheter irrigation supplies, heat lamps, egg crate mattresses, sheep skins, soap and

rubber gloves to enable the nursing home staff to assure that the needs of said resident were met.

- The failure to adequately assess, evaluate, and supervise registered nurses, licensed vocational nurses, nurse assistants, medications assistants, dietary personnel or laundry personnel in said facility so as to assure that said resident received care in accordance with the nursing home's policy and procedure manual and state and federal law.

- The failure of high managerial agents and corporate officials to adequately assess, evaluate and supervise the administrator and director of the nursing home and the director of the nursing home so as to assure that the resident received care in accordance with the nursing home's policy and procedure manual and state and federal law.

- The failure of high managerial agents and corporate officials, including the administrator and director of nurses, after receiving notice that patients accepted for care in the nursing home were not receiving needed care in accordance with the nursing home's policy and procedure manual and state and federal law, failed to recommend direct action and implement strategy designed to correct known deficiencies and prevent their future occurrence.

- Failure to report and document, in said resident's medical record, the resident's symptoms, responses and progress.

- Failure to affect the transfer of said resident to a hospital when said resident developed symptoms, conditions and illnesses beyond the treatment capabilities of the nursing home.

- Failing to report, as required by state law, that residents at the facility had been abused and neglected prior to and during plaintiff's residency.

[B] Negligence Per Se

The unexcused violation of a legislative enactment or an administrative regulation, which is designed to prevent injury to a class of persons to which the injured party belongs, is negligence per se[40].

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[40]DUSINE V. GOLDEN SHORES CONVALESCENT CENTER, INC., 249 SO.2D 40 (FLA. APP. -- 1971).

Under the doctrine of negligence per se, courts use a statute, ordinance or regulation as a legislatively-mandated standard of conduct; that is, as a definition of what a reasonably prudent person would do in a particular situation. If a legislative pronouncement covers the fact situation of a case, the trier of fact is not asked to judge whether the defendant acted as a reasonable and prudent person acted under the same or similar circumstances. Instead, the legislature is deemed to have prescribed, as a matter of law, what a reasonably prudent person would have done. Unless the defendant proves some legally recognizable excuse, the only inquiry for the trier of fact is whether the defendant violated the statute, ordinance, or regulation and whether this violation was the proximate cause of the accident.[41]

In the wake of persistent quality of care problems for the last three decades in America's long term care facilities, federal and state governments have created a myriad of regulations and statutory duties governing the care provided to residents in long term care facilities. These regulations are designed to assure that patients receive safe and adequate care. Failure on the part of the nursing home to conform to such legislative and administrative standards subjects the non-compliant facility to a variety of regulatory sanctions, including: 1) loss of license to operate; 2) loss of federal and state Medicaid revenues; 3) loss of right to participate as a provider in the Medicaid program; and 4) fines for violation of regulations. Without question, these statutes and regulations are designed to protect a class of persons, of which the resident is a member, from the type of injury or hazard created by the violation of such statute or regulation. Accordingly, liability in a nursing home case may be predicated upon a finding, by the trier of fact, that defendant nursing home violated a state or federal long term care regulation or statute.[42] Rather than quibbling over the appropriate standard of care by which to judge defendant's conduct, plaintiff is entitled to frame the charge submitted to the trier of fact in terms of whether the defendant nursing home failed to comply with the applicable rules and regulations.

With respect to this theory, two additional points should be noted. First, although violation of a standard of care borrowed from a legislative enactment is negligence per se, the converse is not necessarily true. The fact that a statute was

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[41]Edgar and Sales, *Torts and Remedies*, Section 1.05 (Negligence Per Se) (Supp 1988).

[42]DUSINE V. GOLDEN SHORES CONVALESCENT CENTER, INC., 249 So2d 40 (Fla. App-1971).

complied with is not an absolute defense to an ordinary negligence action[43]. Compliance with a statute does not prove a lack of negligence.

A statutory provision or regulation is usually considered a minimum standard, and tort law may impose a higher standard under some circumstances. For example, a nursing home was sued for allowing an elderly patient to wander onto the highway and cause an accident in which both the patient and a motorist were injured. The nursing home attempted to argue that its conduct was not negligent because it complied with the Texas Department of Health's minimum licensing standards for nursing homes. The court ruled that compliance with such regulations was irrelevant, and that excluding the regulations from evidence would be, at most, a harmless error. Compliance with such regulations would not have precluded a finding of negligence.[44]

Secondly, long before plaintiff's attorney first interviews his or her client in a nursing home case, substantial evidence of statutory and regulatory violations may have already been documented in the form of investigative and surveillance reports by state and/or federal nursing home inspectors. Characteristically, such findings form an integral part of a significant nursing home maltreatment case.

