COMMENTS

"NOWHERE TO GO AND CHOSE TO STAY": USING THE TORT OF FALSE IMPRISONMENT TO REDRESS INVOLUNTARY CONFINEMENT OF THE ELDERLY IN NURSING HOMES AND HOSPITALS

CATHRAEL KAZIN†

INTRODUCTION

As a nation, we are often sentimental about the old in the abstract but contemptuous of them in practice.[1] Our ambivalence about the elderly can be seen at every point on a wide spectrum, ranging from humor to discrimination in housing and employment. Inadequate health care[2] and deplorable conditions in many of the nation's nursing homes[3] are among the most obvious manifestations of our collective

---

† A.B. 1976, Smith College; Ph.D. 1983, Cornell University; J.D. Candidate 1989, University of Pennsylvania.

[1] In many ways, America's attitude toward its elderly mirrors its attitude toward its young: There is an enormous gap between the ideology of care and actual support and resources. The widespread incidence of child abuse has been increasingly acknowledged and documented, and, in part as a consequence, abuse of the elderly has begun to be more fully recognized and documented. Interestingly, legislation aimed at curbing abuse of the elderly has been modeled on anti-child abuse legislation. *See* Comment, *A Critical Analysis: The Patient Abuse Provisions of the Missouri Omnibus Nursing Home Act,* 24 ST. LOUIS U.L.J. 713, 713 (1981) (comparing the Missouri Omnibus Nursing Home Act, MO. REV. STAT. §§ 198.003 to 198.186 (Supp. 1980) with the Missouri Child Abuse Statute, MO. REV. STAT. §§ 210.110 to 210.165 (1978)).

[2] "Therapeutic nihilism" pervades institutionalized health care for the elderly and makes it more likely that they will receive only custodial care rather than treatment. *See* J. KRAUSKOPF, ADVOCACY FOR THE AGING § 3.1, at 30 (1983); *see also* M. KAPP, PREVENTING MALPRACTICE IN LONG-TERM CARE 68 & n.2 (1987) (many physicians' distaste for chronic care, especially of the elderly, is a significant factor in the medical neglect of nursing home residents); Horstman, *Protective Services for the Elderly: The Limits of Parens Patriae,* 40 MO. L. REV. 215, 234 (1975) ("[M]ost institutionalized elderly are doomed to receive only custodial care.").

[3] As of 1974, the government estimated that half of the nursing homes in the United States were "substandard." *See* SUBCOMM. ON LONG-TERM CARE OF THE 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 AN EXAMINATION OF THE ROOTS OF CONTROVERSY 205-209 (Comm. Print 1974) [hereinafter SENATE REPORT]. But nursing homes do not have to fall below certifiable standards to be damaging to their residents: "They have been described as 'Houses of Death,' 'concentration camps,' 'warehouses

abandonment of many elderly Americans.

These conditions have been widely noted and decried, but the problems remain despite reformist legislation[4] and a number of legislative subcommittee reports.[5] Our paradoxical attitude toward the elderly helps explain, in part, why the conditions persist. Although the fear of "ending up" in a nursing home against our will is probably universal, the dumping of the elderly in hospitals and nursing homes remains a pressing and generally unrecognized problem despite some significant statutory protections.[6]

One factor that may contribute to the problem is our sense that it is inevitable.[7] Many of us simply accept that to become old is to become institutionalized and imprisoned. "Residents of nursing homes are literally captive and at the mercy of the institutions wherein they reside . . . ."[8] This is business as usual, and our law reflects the norm.[9]

---

for the dying.' It is a documented fact that nursing home residents tend to deteriorate, physically and psychologically, after being placed in what are presumably therapeutic institutions." B. VLADECK, UNLOVING CARE: THE NURSING HOME TRAGEDY 3 (1980) (citations omitted).

[4] The regulation of nursing homes is outside the scope of this Comment. It is relevant to note, however, the increased importance of state regulation, which in turn is heavily influenced by federal statutes. This influence is reflected in the inclusion in state nursing home statutes of residents' bills of rights and anti-fraud provisions, both of which were first developed in the federal Medicare system. *See* S. JOHNSON, N. TERRY & M. WOLFF, NURSING HOMES AND THE LAW: STATE REGULATION AND PRIVATE LITIGATION § 1-1, at 2 (1985) [hereinafter S. JOHNSON].

[5] *See, e.g.,* SUBCOMM. ON LONG-TERM CARE OF THE SENATE SPECIAL COMM. ON AGING, 93D CONG., 2D SESS., NURSING HOME CARE IN THE UNITED STATES: FAILURE IN PUBLIC POLICY, INTRODUCTORY REPORT 1 (1974) [hereinafter SENATE INTRODUCTORY REPORT] ("[I]n an alarming number of known cases [nursing home residents] have actually encountered abuse and physical danger, including unsanitary conditions, fire hazards, poor or unwholesome food, infections, adverse drug reactions, overtranquilization, and frequent medical errors."); SENATE REPORT, *supra* note 3, at 205 (stating that more than half of United States nursing homes are substandard).

[6] Federal statutes and regulations afford some protection. *See, e.g.,* 42 U.S.C. § 1395x(j) (1982 & West Supp. 1988) (delineating requirements for skilled nursing facilities); 42 C.F.R. §§ 442.200 to 442.202 (1987) (same); *see also* 42 U.S.C. § 1396d(c) (1982 & West Supp. 1988) (delineating requirments for intermediate care facilities); 42 C.F.R. §§ 442-250 to 442.346 (1987). State legislatures have also responded to the need for higher standards of care. *See, e.g.,* MICH. COMP. LAWS ANN. § 333.20201 (West 1980 & Supp. 1988); *see also* Comment, *Michigan's Nursing Home Reform Law,* 13 U. MICH. J.L. REF. 661, 668 (1980) (discussing the criminal sanctions for violating Michigan's nursing home reform law); *infra* notes 24-28 and accompanying text (discussing state statutes granting patients private rights of action against nursing homes).

[7] *Cf.* SENATE INTRODUCTORY REPORT, *supra* note 5, at 11 ("Individuals with multiple disabilities and advanced age are likely candidates for institutionalization.").

[8] Butler, *A Long-Term Health Care Strategy for Legal Services,* 14 CLEARINGHOUSE REV. 613, 641 (1980).

[9] *See infra* notes 29-39; *see also* Butler, Book Review, 55 N.Y.U. L. REV. 998, 1037 (1980) (reviewing B. VLADECK, *supra* note 3) ("Our society often prefers the rights of private citizens and businesses over the rights of those for whom government

This Comment argues that courts can use the tort of false imprisonment to ensure that senior citizens confined to nursing homes or hospitals are not confined against their will. Elderly nursing home patients remain without rights to self-determination despite the protections accorded two other groups: persons civilly committed in psychiatric hospitals and those subject to guardianship proceedings. Although both the commitment and guardianship processes are fraught with abuses, the legal system has at least recognized the potential problems and has responded accordingly.[10]

Indeed, many senior citizens who may not have been *technically* "committed" to a nursing home are, nonetheless, *constructively* committed. While the law recognizes the right of a guardian to place an unwilling person in a nursing home, even a guardianless old person may, through circumstances beyond her control, find herself unwillingly confined to a nursing home, without clearly defined legal remedies.

This Comment explores the current and potential use of the tort of false imprisonment to redress the elderly patient's lack of rights. It will argue that the overarching problem—the dumping of elderly patients in hospitals and nursing homes—needs to be set against a larger social and political backdrop, and legal solutions need to be placed in context. Specifically, this Comment contends that the disparity in status and resources between the average elderly patient who is unwillingly confined in a nursing home and the nursing home in which she resides places her in constructive or de facto confinement. We should recognize this confinement as equivalent to de jure commitment and grant concomitant recognition and procedural protection.

I. The Problem

A. *Conditions and Demographics*

Conditions in nursing homes have been widely studied and frequently decried.[11] It is worth considering the demographics of the pop-

---

has assumed direct responsibility.").

