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Recommended Citation

Samuel V. Jones, *The Moral Plausibility of Contract: Using the Covenant of Good Faith to Prevent Resident Physician Fatigue-Related Medical Errors*, 48 U. Louisville L. Rev. 265 (2009).

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THE MORAL PLAUSIBILITY OF CONTRACT: USING THE COVENANT OF GOOD FAITH TO PREVENT RESIDENT PHYSICIAN FATIGUE-RELATED MEDICAL ERRORS

*Samuel V. Jones**

INTRODUCTION

At approximately 11:30 p.m., on March 4, 1984, Libby Zion, an eighteen-year-old college student, visited the New York Hospital with an earache and fever.¹ Although Libby's medical team, "consisting of two physically present residents and an attending physician" available by telephone,² was "specifically told she was taking Nardil,"³ one of the resident physicians "prescribed an injection of Demerol,"⁴ a drug that has a tendency to cause death when "taken in conjunction with Nardil."⁵ Libby "immediately began to suffer an adverse reaction" to this fatal pharmaceutical cocktail.⁶ Although "[s]he thrashed about violently" and her fever surged, no physician saw her for approximately four hours.⁷ The only attention Libby received was from an attendant who had restrained her upon instruction from a resident physician "who had never examined her."⁸ By 7:45 a.m. the next day, Libby was dead.⁹

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¹ Anthony Ciolli, Note, *The Medical Resident Working Hours Debate: A Proposal for Private Decentralized Regulation of Graduate Medical Education*, 7 YALE J. HEALTH POL'Y L. & ETHICS 175, 184 (2007) (citing Tom Wicker, *Doctors in the Dock?*, N.Y. TIMES, Dec. 23, 1985, at A17); Clark J. Lee, Comment, *Federal Regulation of Hospital Resident Work Hours: Enforcement with Real Teeth*, 9 J. HEALTH CARE L. & POL'Y 162, 175 (2006).

² Ciolli, *supra* note 1, at 184; Craig Horowitz, *The Doctor Is Out*, N.Y. MAGAZINE, Oct. 3, 2003, available at http://nymag.com/nymetro/health/features/n_9426/.

³ Ciolli, *supra* note 1, at 184.

⁴ *Id.*

⁵ *Id.*

⁶ *Id.*

⁷ *Id.*; see also David Kocieniewski, *Libby Zion Doc Admits Medical Team Failure*, NEWSDAY, Nov. 17, 1994, at A05, available at 1994 WLNR 472597 (reiterating same).

⁸ Ciolli, *supra* note 1, at 184-85.

⁹ Lee, *supra* note 1, at 176; see also Ciolli, *supra* note 1, at 185 ("By morning, Libby had passed away.").

More than a decade later, a hospital physician admitted that the resident physicians erred in their treatment of young Libby.¹⁰ A subsequent investigation revealed that both resident physicians had been working for eighteen hours or more by the time they examined Libby.¹¹ Although a grand jury did not issue criminal indictments, it acknowledged the poor care that patients are at risk of receiving from overworked and fatigued resident physicians.¹²

The fate of Libby Zion is not unique.¹³ Scholars indicate medical errors represent the “nation’s sixth leading cause of death, killing more people annually than automobile accidents or guns.”¹⁴ Medical experts have warned that resident physicians “are working far beyond the limits that society deems acceptable in other sectors” where public safety is of vital concern, and have found that the “practice is incompatible with a safe, high-quality health[-]care system.”¹⁵ In December 2008, the Institute of Medicine, a national panel of medical experts, issued a report lamenting the risks to patients caused by sleep deprivation, attributed to the lack of enforcement of resident physician duty-hour restrictions.¹⁶ According to a recent study, the biggest threat to the resident-physician performance is sleep deprivation.¹⁷ Although a resident physician who works more than eighty hours a week “commits 36% more serious medical errors than one who works normal hours,”¹⁸ many resident physicians report working longer than twenty-four hours a day and more than eighty hours a week.¹⁹

¹⁰ Kocieniewski, *supra* note 7, at A05.