[C] New Theories of Recovery

Commonly, the defense in the nursing home maltreatment case is founded upon the hypothesis that any harm or injury complained of was the inevitable result of the resident's deteriorating condition and a natural and unpreventable part of the dying process. As a consequence thereof, plaintiff is forced, as part of its case, to unravel the harm caused by neglect from that caused by the underlying disease processes (present at the time the plaintiff resident was admitted to defendant nursing home). Many practitioners are reluctant to shoulder such a burden, even in cases where considerable evidence of substandard care exists. Fearing that defendant can produce more expert testimony from more credible sources than plaintiff, potential actions are regularly rejected on the basis that the nursing home victim is without a viable theory of recovery

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[43]*see* GOLDEN VILLA NURSING HOME, INC. VS. SMITH, 674 S.W.2d 343, 348-349 (Tex. App. -- Houston [14th Dist.], 1984, ref. n.r.e.)

[44]*see* GOLDEN VILLA NURSING HOME, INC. V. SMITH, 674 S.W.2d 343, 348-349 (Tex. App. - Houston [14th Dist], 1984, ref. n.r.e.)

that will yield damages substantial enough to compensate the lawyer for his time and resource investment.

Currently, the aforementioned rationalization for rejecting a potential case is being eroded by new remedies afforded to plaintiff under a theory of: 1) violation of unfair and deceptive trade practices act, and 2) tort or breach of good faith and faith dealing duty occasioned by the contractual relationship between plaintiff as a Medicaid recipient and defendant as a Medicaid provider.[45]

These relatively new and evolving theories permit plaintiff to recover for mental anguish, pain and suffering upon a showing that defendant's statutory violation or breach of good faith and fair dealing duty proximately caused (or were the producing cause) of the foregoing conditions. In addition thereto, under an action based on the deceptive, false and misleading practices of defendant nursing home, plaintiff may recover attorney's fees from defendant if he or she prevails. Furthermore, upon showing that defendant's acts or omissions were the result of a conscious indifference to the rights or welfare of the nursing home resident, or was knowingly committed (under the unfair deceptive trade practice statutes), plaintiff may recover punitive damages.

These theories and their respective benefits are generally discussed below.

1. DECEPTIVE TRADE PRACTICE

In addition to common law negligence as a theory of recovery, plaintiff also might consider an alternative cause of action based on the nursing home's false, misleading and deceptive representations as to the quality of care and services provided by said facilities. Since the late 1970s, several state attorneys general have successfully used unfair and deceptive trade practices or consumer protection laws to enjoin a variety of nursing home practices. Such practices as providing substandard care and abusing residents[46] have been the subject of these cases. The emergence of this species

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[45]Such theory is also applicable in a case where plaintiff is a private-pay patient.

[46]For an excellent source manual, see *Unfair and Deceptive Acts and Practices* Cumulative Supplement 1988, National Consumer Law Center, 11 Beacon Street, Boston Massachusetts, 02108.

Belmont Laboratories v. FTC, 103 F2d 538 (3rd Cir 1939; Commonwealth v. Hush-Tarc Industries, Inc., No. 305 CD.1970, Clearinghouse No. 26025 P.A. Commu. Ct. Dec. 22, 1971; (concerning the credulousness of sufferers of disease).

of enforcement litigation, coupled with the development of a general body of unfair and deceptive acts and practices (UDAP) law, provides theories and rationales for private litigants to apply to nursing home practices. Presently, in most jurisdictions, a variety of UDAP statutes offer consumers protection in connection with transactions involving goods or services.[47] These statutes generally prohibit conduct that is deceptive, and the deception standard is much broader than that required for common law fraud. Often the "tendency to deceive" is sufficient to meet the statutory prohibition.

While many statutes enumerate specific proscribed activities, almost all also contain more general prohibitions against deceptive, unfair or unconscionable acts.[48] It is this general language that may provide a cause of action for nursing home residents.[49]

Evidence of document falsification and misleading advertisements are commonly present in nursing home cases that produce large settlements or verdicts. Indeed proof that the quantity of care services charted in patients' nursing home records were over-represented and that the resultant clinical conditions were under-represented is often essential to establishing liability under a theory of negligence. When the blanks in the nursing home treatment record have been routinely and blindly filled in by nursing home employees without regard to the actual provision of services to patients, the success of plaintiff's lawsuit often hinges upon the advocates ability to destroy the credibility of the nursing home record and the representations contained therein.