[10] *See, e.g.,* Vitek v. Jones, 445 U.S. 480, 491 (1980) (civil commitment constitutes a "massive curtailment" of a fundamental right); Big Town Nursing Home, Inc. v. Newman, 461 S.W.2d 195, 197 (Tex. Civ. App. 1970) (finding nursing home guilty of falsely imprisoning elderly plaintiff). *See generally* Annotation, *False Imprisonment in Connection with Confinement in Nursing Home or Hospital,* 4 A.L.R.4th 449 (1981).

[11] *See, e.g.,* Senate Introductory Report, *supra* note 5, at III (calling nursing home care "the most troubled and troublesome component of our entire health care system"); Comment, *Nursing Home Access: Making the Patient Bill of Rights Work,*

ulation: there are nearly 1.5 million nursing home residents. The average nursing home resident is eighty-two years old, female, and widowed with no viable relationships except a collateral relative of approximately the same age. She does not have many visitors and suffers from chronic or crippling diseases and some degree of mental impairment. She cannot walk and needs help to take a bath and get dressed. She is afraid. Only four to nineteen percent of people who enter nursing homes get out alive.[12]

The fact that most residents receive no visitors[13] underlines their essential isolation and lack of access to legal help.[14] Additionally, many nursing home patients are chronically overmedicated,[15] which may undermine a patient's successful opposition to guardianship or commitment proceedings.[16]

B. *Warehousing of the Elderly*

Psychiatric hospitals clearly have been abused as a means of dealing with old people who are unwanted by their families or who do not

54 U. DET. J. URB. L. 473, 474 (1977) ("Nursing home residents are often abused, and this abuse has been well documented.").

[12] *See* Johnson, *Nursing Home Receiverships: Design and Implementation,* 24 ST. LOUIS U.L.J. 681, 681 n.1 (1981); Comment, *supra* note 11, at 473-74.

[13] *See* Comment, *The Old Age Wall: The Problem of Gaining Access to Nursing Home Residents,* 24 GOLDEN GATE U.L. REV. 709, 709 n.11 (1984) (discussing the isolation of nursing home residents from outside social and legal services); *see also* SENATE INTRODUCTORY REPORT, *supra* note 5, at 16 ("Since most nursing home patients are in their 70's and 80's, they may well have outlived their own children. Almost 50 percent have no viable relationship with a close relative, and another 30 percent have only collateral relatives near their own age.").

[14] The isolation is very explicitly maintained by some nursing home administrators, who try to keep out community groups interested in helping residents "by locking the doors in an attempt to maintain the wall of silence between the residents and the outside world, thus preventing the public from interfering with their management of these business enterprises." Comment, *supra* note 13, at 710. While residents have been endowed statutorily with certain rights, the battle to enforce those rights has to be preceded by the battle to inform residents of them. The role of advocacy is crucial in changing the overall situation for nursing home residents, but the barriers to effective advocacy need to be recognized as part of the problem.

[15] *See, e.g.,* B. VLADECK, *supra* note 3, at 3 ("The overuse of potent medications in nursing homes is a scandal in itself.").

[16] In discussing how to prepare to defend patients in commitment and guardianship proceedings, Krauskopf raises, as a "last matter to investigate," the problem of medication changes before a hearing. J. KRAUSKOPF, *supra* note 2, § 3.5, at 36-37. She quotes advice that comes from the general context of psychiatric patients, but her use of it implies that she sees the danger of deliberate or indifferent overmedication as equally relevant in the context of geriatric commitment hearings and guardianship proceedings. *See also* Ennis, *Trial Techniques,* in B. ENNIS & L. SIEGEL, THE RIGHTS OF MENTAL PATIENTS: THE BASIC ACLU GUIDE TO A MENTAL PATIENT'S RIGHTS app. B at 283, 294-95 (1973).

have familial resources.[17] The patients' rights movement has responded to that situation by making it harder to commit someone.[18] But as it has become harder to stash difficult relatives in a psychiatric hospital, it has become easier to put them in a nursing home:

> The past decade has seen an assault on unwarranted mental commitments at the same time as an increase in funding sources has enabled a large growth in nursing homes. These homes vary widely in quality; many are seriously inadequate and offer an environment even more adverse to an elderly person than a mental hospital. They are likely dumping places for persons who would have been committed at one time.[19]

Ironically, however, the confined nursing home resident may be in greater need of legal protection than the committed mental patient, a

---

[17] *See* J. KRAUSKOPF, *supra* note 2, § 3.1, at 29-30 (A large percentage of mental institution inmates are elderly people who were committed for reasons of convenience rather than the severity of their mental impairments.).

[18] The legal and social dynamics of civil commitment are, of course, vast and complex topics outside the scope of this paper. A comparison between the situation of the civilly committed mental patient and the involuntarily confined nursing home resident will be made at greater length in Part IV of this Comment. It has often been observed that civil commitment may constitute a form of particularly dangerous social control. Thomas Szasz goes further and argues that the very distinction between voluntary and involuntary hospitalization is false and that many "voluntary" mental hospitalizations are *in fact* involuntary. *See* Szasz, *Voluntary Mental Hospitalization: An Unacknowledged Practice of Medical Fraud,* in MEDICINE, LAW, AND PUBLIC POLICY 403, 404 (N. Kittrie, H. Hirsch & G. Wegner eds. 1975) ("[R]eview of the laws governing voluntary psychiatric hospitalization makes it unmistakably clear that what is called 'voluntary mental hospitalization' is often actually a type of involuntary mental hospitalization . . . ."). *But see* Slovenko, *Civil Commitment in Perspective,* in MEDICINE, LAW, AND PUBLIC POLICY, *supra,* at 360 (discounting Szasz's alarm). The involuntary nature of this constraint is "revealed by the abridgements of [patients'] liberty to leave the hospital that they have ostensibly entered of their own free choice." Szasz, *supra,* at 404. Szasz's concern may or may not be somewhat dated with respect to mental patients, but it remains very much on target for nursing home residents, who are assumed to have freedom that they do not in fact possess. *See, e.g.,* Pounders v. Trinity Court Nursing Home, Inc., 265 Ark. 1, 576 S.W.2d 934 (1979) (en banc) (discussed *supra* notes 40, 42, 49-50 and accompanying text). Interestingly, Szasz reportedly has urged lawyers to combat the dangers of institutionalization by bringing false imprisonment suits against those participating in the commitment process. *See* Slovenko, *supra,* at 363, 369 n.82 (citing Address by Thomas Szasz at The Annual Convention of the American Trial Lawyers Association (Aug. 4, 1970), *reported in* PSYCHIATRIC NEWS, Sept. 16, 1970, at 1).

[19] J. KRAUSKOPF, *supra* note 2, § 3.1, at 31; *see also* Swan, *The Substitution of Nursing Home for Inpatient Psychiatric Care,* COMMUNITY MENTAL HEALTH J., Spring 1987, at 3, 14-16 (concluding from an empirical study that nursing home care is substituted for inpatient psychiatric care and that Medicaid funding has played a major role in the development of the nursing home industry as a proxy for state mental hospitals for the elderly).

fact courts have failed to recognize.

The policy of decarcerating institutionalized patients, begun as a reform movement in the 1960s, has resulted in some significant problems for elderly persons.[20] Many people released from state mental institutions have been dumped into communities where no resources are available for their care. Elderly patients who are released frequently end up in nursing homes.[21] This seeming paradox—the institutionalization of the old in nursing homes as a result of their release from psychiatric commitment—can also be explained by the influence of Medicaid reimbursement[22] in the development of the burgeoning for-profit nursing home industry.[23]

C. *Statutory Attempts to Regulate Nursing Home Conditions*

Some states have responded to the generally shabby conditions in nursing homes by enacting statutes that give patients a private right of action against nursing homes that violate basic standards of care.[24] These actions may be brought by the residents themselves, by state

---

[20] *See* J. WILLIAMSON, L. EVANS & L. POWELL, THE POLITICS OF AGING 237 (1982) [hereinafter J. WILLIAMSON].

[21] *See id.* at 238.

[22] "The development of public reimbursement for nursing home care, and the resulting expansion of nursing homes and beds, were major factors in the deinstitutionalization from government mental hospitals. The nursing home replaced the state mental hospital as the locus of care for aged and other mentally ill." Swan, *supra* note 19, at 3 (citations omitted).