¹¹ Horowitz, *supra* note 2; Lee, *supra* note 1, at 176.

¹² Ciolli, *supra* note 1, at 185.

¹³ Jennifer F. Whetsell, *Changing the Law, Changing the Culture: Rethinking the “Sleepy Resident” Problem*, 12 ANNALS HEALTH L. 23, 36–37 (2003).

¹⁴ Les Weisbrod, *Recession and Trial Lawyers*, 45 TRIAL 9, 9 (2009).

¹⁵ David M. Gaba & Steven K. Howard, *Patient Safety: Fatigue Among Clinicians and the Safety of Patients*, 347 NEW ENG. J. MED. 1249, 1254 (2002), available at <http://content.nejm.org/cgi/reprint/347/16/1249.pdf>.

¹⁶ Tara Parker-Pope, *Expert Panel Seeks Changes in Training of Medical Residents*, N.Y. TIMES, Dec. 3, 2008, at A23, available at 2008 WLNR 23159567.

¹⁷ See M.H. Klaiman, *Bonded Labor Characteristics of U.S. Postgraduate Medical Training*, 39 J. HEALTH L. 373, 378 (2006) (indicating sleep deprivation is “the largest stress residents face”).

¹⁸ MedicalNewsToday.com, *Sleep Deprived Doctors Commit More Serious Errors*, <http://www.medicalnewstoday.com/articles/15551.php> (last visited Sept. 1, 2009).

¹⁹ Christopher P. Landrigan et al., *Interns’ Compliance with Accreditation Council for Graduate Medical Education Work-Hour Limits*, 296 JAMA 1063, 1066 (2006), available at <http://jama.ama-assn.org/cgi/content/full/296/9/1063>; see also Lee, *supra* note 1, at 202 (citing a study indicating that of “25,176 residents surveyed in [1489] residency programs[.]” roughly 25% of the programs reported resident physicians working more than eighty hours per week; Klaiman, *supra* note 17, at 376–77 (noting that some resident physicians “may work up to 136 hours per week”); Jamie Talan, *Prescription for Danger: Many Physician Residents Violating Cap on Work Hours, Which Can Increase Risks to Patients, Studies Say*, NEWSDAY, Sept. 6, 2006, available at 2006 WLNR 15430987 (reporting that 80% of resident physicians surveyed “said they worked longer than the standards permitted”);

Despite the great weight of scholarship arguing in favor of reduced resident physician duty hours, many supervising physicians assert that grueling duty-hour demands and sleep deprivation serve a legitimate and necessary pedagogical objective within the resident-physician training process.²⁰

Indeed, the ongoing controversy within the medical community regarding the role of sleep deprivation centers on the physiological consequences of resident physician duty hours: the length of time resident physicians should reasonably be expected to provide proper care to patients without succumbing to the ill effects of sleep deprivation.²¹ While the medical profession struggles to reach a consensus regarding appropriate limitations on the number of resident-physician duty hours or on a process for resolving the controversy, the public harm associated with sleep deprivation within residency hospitals continues to hover at catastrophic levels.²² The medical-error controversy has earned its way into the mainstream media.²³ While popular television “shows like ‘Grey’s Anatomy’ glamorize residency training as a gratifying rite of passage for doctors,”²⁴ the President of the United States²⁵ and media icons like Oprah Winfrey²⁶ are making the public aware of the approximately 100,000

Scott Turner, *Medical Residency: An Exercise in Sleep Deprivation*, GEORGE ST. J., Oct. 4, 2001, available at http://www.brown.edu/Administration/George_Street_Journal/vol26/26GSJ06h.html (“To meet educational and clinical obligations, most of the nation’s 100,000 medical interns and residents work between 60 and 130 hours a week.”); Kim Becker, Study Proves Current Work Hour Guidelines for Interns Are Unsafe, <http://www.medicalnewstoday.com/articles/18966.php> (last visited Sept. 1, 2009).