If successful in their task, the potential of not only imposing liability upon defendant nursing home but also obtaining a sizeable recovery increases dramatically. When proof of these false and misleading representations is contrasted against a background of lofty and inflated claims by the facility of "high-quality care rendered by

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[47]Nursing home residents and their families, due to the resident's physical or mental condition, his or her frailty and the general stressfulness of the nursing home placement process on all family members, should be considered such vulnerable consumers.

[48]Neemore and Horvath, *Nursing Home Abuse as Unfair Trade Practices*, 20 Clearinghouse Review (November 1986).

[49]Unfair and Deceptive Acts and Practices statutes are generally subject to liberal interpretations as remedial legislation, and practices that may otherwise be lawful are scrutinized more closely when used on especially vulnerable consumers.

experienced professionals" (as typically found in the yellow pages advertisements; nursing home brochures; certifications made by the facility as a condition for Medicaid payment; patient bill of rights; billboards and radio spots) a formidable case is presented.

The aggravated and inflationary nature of these misrepresentations is potentially so strong that plaintiff may be in a position to obtain a substantial recovery under a deceptive practice theory, even if unable to establish the causal connection between the nursing home's failures and the resident's severe injury or death required in a negligence action. Under the former theory, the inability of plaintiff to link the deceptive acts of defendant to a personal injury or death would not serve as a legal or factual bar to the recovery of actual damages, based upon plaintiff's lost benefit of the bargain, mental anguish, pain or suffering or punitive damages arising out of the conscious indifference of defendant.

2. TORT LIABILITY FOR BREACH OF A GOOD FAITH AND FAIR DEALING DUTY

Typically, the admission to a nursing home of a patient eligible for Medicaid benefits is occasioned by creation of two contracts: 1) a contract between the resident and the facility wherein the resident agrees to pay on a monthly basis his or her social security income[50] to the facility in return for shelter and care; and 2) a contract between the facility and the state Medicaid agency wherein the facility agrees to provide care to said resident in accordance with specific standards prescribed by federal and state laws in return for a Medicaid reimbursement.[51] Under the latter agreement, the resident becomes a third party beneficiary of obligations and covenants flowing between the facility and the state Medicaid agency.

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[50]Generally, the agreement obligates resident to pay to the facility all but $25.00 of his or her monthly social security checks.

[51]Although each state administers the Medicaid program, both the state and federal government contribute dollars under the Medicaid assistance acts. These obligations and covenants emanate from a provider contract executed by the state and facility at the time said facility was certified to participate as a provider in the Medicaid program. Such contract which pertains to the future performance of services is renewed on an annual basis and is applicable to all Medicaid recipients cared for at the nursing home. As a consequence, the obligations contained therein cover every Medicaid recipient admitted to the facility after date of execution.

From these contractual relationships grows an implied duty of good faith and fair dealing owed by the nursing home to residents in connection with the provision of care. Conceptually, this duty is quite simple. It requires: 1) diligent performance by the facility of its service obligation under the contract, consistent with the justified expectations of residents and the state Medicaid agency;[52] 2) faithfulness to the agreed common purpose of the contract;[53] or 3) that the nursing home not impair the rights of residents to receive the benefits of the agreement.[54]

The breach of this duty may serve as the basis for improving liability sounding not only in contract but, more importantly, in tort.[55] Under the latter doctrine, the duty of good faith and fair dealing is seen as unconditional and independent of the contractual obligations. Therefore, a breach of such duty gives rise to an independent

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[52]Restatement (Second) of Contracts §205 (1979).

[53]Id.

[54]Comment, A New Tort for Texas: Breach of the Duty of Good Faith and Fair Dealing 18 St. Mary's L.J. 1295, 1304-1305 (1987). *See* Generally Burton, Breach of Contract and the Common Law Duty to Perform in Good Faith, 94 Harv. L. Rev. 369, 370-71 (1980) (concept of good faith is license for judicial intervention to protect reasonable expectations of parties); Summers, The General Duty of Good Faith -- Its Recognition and Conceptualization, 67 Cornell L. Rev. 810, 812 (1982) (good faith concept is tool to redeem bad faith not remedied under traditional contract theory; Burton More on Good Faith Performance Contracts; A Reply to Professor Summers, 69 Iowa L. Rev., 497, 502 (1984).