[23] Before the mid-1960s, most nursing homes, like other health care facilities, were owned and operated by local governments or private charitable organizations. *See* M. KAPP, *supra* note 2, at 63. Now the large majority of nursing homes are owned and operated by proprietary corporations. *See id.* at 64. As of 1981, approximately 70 percent of nursing homes certified to receive residents under Medicare and/or Medicaid, representing 80 percent of the total number of nursing home beds, were operated on a for-profit basis. *See* COMMITTEE ON NURSING HOME REGULATION, INSTITUTE OF MEDICINE, IMPROVING THE QUALITY OF CARE IN NURSING HOMES 9, 10, app. D at 358 (1986). Multistate nursing home chains represent an increasingly large percentage of the rapidly increasing proprietary sector of the nursing home industry. *See* NATIONAL SENIOR CITIZENS LAW CENTER, NURSING HOME LAW 2 (1982); *supra* note 106 and accompanying text.

[24] S. JOHNSON, *supra* note 4, § 1-22, at 21 ("At least ten state nursing home statutes have explicit provisions for private rights of action against facilities by residents, their guardians [or] family members . . . ."). For examples of such statutes, see CAL. HEALTH & SAFETY CODE § 1430 (West 1979 & Supp. 1988); CONN. GEN. STAT. ANN. § 19a-550 (West 1986 & Supp. 1988); ILL. ANN. STAT. ch. 111, ¶¶ 4153-4601 (Smith-Hurd Supp. 1988); MASS. ANN. LAWS ch. 111, § 70E (Law. Co-op. 1985 & Supp. 1988); MO. REV. STAT. § 198.093 (1983 & Supp. 1988); N.J. STAT. ANN. § 30:13-8 (West 1981 & Supp. 1988); N.Y. PUB. HEALTH LAW § 2801(d) (McKinney 1985 & Supp. 1988); OKLA. STAT. ANN. tit. 63, § 1-1918F (West 1984); W. VA. CODE § 16-5C-15 (1985 & Supp. 1988).

agencies,[25] or by other interested persons.[26]

Many of these statutes contain a patients' "bill of rights," violation of which will support an action against the nursing home.[27] These rights typically include guarantees of freedom from chemical and physical restraints; privacy; confidentiality; prepared transfer; informed consent; and freedom from abuse.[28] To the extent that particular statutory provisions cannot reasonably be construed to cover the situation in which a nursing home resident is confined against her will, the need for a common law remedy is clear.[29]

II. The Application of The Rubric of False Imprisonment to Nursing Home Confinement

A. *The Use of Tort: General Considerations*

One might think that the notorious conditions in nursing homes would have spawned a tremendous amount of litigation challenging the care and treatment of nursing home residents. This has not been the case. Litigation has centered primarily around negligence; the typical nursing home case deals with a simple but poorly documented fall.[30] Nevertheless, it has been argued that tort law can play an important role:

> The irony is that the modern system of tort litigation possesses the sophistication to make a meaningful contribution to the improvement of long-term care. Tort law is flexible;

---

[25] *See, e.g.,* N.J. Stat. Ann. § 30:13-8 (West 1981 & Supp. 1988) (empowering Department of Health to bring suit); N.C. Gen. Stat. § 131E-123 (1987) (allowing Department of Human Resources to bring suit).

[26] *See, e.g.,* Mo. Ann. Stat. § 198-093(1) (Vernon 1983) (permitting an estate of the resident to sue); N.J. Stat. Ann. § 30:13-8 (West 1981 & Supp. 1988) (allowing a legal guardian, but not next of kin, to sue), *construed in* Profeta v. Dover Christian Nursing Home, 189 N.J. Super. 83, 86-87, 458 A.2d 1307, 1309, *cert denied,* 94 N.J. 576, 468 A.2d 217 (1983); N.C. Gen. Stat. § 131E-123 (1987) (same).

[27] *See* Conn. Gen. Stat. Ann. § 19a-550(b) (West 1986); Mass. Ann. Laws ch. 111, § 70E (Law. Co-op. 1985 & Supp. 1988); Mo. Ann. Stat. § 198.088 (Vernon 1983 & Supp. 1988); N.J. Stat. Ann. § 30:13-5 (West 1981).

[28] *See, e.g.,* Ohio Rev. Code Ann. § 3721.13 (Anderson 1980 & Supp. 1987) (listing the rights of nursing home residents); *see also* S. Johnson, *supra* note 4, § 1-3, at 2-3 (discussing the similarity of most state nursing home statutes).

[29] *See* Caldwell & Kapp, *The Rights of Nursing Home Patients: Possibilities and Limitations of Federal Regulations,* 6 J. Health Pol. Pol'y & L. 40, 47 (1981) ("The incontrovertible fact . . . is that the most comprehensively written and vigorously enforced regulations in the world can only work to a small degree to protect dependents from abuse.").

[30] *See* S. Johnson, *supra* note 4, § 3-2, at 69; *see also* Butler, *supra* note 8, app. A at 662-63 (listing reported nursing home cases, including the nature of injury, the age and sex of plaintiff, the disposition of the case, and the damages when awarded).

> its practitioners are imaginative. Today's post-realist amalgam of economics and hornbook doctrine permits adventurous functional manipulation to achieve not only compensation, but also finely tuned regulation.[31]

There are many reasons, in general, tort law has been inadequately used to remedy nursing home abuses and, in particular, few false imprisonment claims have been filed against nursing homes. This Comment argues that this dearth of cases represents not a lack of need, but rather an undervaluing of essential rights that litigation may be able to help protect. Tort law has only recently been recognized as an important part of nursing home litigation—one that can address inadequate and inefficient government regulatory systems.[32] The tort of false imprisonment, in particular, has lagged behind.

B. Big Town Nursing Home v. Newman[33]

An action for the intentional tort of false imprisonment may be maintained against a nursing home.[34] In the leading case, *Big Town Nursing Home v. Newman,* the plaintiff, who had "Parkinson's disease, arthritis, heart trouble, a voice impediment, and a hiatal hernia," was kept against his will in a nursing home.[35] He tried to escape five or six times but each time was brought back without his consent. He was not allowed to use the telephone or have visitors unless the manager knew them,[36] and he was locked up with "senile patients, drug addicts, alcoholics, [the] mentally disturbed, incorrigibles, and uncontrollables," even though nursing home personnel knew this was inappropriate treatment for him.[37] The appellate court held that ample evidence existed to support the jury's finding of false imprisonment, concluding that the nursing home "acted in the utter disregard of plaintiff's legal rights, knowing there was no court order for commitment and that the admission agreement provided he was not to be kept against his will."[38]

An authority in the field of nursing home law has observed that

---

[31] S. JOHNSON, *supra* note 4, § 3-2, at 69-70.

[32] *See id.* § 3-2, at 69.

[33] 461 S.W.2d 195 (Tex. Civ. App. 1970).

[34] *See id.* at 196-97.

[35] *Id.* at 196.

[36] *See id.* at 197. Holding a patient incommunicado has been treated as a form of restraint that may constitute false imprisonment. *See* Stowers v. Wolodzko, 386 Mich. 119, 135, 191 N.W.2d 355, 363 (1971); S. JOHNSON, *supra* note 4, § 3-11, at 81.

[37] *Big Town,* 461 S.W.2d at 197; *see* J. KRAUSKOPF, *supra* note 2, § 23.12, at 487.

[38] *Big Town,* 461 S.W.2d at 197.

"[w]hen a nursing home knows of the disabled condition of a resident, it would seem that little restriction would be needed to support a contention of false imprisonment."[39] Generally, however, this has not been the case.