²⁰ See Ann Pomeroy, *The Doctor Is Still In*, HR MAG., Feb. 2002, at 37, 38–39, available at http://findarticles.com/p/articles/mi_m3495/is_2_47/ai_83058908/?tag=content;coll (“Older doctors who went through the same rite of passage may believe that it weeds out those who don’t have ‘the right stuff.’”).

²¹ See CHERYL ULMER ET AL., RESIDENT DUTY HOURS: ENHANCING SLEEP, SUPERVISION, AND SAFETY 47–48 (2009) (framing the duty-hour limit and quality-of-care issue).

²² Courtney Humphries, Extended Shifts for Residents Called Risky for Patients, http://focus.hms.harvard.edu/2004/Nov12_2004/sleep_medicine.html (last visited Sept. 1, 2009) (citing a study that found “interns made 35.9[%] more medical errors considered serious during the traditional [thirty-hour shift], including 20.8[%] more medication errors and more than five times as many serious diagnostic errors”).

²³ See, e.g., Pauline W. Chen, *Does More Sleep Make for Better Doctors?*, N.Y. TIMES, Dec. 5, 2008, available at 2008 WL 25145629.

²⁴ Parker-Pope, *supra* note 16, at A23.

²⁵ President Barack Obama, Remarks by the President at the Annual Conference of the Am. Med. Ass’n. (June 15, 2009) (transcript available at http://www.whitehouse.gov/the_press_office/Remarks-by-the-President-to-the-Annual-Conference-of-the-American-Medical-Association/) (advising the audience that 100,000 lives are unnecessarily lost every year in United States hospitals because of medical errors).

²⁶ *The Oprah Winfrey Show: Medical Mistakes: Dr. Oz Talks to Actor Dennis Quaid* (ABC television broadcast Mar. 10, 2009) (storyboard photos and explanatory excerpts available at <http://www.oprah.com/dated/oprahshow/oprahshow-20090219-dennis-quaid>) (drawing the public’s attention to a medical error that nearly killed actor Dennis Quaid’s newborn twins); see also Kayshan Parsi, *To Err Is Human: Understanding the Data*, 6 VIRTUAL MENTOR, No. 3 (2004), <http://virtualmentor.ama-assn.org/2004/03/msoc1-0403.html> (recognizing that Oprah Winfrey “devoted a special episode” of her talk show to apprising the public about the approximately 100,000 people who die each year because of medical errors).

patients just like Libby Zion that die each year because of medical errors linked to sleep-deprived resident physicians, medication overdoses, and hospital-acquired infections.²⁷

Typically missing from any discussion regarding the problem of sleep deprivation in residency hospitals is an evaluation of the rights and duties that emanate from the contractual arrangement between the resident physician and the residency hospital. Exchanges about social harm reveal a deeply rooted mental habit that permeates everyday life and engenders a divergence between the law of contracts and morality. In tragic cases like that of young Libby Zion, the initial reaction is often to look exclusively to tort law or, perhaps, criminal law to address the social harm.²⁸ Contract law, long accepted as the juridical construct aimed at ascribing rights and duties strictly based on the private ordering of performance and the utility of efficiency and certainty of transactional outcomes, is seldom, if ever, considered in this context. Indeed, my research has not revealed any scholarship that has examined whether contractual formulations may be a firm vehicle for guarding against societal harm related to performance under medical-residency agreements.

The purpose of this Article is not to resolve questions regarding the physiological effect of sleep deprivation on resident physicians from a medical or scientific perspective. Rather, given the problem of sleep deprivation, the intent is to identify the exact point at which a hospital's exercise of discretion exceeds the legal limits established by the law of contracts. The medical literature, therefore, cannot be wholly detached from the legal question. The good-faith doctrinal analysis requires some consideration of what the modern scholarship reflects about this domain. At first glance, it may appear that the discussion is overly critical of the role of sleep deprivation in medical-residency programs. The objective, nevertheless, is not to render a decisive opinion on medical pedagogies.