[55]See generally, Comment, Tort Remedies for Breach of Contract: The Expansion of Tortious Breach of the Implied Covenant of Good Faith and Fair Dealing into the Commercial Realm, 86 Colum. L. Rev. 377, 380 (1986) (good faith and fair dealing covenant has introduced a modicum of morality into contract law); Note, Extending the Bad Fair Tort Doctrine to General Commercial Contracts, 65 B.U.L. Rev. 355 (1985); Comment, A New Tort for Texas: Breach of the Duty of Good Faith and Fair Dealing, 18 St. Mary L.J. 1295.

action in tort[56] which subjects the offending party to the full spectrum of tort damages, including exemplary damages and damages for mental anguish.

A major stumbling block in understanding the case law on the duty or covenant of good faith and fair dealing is determining whether the court is referring to an implied covenant in contract or a tort duty implied by law. Presumably, remedies in the first situation would be limited to contract damages, while the second could give rise to tort liability, including punitive damages. Unfortunately, the courts have not made their holdings on this subject very clear. In Communale v. Traders & General Insurance Co., 50 Cal. 2d 654, 328 P.2d 198 (1958), one of the seminal cases in the area of good faith and fair dealing in California, the court stated: "There is an implied covenant of good faith and fair dealing in every contract...." It is apparent from language in the opinion, however, that the court did not view the insurance company's conduct as a breach of a contractual obligation, but rather as a breach of a duty in tort. Other courts have referred to a breach of the duty as a "tortious breach of contract." The Supreme Court of Wisconsin addressed this misnomer in Anders v. Continental Insurance Co., 85 Wis. 2d 675, 271 NW2d 368 (1978**):**

> "While that term may be a convenient shorthand method of denominating the intentional conduct of a contracting party when it acts in bad faith to avoid its contract obligations, it is confusing and inappropriate because it could lead one to believe that the wrong done is the breach of the contract. It obscures the fact that bad faith conduct by one party to a contract toward another is a tort separate and apart from a breach of contract per se and it fails to emphasize the fact that separate damages may be recovered for the tort and contract breach."[57]

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[56]The many states that have adopted a cause of action in tort for bad faith breach of duty arising out of a court's actual relationship have established standards that are sui generis to their own situations. Some common elements, however, do transcend the geopolitical differences. First, plaintiff would need to establish the duty arising out of the contractual relationship, whether the connection be direct or as a third-party beneficiary. Second, he or she would have to show an absence of a reasonable basis for failing to faithfully provide the justifiably expected services. Implicit in any standard would be a showing of the defendant's conscious indifference to the rights and welfare of individuals to whom defendant was obligated. Finally, any test would need as its basis an objective standard for review. Anderson v. Continental Ins. Co., 82 Wis.2d 675, 271 NW2d 368 (1978); Massey v. Armco Steel Co. 635 S.W.2d 596 (Tex. Civ App. 14 Dist -- 1982)

[57]Id., 271 NW2d at 374.

Regardless of the language used or the jurisdiction involved, most discussions of the duty of good faith and fair dealing appear to assume that the duty is one in tort when a "special relationship" exists between the parties. See Aetna Casualty & Surety Co. v. Broadway Arms Corp., 664 S.W.2d 463 (Ark. 1984); National Savings Life Insurance Co. v. Dutton, 419 So.2d 1357 (Ala. 1982); Anderson v. Continental Insurance Co., 271 NW2d 368 (Wis. 1978); Gruenberg v. Aetna Insurance Co., 9 Cal. 3d 566, 108 Cal. Rptr. 480, 510 P.2d 1032 (1973).

That special relationship either arises from the element of trust necessary to accomplish the goals of the undertaking, or from the huge disparity in bargaining power between the parties.[58] Both of these events are plainly present in the special relationship existing between resident and nursing home. Accordingly, the failure on the part of the facility to exercise its broad discretion in matters pertaining to the case of frail and debilitated residents in a manner consistent with their health, safety and best interest would appear to be actionable under the tort doctrine of breach of a good faith and fair dealing duty. Under such theory, proof of these ministerial omissions specifically set forth in the *Checklist of Omissions* above, or the false, misleading and deceptive practices will convincingly support a finding of such breach.