C. Pounders v. Trinity Court Nursing Home[40]

The other central case in this area is *Pounders v. Trinity Court Nursing Home, Inc.* There, the plaintiff testified that she was not allowed to have visitors, use the telephone, or write anyone. She was told further that if she tried to run away, she would be brought back. One of her reasons for not leaving was that the home had taken her shoes,[41] and she did not feel able to go out in bedroom slippers. The *Pounders* court held that, because the nursing home had not physically restrained Mrs. Pounders, it had not "imprisoned" her.[42]

D. *The Rubric*

The tort of false imprisonment is especially interesting when viewed in the larger context of tort law. It is, of course, an intentional tort.[43] Intentional tort theory has been overshadowed because of the emphasis on negligence in modern malpractice litigation. Yet existing studies of nursing home conditions suggest that the most troublesome conduct is that typically associated with intentional torts.[44]

Despite the paucity of reported cases, intentional tort doctrine thus has an important contribution to make to nursing home litigation.[45] The abuses commonly suffered by nursing home residents are ideally suited to redress by false imprisonment causes of action.[46] From a practical standpoint, however, false imprisonment has been criticized as lacking the flexibility of a negligence cause of action.[47]

Another obstacle to the use of the false imprisonment rubric in

---

[39] J. KRAUSKOPF, *supra* note 2, § 23.12, at 487.

[40] 265 Ark. 1, 576 S.W.2d 934 (1979).

[41] *See id.* at 2, 576 S.W.2d at 935.

[42] *See id.* at 4-5, 576 S.W.2d at 936. The Restatement implicitly recognizes the role of personal dignity and internalized societal mores in forming constructive boundaries: "A is naked in a Turkish bath. B locks the door into the dressing room but leaves open the door to the general waiting room where persons of both sexes are congregated. B has confined A." RESTATEMENT (SECOND) OF TORTS § 36 comment a, illustration 5 (1965).

[43] *See* RESTATEMENT (SECOND) OF TORTS § 35(1) (1965).

[44] *See* S. JOHNSON, *supra* note 4, § 3-8, at 75 (noting that possible assault and battery claims often arise in the nursing home context).

[45] *See id.*

[46] *See id.*

[47] *See id.* § 3-11, at 80.

nursing home litigation has been the tendency of courts to interpret the phrase "false imprisonment" literally, thereby restricting its application. The trial court in *Pounders,* for instance, gave an erroneously limited statement of the law, which proved fatal to Mrs. Pounders' case: "False imprisonment means to be in custody against your will, to have restraints, such as chains, handcuffs, locked doors, barriers or keeping someone behind walls or within the premises, under a hidden identity or things of that nature."[48] As Prosser has noted, however, "too much emphasis has been placed upon the technical name of the tort."[49]

The Restatement notes that:

> (1)An actor is subject to liability to another for false imprisonment if
> (a) he acts intending to confine the other or a third person within boundaries fixed by the actor, and
> (b) his act directly or indirectly results in such a confinement of the other, and
> (c) the other is conscious of the confinement or is harmed by it.[50]

Section 36 specifies what constitutes confinement:

> (1) To make the actor liable for false imprisonment, the other's confinement within the boundaries fixed by the actor must be complete.
> (2) The confinement is complete although there is a reasonable means of escape, unless the other knows of it.[51]

One comment to Section 36 suggests that what is "complete" confinement will vary from person to person: "[E]ven though there may be a perfectly safe avenue of escape, the other is not required to take it if the circumstances are such as to make it offensive to a reasonable sense of

---

[48] *Pounders,* 265 Ark. at 7-8, 576 S.W.2d at 937 (Purtle, J., dissenting) (quoting unpublished trial court opinion).

[49] P. KEETON, D. DOBBS, R. KEETON & D. OWEN, PROSSER AND KEETON ON TORTS § 11, at 47 (5th ed. 1984) [hereinafter PROSSER]. *But see* Schanafelt v. Seaboard Fin. Co., 108 Cal. App. 2d 420, 423, 239 P.2d 42, 43 (1951) ("Words or conduct furnishing a reasonable apprehension on the part of the one restrained that he will not be allowed to depart is sufficient."); National Bond Inv. Co. v. Whithorn, 276 Ky. 204, 209, 123 S.W.2d 263, 266 (1938) (finding false imprisonment through wrongful detention of one's property); Zayre of Va., Inc. v. Gowdy, 207 Va. 47, 51, 147 S.E.2d 710, 713 (1966) ("If a person is under a reasonable apprehension that force will be used unless he willingly submits, and he does submit to the extent that he is denied freedom of action, this, in legal contemplation, constitutes false imprisonment."); *cf. infra* notes 115-122 and accompanying text (discussing de facto confinement).

[50] RESTATEMENT (SECOND) OF TORTS § 35(1) (1965).

[51] *Id.* § 36.

decency or personal dignity."[52] This accommodation is important in the kind of situation encountered by Mrs. Pounders. Similarly, Section 38 notes that "[t]he confinement may be by actual or *apparent* physical barriers."[53] The comment to Section 38 also stresses the subjective and varying nature of what constitutes confinement:

> *a.* There is a confinement by physical barriers, under the rule stated in § 35, if the barriers are actually efficient to restrain the other or, though they are actually inefficient to do so, the other believes them to be efficient and the one setting the barriers intends him so to believe.
>
> . . . .
>
> *b.* An act which prevents another from availing himself of a reasonable means of escape from the area of confinement may result in a confinement by physical barriers.[54]

The physical limitations experienced by the elderly patient, when coupled with her dependence on her caretakers, combine to create a forceful case for false imprisonment. Indeed, one of the Restatement's guiding illustrations is of the "cripple" whose crutches have been taken by A; her resulting inability to walk amounts to confinement.[55]

E. *The Failure of the Rubric*

Where does this leave Mrs. Pounders? There are several ways in which the typical nursing home resident may be as effectively imprisoned in a home or hospital as the prototypical imprisonee. The imprisonment may begin before she sets foot in the home, through her real and/or perceived lack of alternatives. Mrs. Pounders did not want to enter the home, according to the court, but did so without protest because she had no place else to go. Her status and lack of bargaining power rendered her unable to consent. While courts cannot change the factors leading to the absence of choice, they can recognize the element of coercion. Again it is important to recognize that "the interest is in a sense a mental one,"[56] analogous to the apprehension of contact in assault cases.[57] Furthermore, the action may be maintained without proof

[52] *Id.* comment a.

[53] *Id.* § 38 (emphasis added).

[54] *Id.* comments a & b.

[55] *See id.* § 38 comment b, illustration 2.

[56] PROSSER, *supra* note 49, § 11, at 47. *But see* Faniel v. Chesapeake & Potomac Tel. Co., 404 A.2d 147, 151 (D.C. 1979) (finding that plaintiff's feeling "mentally restrained" by defendant not enough to make out false imprisonment).

[57] *See* PROSSER, *supra* note 49, § 11, at 47-48; RESTATEMENT (SECOND) OF TORTS § 29(1) (1965). *See generally* State v. Ingram, 237 N.C. 197, 201, 74 S.E.2d

of actual damage.[58]

Recognition of the mental or subjective element might overcome the most difficult hurdle in false imprisonment litigation: the physical element. The *Pounders* court viewed this obstacle as insurmountable: No false imprisonment existed because there was "no evidence whatever either of physical force or of any threat of physical force. To the contrary, Mrs. Pounders could have left the nursing home at will, but she simply had nowhere to go and chose to stay."[59]

Obviously, the easiest cases will involve patients who are subjected to physical barriers or actual physical force. In such cases, the subjective element is irrelevant. *Big Town* presented a combination of physical and mental restraints; the plaintiff was punished by being locked and taped in a "restraint chair" for more than five hours.[60] The court did not rest its holding on this factor alone, however; it found evidence of confinement in that the nursing home prevented him from using the telephone,[61] locked up his clothes, told him that he could not be released from the ward until he obeyed the rules, and detained him for fifty-one days despite his persistent demands to be released. Most significant, there was no court proceeding to confine the patient. The court held that the defendant nursing home "acted in the utter disregard of plaintiff's legal rights, knowing there was no court order for commitment, and that the admission agreement provided he was not to be kept against his will."[62]

False imprisonment doctrine, by acknowledging the restrictive power of threats, provides courts with a way to assess individual cases using the subjective effect of the threats on the patient. Threats to restrain are more difficult to prove than literal restraint, but, as discussed above, they may play a significant role in keeping the confined person

---

532, 535 (1953) (holding violent display "must be such as to cause the reasonable apprehension of immediate bodily harm"(citation omitted)); Cucinotti v. Ortman, 399 Pa. 26, 27, 159 A.2d 216, 217 (1960) (finding that assault is an act "intended to put another person in reasonable apprehension of an immediate battery," and one that succeeds in doing so); Redfearn v. State, 738 S.W.2d 28, 29 (Tex. Ct. App. 1987) ("[A] threat to release snakes into a person's residence . . . is calculated to raise a reasonable apprehension of bodily harm on the part of the person threatened.").