²⁷ See R. Monina Klevens et al., *Estimating Health Care-Associated Infections and Deaths in U.S. Hospitals*, 122 PUB. HEALTH REP. 160, 164 (2007), available at http://www.cdc.gov/ncidod/dhqp/pdf/hicpac/infections_deaths.pdf (finding that "approximately 99,000" people die each year from infections acquired while hospitalized); Lee, *supra* note 1, at 162 ("In recent years, there has been an increase in the public's awareness of medical errors committed by hospital interns and residents who have been acutely and chronically sleep-deprived as a result of extremely long work hours."); Parker-Pope, *supra* note 16, at A23 (national publication drawing the public's attention to the problem); President Barack Obama, *supra* note 25; *Today: Profile: John Connolly, Health Care Expert, Discusses the Need for Researching Doctors and Hospitals* (NBC television broadcast July 12, 2006) (transcript available at 2006 WLNR 12014740) [hereinafter *Connolly*] ("[T]here are about 100,000 medical[-]error deaths a year in this country, and many of them can be prevented.").

²⁸ See Wicker, *supra* note 1, at A17 (indicating that the first two options for holding the physicians accountable in the Libby Zion matter were criminal sanctions and tort liability).

The aim, rather, is to highlight the detriment that sleep deprivation causes to the public and to provide the reader with the opportunity to weigh the solution advanced here against the plausibility of leaving its legal footing untouched, which some medical professionals suggest is appropriate, given resident-hospital labor and pedagogical objectives.²⁹

This Article contends that contract law is in the proper position to respond to the moral urge to address the problem of sleep deprivation without encroaching upon the libertarian strictures that prioritize efficiency and certainty of contractual outcomes over the demands of social welfare. It illustrates how medical practice has fostered a belief that residency hospitals have an unbridled discretion to set resident physician duty hours, which is based on latent individualistic conceptions of justice that cannot be defended. It asserts that when residency physician agreements are silent on the question of duty hours or grant the residency hospital absolute discretion to set duty hours, the implied covenant of good faith and fair dealing may provide a sufficient jurisprudential basis to trigger a contractual commitment by the resident hospital to comply with the duty-hour guidelines enunciated by the Accreditation Council for Graduate Medical Education (ACGME).³⁰

Part I introduces the reader to the resident physician and the ACGME. Part II explores the problem of sleep deprivation and its human and economic costs. In so doing, it articulates the competing philosophies that fuel the sleep-deprivation debate. Part III examines federal and state legislative efforts to reduce the effects of sleep deprivation in residency hospitals. Part IV examines competing judicial treatments of medical-residency agreements and resident-physician employment status. It argues against the judiciary's penchant for evading good-faith evaluations of the performance required under medical-residency agreements because of "medical deferentialism." Part V contends that existing common-law constructions of the implied covenant of good faith and fair dealing are properly suited to respond to the societal need to reduce the ill effects of

²⁹ See Lee, *supra* note 1, at 186.

³⁰ The analysis in the Article is limited to the 8747 U.S. medical residency programs sponsored or accredited by the ACGME, which oversees approximately 110,000 resident physicians. See ACGME, Number of Accredited Programs for the Current Academic Year (2009–2010), http://www.acgme.org/adspublic/reports/accredited_programs.asp (last visited Sept. 1, 2009) (listing the number of accredited programs by practice specialty). This Article does not address situations in which the residency agreement specifically purports to grant the residency hospital the right to impose duty hours that exceed the limits promulgated by the ACGME. Although there may be reason to deny the enforceability of such contracts on public policy grounds, such an analysis lies outside the scope of this Article.

sleep deprivation on patients and resident physicians. In so doing, it challenges the separatist claim that the law of contracts must insulate itself from the infusion of moral principle if it is to supply the efficiency drawn from the certainty of contractual outcomes.