§1.07 Conclusion

In the not too distant past, malpractice cases involving long term care residents generated little interest on the part of the legal profession. Despite the fact that voluminous investigative reports had chronicled an epidemic of widespread neglect, recurrent physical abuse, and abysmally poor care in America's long term care institutions for over two decades, and despite the fact that complaints by family

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[58]See, e.g., Commercial Cotton Co. v. United Cal. Bank, 209 Ca. Rptr. 551, 554 (Ct. App. 1985) (bank depositor relationship is "at least quasi-fiduciary" entailing good faith duties); Gates v. Life of Mont. Ins. Co., 668 P.2d 213, 214 (Mont. 1983) (employment relationship parallels insurance relationship requiring implied tort duties of good faith and fair dealing); Hoskins v. Aetna Life Ins. Co., 452 N.E.2d 1315, 1319 (Ohio 1983) (the special nature of the relationship existing between the insurer and its insured necessitates good faith requirements); Nicholson v. United Pac. Ins. Co., 710 P.2d 1342, 1348 (Mont. 1985); Bay Point Mortgage v. Crest Premium Real Estate Investment Retirement Trust, 168 Ca. App. 3d 818, 214 Ca. Rptr. 531 (1985); Commercial Cotton Co. v. United California Bank, 103 Cal. App. 3d 511, 209 Cal. Rptr. 551 (1985); Schweiso v. Williams, 150 Cal. App. 3d 846, 198 Cal. Rptr. 238 (1984); Cleary v. American Airlines, 111 Cal. App. 3d 487, 168 Cal. Rptr. 722 (1980).

See, Comment, New Tort for Texas: Breach of the Duty of Good Faith and Fair Dealing 18 St. Mary's L.J. 1295, 1309.

members to lawyers about such care abounded, civil litigators were unenthusiastic about these cases. Perceived by practicing lawyers as extremely difficult cases due to the absence of provable lost income and the presence of complex medical histories presented by the alleged victims, geriatric residents had virtually no recourse against a nursing home or its employees for neglect or abuse.

In recent years, however, as the standard of care in nursing home has escalated by reason of upgraded regulations and legislative enactments; as the number and amount of exemplary damage awards and awards for pain, suffering, and mental anguish in tort cases has radically increased throughout the country; and as lawyers have realized that when the egregious and deviant behavior of nursing home employees and/or operators is combined with the magnified vulnerability of the nursing home resident, a case capable of yielding significant damages for pain, suffering, mental anguish and punitive damages is produced; the legal community has reassessed its earlier position.

Undoubtedly fueling this evolutionary process is the continual flood of profoundly disturbing exposes, studies, and investigations dealing with the hazardous and life-threatening conditions that many nursing home residents frequently encounter. Typically, these reports conclude, as did the Institute of Medicine, that:

> Today, nursing homes can be found in every state that provide seriously inadequate quality of care. In many government-certified nursing homes, individuals who are admitted receive very inadequate -- sometimes shockingly deficient -- care that is likely to hasten the deterioration of their physical, mental, and emotional health.[59]

Such reports have galvanized public concern for the quality of care provided the aged; increased the likelihood that residents and family members in cases where elder malfeasance is suspected will seek the advice and/or legal assistance of an attorney; and created a substantial degree of bias in potential jury pools in most jurisdictions. Not surprisingly, long term care facilities have become, in the mind of the general public, symbols of abandonment, isolation, and neglect. Awakened to the foregoing realities, and fearful of a jury whose preconceived notion of nursing home care may be aggravated by the events and evidence described in §1.06 [Summary of Factors

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[59] *Improving the Quality of Care in Nursing Homes, Appendix A.* 239-253. National Academy of Science, Institute of Medicine, Committee on Nursing Home Regulation. 1986.

Influencing the Size of Verdict or Settlement], insurance carriers and defense attorneys have begun to pay careful attention to allegations of substandard care. No longer are these suits merely assigned a nuisance value. Today, the nursing home maltreatment case represents a substantial threat to the economic viability of a long term care institution who maintains first dollar insurance coverage or carries no excess policy, or alternatively to the pocketbook of the insurance carrier, who is responsible for such coverage.

Concomitantly, a heightened awareness to the effects of iatrogenic and nursigenic[60] behavior and increased interest in litigation arising therefrom has emerged within the plaintiff's bar. Such interest heralds the arrival of a new legal frontier. The skeleton which long has existed in the proverbial nursing home closet has emerged and entered the courtroom. It is this author's sincere hope that the materials contained herein will prove beneficial to the medical profession in its efforts to promote risk management and quality assurance in the nursing home environment.

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[60]For a proposed definition of nursigenic, see Miller, M.: Iatrogenic and Nursigenic Effects of Prolonged Immobilization of the Ill Aged, *Journal of American Geriatric Society*, 1975; Volume 23, pages 360-369. "...in a variety of dictionary and word sources, terminology identifying a nurse-induced abnormal state in a patient by inadvertent or erroneous treatment is singularly lacking. In the absence of a suitable word, we propose the term 'nursigenic' derived from the French 'inourric' for nurse."