[58] *See* PROSSER, *supra* note 49, § 11, at 47.

[59] *Pounders,* 265 Ark. at 3, 576 S.W.2d at 935. This point is logically inconsistent and factually inaccurate. The confining nature of Mrs. Pounders' residence became clear precisely when the nursing home would not release her to her niece, despite the niece's willingness to take her and Mrs. Pounders' willingness to go. It was the niece who arranged for the lawyer who finally secured Mrs. Pounders' release. *See id.* at 6, 576 S.W.2d at 936 (Purtle, J., dissenting).

[60] *See Big Town,* 461 S.W.2d at 197.

[61] Holding a patient incommunicado can, in and of itself, constitute a restraint giving rise to a finding of false imprisonment. *See id.*

[62] *Id.*

effectively imprisoned. The Restatement requires that the threat be to apply present physical force, but what constitutes a present threat has been interpreted with some degree of elasticity.[63] It is particularly important, given the climate of intimidation that may exist in a nursing home,[64] to remember that confinement can result from duress other than threats of physical force.[65] For example, an Illinois appellate court held that a threat to commit a patient to a state hospital constituted a present, not future, threat.[66] Furthermore, the defendant bears the burden of justifying the confinement of the plaintiff;[67] the law does not require the confined person to justify her desire to leave the nursing home.[68]

---

[63] *See* RESTATEMENT (SECOND) OF TORTS, § 40 comment a (1965).

> [T]he actor's threat [to confine the other] may be by words as well as by other acts. It is not necessary that he do any other act actually or apparently effectual in carrying a threat into immediate execution. It is enough that he threatens to apply and has the apparent intention and ability to apply force to the other's person immediately upon the other's attempting to escape from the area within which it is the actor's intention to confine him.

Id.

The illustration to section 40 emphasizes that the immediacy requirement goes to the thwarting of the attempted escape, not the time of the threat: "B, standing at the door some feet away, says to A, 'If you attempt to leave this room, I will knock you down.' B makes no threatening gesture. A, in submission to the threat remains in the room. B has confined A." *Id.* illustration 1. Thus, the need for a so-called "present threat" in making out a case of false imprisonment has been liberally construed. *See, e.g.,* Hales v. McCrory-McLellan Corp., 260 N.C. 568, 570, 133 S.E.2d 225, 227 (1963) (noting that words that cause a reasonable apprehension in plaintiff concerning her ability to exercise her liberty constitutes false imprisonment); Gathers v. Harris Teeter Supermarket, Inc., 282 S.C. 220, 230, 317 S.E.2d 748, 755 (1985) ("The tort of false imprisonment may be committed by words alone . . . and by merely operating on the will of the individual . . . .").

[64] "Even the best nursing homes are total institutions that form an inherently intimidating environment that has a debilitating effect on the resident and the resident's sense of personal control over both mundane and major activities." M. KAPP, *supra* note 2, at 80.

[65] *See, e.g.,* Faniel v. Chesapeake & Potomac Tel. Co. 404 A.2d 147, 151-52 (D.C. 1979) (noting that false imprisonment may be proven if the evidence establishes "a restraint against the plaintiff's will, as where she yields to force, to the threat of force *or to the assertion of authority*" (emphasis added)).

[66] *See* Marcus v. Liebman, 59 Ill. App. 3d 337, 341, 375 N.E.2d 486, 489 (1978) (finding no false imprisonment when plaintiff voluntarily entered the psychiatric wing of her local hospital).

[67] *See, e.g.,* Beaumont v. Segal, 362 Mass. 30, 32, 283 N.E.2d 858, 860 (1972) (noting that defendant had the burden of showing justification for the confinement); S. JOHNSON, *supra* note 4, § 3-11, at 81 (noting that "[t]he burden of justifying the confinement lies with the defendant").

[68] *See* Geddes v. Daughters of Charity, 348 F.2d 144, 148 (5th Cir. 1965) (holding false imprisonment shown when psychiatric hospital detained plaintiff after plaintiff "begged" to be released, because "further detention in the hospital subsequent to such withdrawal of the consent consituted a false imprisonment"). *See generally* 40

III. Reasons for the Failure of the False Imprisonment Rubric

The reasons for the failure of the false imprisonment rubric may be stated briefly: unlike nursing homes, nursing home residents lack political and economic power. The institutionalized elderly are in a double bind, however. While they may perceive themselves to be politically and economically impotent, courts and the political process assume that the elderly as a group have more power than they actually have, and that therefore nursing home residents are not in need of special protections.[69] This Part explains the failure of the false imprisonment rubric by examining the societal, economic, and political underpinnings of both the tort system and the nursing home industry. The analysis assumes that the legal problem cannot be understood outside of its political, societal, and economic context. Part IV discusses possible legal solutions within this context.

A. *"Internal" and Inherent Obstacles*

The problems of perception are both internal and external, individual and societal. Age, like

> class, race, and gender[,] will affect the extent to which and the way in which the experience of injury is transformed into a claim for legal redress: the sense of entitlement to physical, mental, and emotional well-being . . . the feeling of competence to assert a claim and to withstand retaliation; the capacity to mobilize the legal process, which includes choosing and controlling a lawyer and preparing evidence; and financial and emotional resources, which will affect the quality of legal representation obtained and the ability of the claimant to overcome opposition and delay in order to pursue negotiation or litigation to a satisfactory conclusion.[70]

Old age, although neither an immutable nor lifelong characteristic,[71]

AM. JUR. PROOF OF FACTS 2D *False Imprisonment in Connection with Confinement in Nursing Home or Hospital* § 4 (1984) ("[P]atients must be released on request.").

[69] *See infra* note 83 and accompanying text; *see also* B. VLADECK, *supra* note 3, at 193 (describing the elderly as "among the most powerful and well served groups in society" but noting "the relative indifference of general-purpose organizations of the elderly toward nursing home issues: 'Those "consumers" who do care about nursing homes [are] . . . unmobilized and politically impotent' ").

[70] Abel, *Torts,* in THE POLITICS OF LAW 185, 189 (D. Kairys ed. 1982).

[71] *See* Massachusetts Bd. of Retirement v. Murgia, 427 U.S. 307, 313-14 (1976) (per curiam) ("But even old age does not define a 'discrete and insular' group in need of 'extraordinary protection from the majoritarian political process.' Instead, it marks a

nevertheless crucially affects how one views oneself vis-à-vis the legal system. The paucity of nursing home litigation—most of it filed by survivors[72]—underlines the self-and-other selection involved. In short, the elderly, like other oppressed groups, are effectively barred from tort recovery.[73] The legal system as a whole, the courts, and even the victims (because they assume they have no redress) create and perpetuate this process of exclusion.

The relative lack of nursing home litigation points less to the absence of a problem than to the economics and politics of nursing home litigation. Nursing homes are well-financed and organized; the patients are unorganized, and, by definition, dependent on others. Nevertheless, although the tort of false imprisonment has its limitations, it can be used to protect basic physical and emotional rights of nursing home residents.[74]

The use of tort law in this context raises specific practical and political problems. Although obvious, it is important to remember that the potential litigants are the victims; precisely what makes them so vulnerable as victims renders them ineffective as litigants: "Resident plaintiffs in reported tort cases range from 67 to 95 years; females outnumbered males more than three to one and the plaintiffs were hemiplegic, senile, incontinent and unsteady in ambulation."[75] These characteristics accord with those of nursing home residents generally.[76] Of course, the combination of old age and low earning capacity translates into paltry damage awards.[77]

The victims' very powerlessness—the cause of these actions to begin with—makes it difficult to bring tort claims. Why does a person reside in a nursing home where she does not want to be? She has no place else to go; she has no relatives; she has relatives who are unwilling or unable to house her; she cannot take care of herself; she has significant physical and/or mental impairment. Recognition of these factors, however, should not replace the court's independent inquiry into the plaintiff's claim. Mrs. Pounders ended up in a home because the relatives with whom she was staying became dissatisfied with the

---

stage that each of us will reach if we live out our normal span." (citation omitted)).