I. THE RESIDENT PHYSICIAN WORK ARRANGEMENT

A. *The Resident Physician Work Environment*

Resident physicians are “hospital physicians pursuing training in medical specialties.”³¹ Despite having completed medical school, resident physicians are considered “physicians in transition” because they lack the necessary skills to practice medicine independently.³² Medical-residency programs are generally three to seven years long, during which time the resident physician attempts to learn by providing care to patients under the supervision of a medical faculty member or an attending private practitioner.³³ Among the core goals of the residency program is to provide “excellent training with an appropriate balance between educational and clinical areas of instruction.”³⁴ As the Libby Zion case illustrates, however, substandard performance by a resident physician can lead to death or irreparable physical harm to patients, in addition to the traditional pecuniary losses generally associated with breach-of-contract cases. This undeniable high risk to the public weighs in favor of strong, effective monitoring and oversight. Responsibility for this oversight of medical residency programs falls upon the ACGME.³⁵

³¹ Klaiman, *supra* note 17, at 375.

³² Stewart R. Reuter, *Professional Liability in Postgraduate Medical Education: Who Is Liable for Resident Negligence?*, 15 J. LEGAL MED. 485, 485 (1994).

³³ *Id.* at 486–87; Whetsell, *supra* note 13, at 26–28.

³⁴ Cameron Bruce Dibb, *Medical Residency: When Are Program Administrators Liable?*, 36 J.L. & EDUC. 281, 281 (2007). Resident physicians generally enter into “one-year[] renewable contracts” with the residency hospital. Klaiman, *supra* note 17, at 379. Although the resident physician–residency hospital relationship is based on contract principles, the negative consequences stemming from poor performance of the residency agreement transcend private concerns. *Id.* At the expiration of the contract, the residency hospital has “no legal obligation to renew” the resident physician’s contract. *Id.* In fact, if a residency hospital “decides to discontinue a resident [physician’s contract] . . . , it is . . . not obligated to provide notice to enable the resident to seek training elsewhere.” *Id.*

³⁵ *See* Reuter, *supra* note 32, at 486.

B. The Role of the Accreditation Council for Graduate Medical Education

The ACGME establishes, approves, and assesses national standards for graduate medical educational programs under its sponsorship.³⁶ ACGME standards prohibit residency hospitals from allowing resident physicians' weekly duty hours to exceed eighty hours, averaged over a four-week period.³⁷ Duty hours include program, clinical, and academic activities.³⁸ Duty hours do not include any preparation, reading, or studying performed outside of the hospital.³⁹

The "ACGME monitors compliance with its standards through triennial on-site program inspections, through data collection by anonymous resident surveys, and through a mechanism for accepting 'whistle-blower' complaints by individual residents, albeit not anonymously."⁴⁰ It also "compiles statistics on the frequency with which various programs are cited for noncompliance[,] and it publicly disseminates the results."⁴¹ Critics, however, have found the ACGME's oversight wanting for two reasons. First, the penalty for violation of the duty-hour standards is merely probation and possible loss of accreditation.⁴² Second, the ACGME does not provide whistle-blower protections for resident physicians who report program violations.⁴³ This arrangement

³⁶ Dobb, *supra* note 34, at 282; see also W. Paige Hren, *Is It the End of an Era or the Beginning of an Error? The American Medical Association Finally Approves Work Hour Limits for Overworked and Sleep Deprived Medical Residents: Should OSHA Still Step In?*, 23 J. NAT'L ASS'N ADMIN. L. JUDGES 457, 460 (2003) ("In February 2003, the ACGME's final standards were approved and became effective for all accredited United States residency programs on July 1, 2003.") (footnote omitted); ACGME, *The ACGME at a Glance*, http://www.acgme.org/acWebsite/newsRoom/newsRm_acGlance.asp (last visited Sept. 4, 2009) (explaining the responsibilities undertaken by the ACGME regarding medical-residency programs in the United States). To maintain accreditation, a medical residency program must be in "substantial compliance" with the ACGME standards, policies, and procedures. Dobb, *supra* note 34, at 283.