[72] Approximately 50 percent of the claims against nursing homes are brought by nursing home residents' "survivors." *See* S. JOHNSON, *supra* note 4, § 3-1, at 69 n.10. "It is perhaps significant that of the small number of reported cases involving injuries suffered by nursing home residents, a large percentage are instigated by the resident's family, after the elderly patient's death." *Id.* at 68.

[73] *See* Abel, *supra* note 70, at 189.

[74] *See* S. JOHNSON, *supra* note 4, § 3-7, at 75.

[75] Butler, *supra* note 8, at 641.

[76] *See id.*

[77] *See* S. JOHNSON, *supra* note 4, § 3-1, at 68.

arrangement. The court concluded therefore that "she simply had nowhere to go and chose to stay."[78]

Mrs. Pounders' case, however, illustrates the possibility of alternative arrangements, because she ultimately found a place with another relative. Furthermore, the fact that no obvious alternatives may exist to a nursing home does not establish that the resident is not being falsely imprisoned; at the very least, a different nursing home may be preferable. It is important to keep the practical problems distinct from the legal questions; consent must not be determined by convenience or by unexamined assumptions that the elderly "belong" in nursing homes.[79]

The profile of the typical plaintiff in nursing home litigation reflects the profile of the typical nursing home resident.[80] If she is helpless, disoriented, mentally impaired, or disabled, she is per se dependent on the very people who are not protecting her rights. These are not reasons to refrain from bringing such actions; these are reasons for the courts to be vigilant about protecting the rights of those who may be unable to protect themselves.

B. *Political Factors*

To use tort law effectively, one must place the individual in a larger social and political context, a step the courts are reluctant to take. Even Mrs. Pounder's champion, the dissenting Justice Purtle, suggests that the case is "no doubt of little consequence to anyone other than Margaret Pounders."[81] He observes, however, that "[a]s it is with a large number of our senior citizens, she dreaded the thought of being placed in a nursing home."[82] The juxtaposition of these two statements reveals an interesting anomaly. The first statement suggests a common willingness to trivialize and isolate the elderly individual. Implicit in the second statement is the recognition that this disabled elderly woman belongs to a class of people who cannot control their most basic choices. They lack liberty in the most fundamental sense. At the same time, individual members of this class, especially if they are female or members of a racial minority, are perceived not to have political clout. They

---

[78] Pounders v. Trinity Court Nursing Home, Inc., 265 Ark. 1, 3, 576 S.W.2d 934, 935 (1979) (en banc).

[79] *See* B. VLADECK, *supra* note 3, at 215-18 (discussing the pervasive bias in this country toward institutionalization of the elderly). Vladeck's major suggestion for nursing home reform is to encourage the funding of noninstitutionalized care rather than nursing homes.

[80] *See supra* notes 75-76 and accompanying text.

[81] *Pounders*, 265 Ark. at 5, 576 S.W.2d at 936 (Purtle, J., dissenting).

[82] *Id.*

are foolish in the particular and powerless in the aggregate.[83]

The tort of false imprisonment requires us to ask whether the victim has agreed to be imprisoned, but the question of consent cannot be understood outside the context of power relations. *Pounders* found that, although Mrs. Pounders did not want to enter the home, "she went without protest."[84] Therefore, by agreeing to surrender her freedom of motion, she agreed to be imprisoned. This double bind is uncomfortably reminiscent of the rape victim who does not want to have sex but cannot safely refuse; her "consent" is compelled by the situation.[85]

The analogy can serve us in another way. One legacy of the women's movement stems from the axiom "the personal is political."[86] Individual interactions between two people cannot be understood apart from overarching questions of status and power. We perpetuate inequalities by our perception of some wrongs as trivial, or "merely" personal: "This is a very close question and no doubt of little consequence to anyone other than Margaret Pounders."[87]

It is important to recognize that the dumping of the elderly in nursing homes and hospitals is a problem with political dimensions, no matter how we define "political." From the legislative perspective, nursing-home political action committees are big political contributors.[88] In contrast, "[f]ew nursing-home patients vote. They are not organized. There is no patient PAC [compared to the powerful nursing-

---

[83] This Comment does not mean to ignore the existence of the senior power movement. The political power of the elderly has been exhaustively studied and is considerably more complex a subject than is herein acknowledged. *See* J. WILLIAMSON, *supra* note 20, at 9-14 (surveying the literature and noting that the power of the aged has been both overestimated and underestimated). But while there has been extensive consideration of the elderly as a political force, it has also been argued that "[t]he elderly are perceived as being more effectively organized than they are." *Id.* at 103. This Comment argues that the court looking at the individual in isolation may not be able to see how the individual is imprisoned.

[84] *Pounders*, 265 Ark. at 2, 576 S.W.2d at 935.

[85] The Restatement hints at this, 1965 style: "A, a young man, takes B, a girl, for a ride in his car, and offers indecent liberties. A refuses to allow B to leave the car unless she consents, and drives her several miles. A has confined B." RESTATEMENT (SECOND) OF TORTS § 36 comment c, illustration 9 (1965).

[86] " 'To say that the personal is political means that gender as a division of power is discoverable and verifiable through women's intimate experience of sexual objectification, which is definitive of and synonymous with women's lives as gender female.' " Colker, *Feminism, Sexuality, and Self: A Preliminary Inquiry Into the Politics of Authenticity* (Book Review), 68 B.U.L. REV. 217, 239 n.72 (1988) (quoting MacKinnon, *Feminism, Marxism, Method and the State: An Agenda for Theory,* 7 SIGNS: J. WOMEN CULTURE & SOC'Y 515, 535 (1982)).

[87] *Pounders,* 265 Ark. at 5, 576 S.W.2d at 936 (Purtle, J., dissenting).

[88] They have been instrumental in some states in blocking passage of nursing home bills of rights. *See* McMath, *The Nursing-Home Maltreatment Case,* TRIAL, Sept. 1985, at 52, 52 & 53 n.3.

home lobby]."[89]

There are complex issues involved in translating the recognition of the elderly as a political force into significant legal protection for nursing home residents. One danger is to characterize the elderly monolithically, to see the label of "elderly" as all-embracing. As the burgeoning field of "political gerontology"[90] makes clear, the creation of old people as a political bloc involves certain pitfalls. Another problem is derived from the "special treatment/interest" model, which, while providing certain essential services, separates the elderly from the rest of the population. Once old people are set aside as a problem group that needs special help, their resource deprivation must be maintained for their caretakers to justify their existence. Perhaps because more bureaucrats are needed to deliver indirect services as opposed to direct services, more resources are funneled into referral agencies at the local level instead of housing or income maintenance.[91] The elderly are, as a group, exhaustively subjected to social control by the state and others. The realities of aging help to contribute to dependency, and the separateness of being a problem group stigmatizes the elderly, even in the name of reform.

Thus even the solutions perpetuate the problems. Nevertheless, age-based stereotypes are less damaging than the present alternative. The elderly patient, involuntarily confined to a nursing home, is subjected to "forced communal living, regimentation, infantilism, segregation from the outside world, staff impersonalism, and task orientation."[92] All of these conditions facilitate a complete degradation of self. While the need for political activity is great, the potential for organizing is low. Residents who refuse to submit to this institutional routine may face the use of chemical or mechanical restraints.[93] Other restraints, such as threats, social disapproval, and fear of retaliation, may be less tangible but equally coercive.[94]

---

[89] *Id.* at 52.

[90] *See* J. WILLIAMSON, *supra* note 20, at 3 (defining the field of political gerontology as "the study of power as it involves the elderly").

[91] *See id.* at 241.

[92] *Id.* at 233.