³⁷ ACGME, *Duty Hours Language*, http://www.acgme.org/acWebsite/dutyHours/dh_Lang703.pdf (last visited Sept. 4, 2009) [hereinafter *Duty Hours Language*]; see also Klaiman, *supra* note 17, at 381 ("Under the ACGME standards, accredited programs were to impose a weekly duty hour limit of eighty hours (averaged over each four-week period), with on-call schedules limited to no more frequently than every third night.")

³⁸ *Duty Hours Language*, *supra* note 37.

³⁹ *Id.*

⁴⁰ Klaiman, *supra* note 17, at 381.

⁴¹ *Id.*

⁴² Press Release, ACGME, *ACGME Duty Hour Standards Now in Effect for All Residency Programs* (July 1, 2003) (available online at http://www.acgme.org/acWebsite/newsReleases/newsRel_07_01_03.asp).

⁴³ Robert R. Elder, Note, *Expanded Hospital Liability Under the Federal False Claims Act: An Unexpected Solution to the Resident Duty Controversy*, 5 IND. HEALTH L. REV. 53, 66 (2008); see also Ciolli, *supra* note 1, at 207 n.207 (noting that the ACGME's lack of whistle-blower protections possibly prevents residents from reporting suspected violations); AMSA, *The ACGME Regulations vs. Federal Legislation*, <http://www.amsa.org/rwh/acgme.cfm> (last visited Aug. 17, 2009) [hereinafter *ACGME vs. Federal*] (referencing the lack of whistle-blower protection).

leaves resident physicians in a perpetual state of duress because they are compelled to choose between jeopardizing their medical education, by reporting violations, or compromising their own safety and that of their patients by enduring the potentially high-risk effects of sleep deprivation brought on by grueling duty-hour demands.⁴⁴ Therefore, reliance on resident physicians' reporting as a policing mechanism is undeniably untrustworthy, causing some commentators to view the ACGME as an ineffective organization.⁴⁵

II. CONDITIONS OF WORKER DURESS WITHIN THE MEDICAL-RESIDENCY PROGRAM HOSPITALS

A. *The Sleep-Deprivation Factor in Residency Hospitals*

Some physicians contend that sleep deprivation is an unfortunate-but-necessary element of a resident physician's development as a fully skilled, certified physician.⁴⁶ Adherents of this view oppose changing the medical-residency programs to alleviate the effects of sleep deprivation, claiming "[a] fatigued doctor who is familiar with a case is better than a fresh physician who doesn't know a thing about the patient."⁴⁷ Granted, traditional claims that the continuity of care for patients represents an important medical imperative have merit.⁴⁸ Nevertheless, recent studies,

⁴⁴ See Elder, *supra* note 43, at 66 ("[F]ew [r]esidents are willing to complain to the ACGME[] or to anyone else[] when they are required to work irrationally long hours because they fear retaliatory discharge. Furthermore, those [r]esidents that do raise allegations of regulatory violation, in the hope of improving working conditions and enhancing the quality of care, risk having their programs terminated[,] thereby[] inspiring the ire of their contemporaries and discrediting the academic reputations of the very institutions and superiors to which they are looking for career advancement.") (footnote omitted); ACGME vs. Federal, *supra* note 43 ("The penalty for violating the regulations is loss of accreditation—presenting an unfair dilemma for residents who, in addition to the personal risks involved, must choose to report violations at the risk of losing accreditation for the entire program.").

⁴⁵ *E.g.*, Dori Pagé Antonetti, *A Dose of Their Own Medicine: Why the Federal Government Must Ensure Healthy Working Conditions for Medical Residents and How Reform Should Be Accomplished*, 51 CATH. U. L. REV. 875, 892 n.91 (2002); Elder, *supra* note 43, at 64; see also ACGME vs. Federal, *supra* note 43 (noting "serious flaws" with the ACGME duty-hour regulations).

⁴⁶ See Lee, *supra* note 1, at 185 (citing Robert E. Condon, *Sleep Deprivation and Resident Call Schedules*, 46 CURRENT SURGERY 361, 364 (1989)).