[93] *See id.*

[94] Another danger is that the nursing home promotes social control through drugs or therapies that further the larger goals of the institution: the continuation of the individual's inability to act autonomously. *See id.* at 233. Again, what would otherwise be legally protected—for example, the ability of the individual to be free from restraint—will not be considered restraint if ordered under medical supervision. The Patients' Bill of Rights constitutes a condition of participation for "skilled nursing facilities" and a standard to be met for "intermediate care facilities" to receive Medicare or Medicaid reimbursement. *See* 42 C.F.R. § 442.311(f)(2) (1987). One provision is that the patient be free from mental and physical abuse as well as chemical and physical

Furthermore, what gains have been accomplished may stall further progress. Many protections have evolved from the patient-as-consumer model, a product of the patients' rights movement,[95] itself an outgrowth of the civil rights movement.[96] One possible consequence of this model is that it may assume elderly patients have more bargaining power than they actually possess, presupposing that the marketplace is an adequate regulatory mechanism, and that empowerment comes from economic clout, not political change.

C. *Economic Factors*

When attempting to understand the economic factors underlying the relationship between the average nursing home resident and her nursing home, one must look not only at the economics of the nursing home business, especially compared to the relative inadequacy of the patient's resources, but also at the tort system itself. The numerical disparity between medical malpractice cases and nursing home cases[97] reflects both the economic impetus for the tort system, and the fact that, virtually by definition, nursing home residents are generally old and/or disabled. "Injuries to them, whether fatal or merely debilitating, may be perceived as having little remunerative potential, especially when the

---

restraints, unless the restraints are

> (i) Authorized by a physician in writing for a specified period of time; or
> (ii) Used in an emergency under the following conditions:
> (A) The use is necessary to protect the resident from injuring himself or others.
> (B) The use is authorized by a professional staff member identified in the written policies and procedures of the facility as having the authority to do so.
> (C) The use is reported promptly to the resident's physician by that staff member.

Id.

[95] This Comment deals with common law tort actions rather than federal or state statutory provisions, although alternative remedies are made available under the statutes. The patients' bill of rights, as codified in the relevant state statute, may support a private right of action. *See* S. JOHNSON, *supra* note 4, § 1-22 at 22; *see also* Hoffman & Schreier, *A Private Right of Action Under Missouri's Omnibus Nursing Home Act,* 24 ST. LOUIS U.L.J. 661, 674-79 (1981) (discussing the potential of private right of action to help nursing home residents enforce their rights). The most relevant provision for our purposes is the guarantee of freedom from chemical and physical restraint. *See* 42 C.F.R. § 442.311(f)(2) (1987). There is voluminous literature on bills of rights and their limitations. *See, e.g.,* Caldwell & Kapp, *supra* note 29, at 41-47 (discussing the evolution and provisions of a bill of rights for nursing home patients).

[96] *See* Caldwell & Kapp, *supra* note 29, at 41 ("The notion of patients' rights is rooted in at least two sociological phenomena: 'consumerism,' which advocates a questioning, better-informed public; and the civil rights movement, which champions the cause of vulnerable and powerless minorities.").

[97] *See* S. JOHNSON, *supra* note 4, § 3-2, at 69.

injured person has a short life expectancy and no earning capacity, the standard measures of damages."[98] Also, the type of injury the tort of false imprisonment attempts to remedy—the resident's lack of autonomy and self-determination—while recognized in the abstract as important, may be perceived as too intangible to warrant remuneration.[99] Again, however, the tort itself acknowledges the importance of the mental component.[100]

Furthermore, the question of how to use tort remedies involves a consideration of the role tort law plays in our legal system and society; it does not exist apart from the economic and political values it embodies and perpetuates: "Contemporary tort law is intimately related to the rise of capitalism, as both cause and effect."[101] The economic underpinnings of tort law raise a number of issues relevant to nursing home litigation. First, at least seventy percent of nursing homes are operated for profit;[102] the care and housing of the disabled elderly[103] are secondary to profit considerations. Even more particularly, tort law is inextricably bound up in the economics not only of the industry, but of its victims. If damages are dependent on earning power and "worth," the typical nursing home resident is not likely to engender much economic respect.[104]

As already suggested, the absence of leading cases and the relative lack of interest in nursing home litigation[105] speak volumes about the

---

[98] Butler, *supra* note 8, at 641. However, courts have begun to recognize the inherent disadvantages and lack of incentive elderly nursing home residents face in bringing suits against nursing homes. *See, e.g.,* Harris v. Manor Healthcare Corp., 111 Ill. 2d 350, 369-70, 489 N.E.2d 1374, 1383 (1986) (holding that the legislature could allow treble damages for ordinary negligence in order to encourage private enforcement of the state Nursing Home Care Reform Act, when actual damages might not be enough to warrant instituting an action).

[99] Furthermore, we tend to assume that dependence, both physical and social, is a natural or inevitable consequence of growing old, and that aging equals lack of self-determination. These assumptions have been increasingly challenged by fields as diverse as geriatric medicine (which has shown that "senility" is not a natural consequence of growing old, but a catch-all for distinct biological events such as Alzheimer's disease, depression, and poor nutrition) and political gerontology (which has articulated the nature of elder power). *Cf.* Comment, *Involuntary Relocation of Nursing Home Residents and Transfer Trauma,* 24 ST. LOUIS U.L.J. 758, 758-61 (1981) (discussing the physical and psychological effects of relocation of the elderly or disabled).

[100] "[T]he interest is in a sense a mental one, resembling the apprehension of contact in the assault [situation]." PROSSER, *supra* note 49, § 11, at 47.

[101] Abel, *supra* note 70, at 186.

[102] *See supra* note 23 and accompanying text.

[103] Most, but not all nursing home residents are elderly. *See* S. JOHNSON, *supra* note 4, § 3-1, at 68; Johnson, *supra* note 12, at 681 n.1.

[104] *See* Butler, *supra* note 8, at 641; *see also* Nemore, *Protecting Nursing Home Residents: Tort Actions Are One Way,* TRIAL, Dec. 1985, at 54, 57 (discussing the corporatization of nursing homes).

[105] *See* S. JOHNSON, *supra* note 4, § 3-2, at 69.

situation. They also raise some specific practical problems for the would-be nursing home litigator. The nursing home industry has become and continues to be increasingly corporate in nature; large corporate chains now dominate the field in contrast to twenty-five years ago, when nursing homes were primarily owned by sole proprietors.[106] This fact has a pervasive impact. The optimistic interpretation is that nursing home residents may benefit from juries' recognition of the economic mismatch: if they hear the financial report of a large, "good investment" nursing home corporation, they "may seriously wonder if too much money is being spent on corporate growth rather than on necessary patient care."[107] On the other hand, this litigation pits a vulnerable and dependent older person against the resources of a wealthy corporation. Nevertheless, it is important not to assume the victimization of the nursing home resident as an inevitable fact of life, lest such victimization become a self-fulfilling prophecy.

IV. Proposed Solution: Borrowing from Other Rubrics

A. *Reasoning from Civil Commitment and Guardianship*

Despite the current situation, the false imprisonment tort action has a significant role to play in protecting basic rights of nursing home residents, particularly in conjunction with the concepts of de facto guardianship and commitment. The problems of civil commitment have long been recognized, and persons threatened with commitment are endowed with certain basic due process rights to protect their freedom of liberty.[108] The standard generally is danger to oneself or others.[109] There are also less stringently scrutinized protections for persons who are assigned guardians.[110] In other words, once there is a legal process, there is some degree of scrutiny, however minimal or pro forma. Indeed, abundant evidence exists that these protections are inadequate.[111]

---

[106] *See* Nemore, *supra* note 104, at 57.

[107] *Id.* at 57.

[108] *See, e.g.,* Vitek v. Jones, 445 U.S. 480, 491 (1980) (noting that civil commitment constitutes a "massive curtailment" of one of the most fundamental rights: liberty of movement).

[109] *See* O'Connor v. Donaldson, 422 U.S. 563, 576 (1973); *see also* J. KRAUSKOPF, *supra* note 2, § 4.3, at 43 (describing the five requirements that must be met to justify involuntary commitment).

[110] *See generally* J. KRAUSKOPF, *supra* note 2, § 5.2, at 110 (describing procedural protections against abuse of the system).

[111] *See id.* (arguing that the traditional practice in guardianship proceedings accords "even less protection to the subject person than in mental commitments"); *see also* Alexander, *Premature Probate: A Different Perspective on Guardianship for the Elderly,* 31 STAN. L. REV. 1003, 1010 (1979) (discussing "illusory procedural safeguards"

There is a tendency to assume that civil commitment represents the greatest potential lack of autonomy faced by an elderly person. One expert argues that this is not so: imposition of a guardianship may be just as devastating for the elderly person as commitment to a mental institution.[112]

> Mental commitment, based on mental illness causing dangerousness, imposes the greatest restraint upon personal liberty but does not necessarily render the committed person legally incapable of making personal and property decisions. Guardianship of the person, based on the need for personal care, grants power to a guardian to make medical decisions and grant consents, *to determine the place of abode of the ward including a nursing home,* and to voluntarily commit the ward to a mental hospital.[113]

Obviously, this degree of power endows the guardian with significant potential to abuse the ward's dependence, and this potential has been recognized in the need for proceedings.[114] This power may, in practical and immediate terms, be even greater than the state's, which we recognize in involuntary civil commitment proceedings.

B. *De Facto Guardianship and Commitment*

This Comment has argued that many elderly nursing home patients are subject to the same dangers as persons who are committed or for whom a guardian is appointed. They are not, however, afforded the same protections. Mrs. Pounders, it may be recalled, was confined to the nursing home without having been legally declared incompetent (in need of a guardian) or dangerous to herself (in need of commitment).[115] In other words, the relative who placed her there effectively became her

---

that do not protect elderly people from being adjudged incompetent at hearings at which they are neither present nor represented by counsel, despite law specifically providing for their presence or representation on their behalf).

[112] *See* J. KRAUSKOPF, *supra* note 2, § 3.1, at 31.

[113] *Id.* § 5.1, at 109 (emphasis added) (citing Uniform Probate Code § 5-312).

[114] The power of guardianship includes the power to commit "voluntarily." *See id.* As this Comment has argued, the normative concept "voluntary" may mask a multitude of political and societal sins. *See, e.g.,* Szasz, *supra* note 18, at 404 (discussing "voluntary" hospitalization as a type of involuntary confinement).

[115] *See* Pounders v. Trinity Court Nursing Home, Inc., 265 Ark. 1, 576 S.W.2d 934 (1979) (en banc). There seems to have been no question regarding Mrs. Pounders' mental competence, except perhaps in the mind of the appellate judges; both the majority and dissenting opinions find it important to note that the lawyer who unsuccessfully attempted to get Mrs. Pounders released found that she was in "full possession of her faculties." *Id.* at 937 (Purtle, J., dissenting).

guardian without any guardianship proceeding taking place. The nursing home's rule that a patient be released to the person who arranged for her admission[116] constituted a form of ad hoc, de facto guardianship.

In some situations, courts have recognized that even patients who have been placed voluntarily in institutions may be subject to what amounts to de facto confinement and have accorded them legal protections similar to those given to persons who have been involuntarily committed to institutions.[117] These cases are cause for hope. Courts have found de facto confinement in the case of residents who are disabled, lack readily available resources, or do not have spouse, parents, friends, or a guardian.[118] De facto confinement, like the tort of false imprisonment, has at its heart the acknowledgment that not all restraints are physical or even literal, and that what amounts to confinement will vary from situation to situation.[119]

Mrs. Pounders' case underlines the need to recognize the binding nature of de facto confinement, which may come from social control, medication, threats, and nursing home "policy." *Pounders* held that there was no literal constraint, despite the nursing home's refusal to release Mrs. Pounders with her consent into the custody of a relative who was willing to take her home with her. The nursing home rejected the relative's request and "informed her it was the policy of [the nursing home] to release residents of the home only to the party who entered them into the facility."[120] The potential for abuse—specifically, collusion between the nursing home and relatives to "dump" the resident—is obvious.[121] In this case, so insistent was the nursing home in

---

[116] *See id.* at 936.

[117] *See, e.g.,* Goodman v. Parwatikar, 570 F.2d 801, 804 (8th Cir. 1978) (stating that a voluntarily committed woman has a constitutional right to a safe and humane environment); Harper v. Cserr, 544 F.2d 1121, 1123 (1st Cir. 1976) (finding de facto confinement of a voluntarily committed person); *see also* Comment, *supra* note 99, at 767 (discussing de facto confinement of voluntarily committed persons).

[118] *See Harper,* 544 F.2d at 1123; Comment, *supra* note 99, at 767.

[119] The disabled resident of a nursing home requires protection akin to that afforded to the psychiatric patient. Although these protections are for the most part statutory, their existence testifies to the special vulnerability of those subject to social control by labelling and to the power of context to create constructive imprisonment.

[120] *Pounders,* 265 Ark. at 5-6, 576 S.W.2d at 936 (Purtle, J., dissenting).

[121] *Big Town* is shorter on narrative, but it also suggests that Newman was essentially dumped by a relative who found him difficult. *See* Big Town Nursing Home, Inc., v. Newman, 461 S.W.2d 195, 196 (Tex. Civ. App. 1970) (finding that Newman was taken to the home by a nephew who "signed the admission papers and paid one month's care in advance"). Newman's repeated attempts to escape (he left at least five times and each time was brought back) indicate that the relative was not eager or able to house him. A false imprisonment action presumably could also be brought against the relative.

keeping Mrs. Pounders that even the intervention of a lawyer hired by the relative attempting to free Mrs. Pounders did not sway it. It refused to relinquish her without the permission of the relative who had brought her there to begin with. Interestingly, it was only when the lawyer threatened to file a writ of habeas corpus that the nursing home decided to release Mrs. Pounders.[122]

V. CONCLUSION

Elderly residents of nursing homes lack autonomy to make basic choices and secure basic rights. This problem cuts across doctrinal boundaries. The issue is not only complex from a legal standpoint, but also necessarily involves political, sociological, and medical considerations.

One approach to nursing home abuses has been through patients' bills of rights.[123] These mechanisms presuppose a certain degree of autonomy and self-determination, and there are inequalities that prevent them from being meaningful.[124]

Tort law traditionally has been fluid, and it has a unique role to play in the drama of securing basic rights for nursing home residents. But "modern American legal thought continues to be premised on the distinction between private law and public law. Private law is still assumed to be *about* private actors with private rights, making private choices . . . ."[125] These assumptions are implicit in decisions such as *Pounders* and they are why the doctrinal rubrics, taken on their own terms, are inadequate. Mrs. Pounders' imprisonment cannot be understood by courts who insist that only physical imprisonment is true imprisonment. Mrs. Pounders was tied down by her age, her sense of her lack of alternatives, nursing home policies, her status as an elderly person in society, her own disabilities, her perception of herself, and, finally, by antiquated and literalist notions of what constitutes false imprisonment.

---

[122] *See Pounders,* 265 Ark. at 6, 576 S.W.2d at 937. The majority saw no significance in this fact: "That [the attorney] saw fit to suggest the possibility of an application for a writ of habeas corpus did not somehow have the effect of physically imprisoning Mrs. Pounders, who was upstairs in her room and could have walked out by herself if she had chosen to do so." *Id.*

[123] *See supra* notes 27-28 and accompanying text.

[124] Even the relatively politically neutral approach of the practitioner suggests that tort may do what legislation cannot: "[W]ith an impotent regulatory agency and timid politicians, the only place nursing-home victims and their families can go for relief is to court with a good trial lawyer." McMath, *supra* note 88, at 52.

[125] Mensch, *The History of Mainstream Legal Thought,* in THE POLITICS OF LAW, *supra* note 70, at 32.

This Comment does not suggest that one court can or should dispose of all those difficulties in a single tort action. Rather, it suggests that the framework is there for us to build on: the doctrinal capaciousness of the tort of false imprisonment; the recognition of de facto commitment and guardianship; and the increasing refusal to pretend that the individual functions in a vacuum, outside of the larger political and economic dimensions governing her.

It is imperative that we build on these factors in order to anticipate the objections that have limited the tort's effectiveness in the past. The tort of false imprisonment can be a viable tool for securing the rights of elderly nursing home residents. None of us can afford for long to dismiss these rights or take them for granted.