⁴⁷ Turner, *supra* note 19; Leora I. Horwitz et al., *Changes in Outcomes for Internal Medicine Inpatients After Work-Hour Regulations*, 147 ANNALS INTERNAL MED. 1, 1 (2007), available at <http://www.annals.org/cgi/reprint/0000605-200707170-00163v1.pdf> (indicating the ACGME duty-hour regulations may mitigate fatigue but also cause "increased handoffs" of patients from physician to physician, which can harm patient care).

⁴⁸ See, *e.g.*, Whetsell, *supra* note 13, at 43–44 (noting the "continuity argument": that medical mistakes increase when patient hand-offs occur at shift changes, due to lack of adequate communication between the physicians, and also that residents miss out on following their patients "at every critical stage" of the hospital stay).

advances in technology, and an increased awareness of the effects of sleep deprivation have thoroughly discredited the notion that imposing harsh duty-hour demands upon resident physicians will result in better care for patients.⁴⁹ It is undeniable that technological advances, improved supervision, and increased rest periods have consistently resulted in superior patient care.⁵⁰ Medical studies have failed to reveal any deterioration in patient care for residency hospitals that have implemented and complied with the ACGME regulations.⁵¹ Still, some medical professionals object to change because there is no clear “clinical evidence to tie physician fatigue to medical errors,”⁵² arguing that reduced hours would compromise the resident education, quality of health care, or the financial solvency of the residency hospital.⁵³

Though some assertions supporting the role of sleep deprivation may appear legitimate, they are often underlain by attitudinal mischief and old-guard philosophy, such as “we made it through. So should you.”⁵⁴ Some supervising physicians view the resident physician’s grueling work conditions as a necessary rite of passage that every resident physician must endure in order to become a certified physician.⁵⁵ For many, the solution is simply for resident physicians to “learn to ‘subordinate their needs for sleep and food to the unpredictable and often consuming demands of patient care.’”⁵⁶ In fact, some supervising physicians liken themselves to seasoned soldiers, Marines, or Navy Seals⁵⁷ and liken resident physicians to “military

⁴⁹ See, e.g., *id.* at 44–45.

⁵⁰ See Humphries, *supra* note 22 (discussing a study conducted at Brigham and Women’s Hospital, called the “Landrigan study,” which “pointed out that a computerized patient sign-off system . . . reduced the errors caused by cross-coverage” and found that “even with more patient handoffs, fewer errors occurred when interns were better rested[]”).

⁵¹ Horwitz, *supra* note 47, at 6.

⁵² Tumer, *supra* note 19.

⁵³ See Adam E. Block & Douglas M. Norton, *Nurse Labor Effects of Residency Work Hour Limits*, 26 NURSING ECON. 368, 368 (2008), available at 2008 WLNR 25970886 (stating that “there was substantial pushback” to work hour restrictions because of concerns regarding medical education, quality of care, and “fiscal consequences of the work-hour limits”).

⁵⁴ *Lightening the Load*, THE PLAIN DEALER (Cleveland), Mar. 13, 2005, Sunday Magazine, at 15, available at 2005 WLNR 3930447.

⁵⁵ Pomeroy, *supra* note 20, at 38–39.

⁵⁶ Ciolli, *supra* note 1, at 182 (quoting Sandra G. Boodman, *Waking Up to the Problem of Fatigue Among Medical Interns*, L.A. TIMES, Apr. 16, 2001, Health, at S1, available at 2001 WLNR 10573165).

⁵⁷ See Boodman, *supra* note 56 (“[T]he ability to ‘handle it’ is a core value in medicine, which is . . . ‘a ‘Right Stuff’ kind of environment’—a culture shared by astronauts, pilots, Navy Seals and other highly trained elite groups. ‘Right Stuff’ cultures prize exceptionally hard work, toughness, intelligence, self-sufficiency[,] and a refusal to complain. Residents at Johns Hopkins are even called ‘Osler marines’ after William Osler, the legendary physician whose [nineteenth] century vision that young doctors would best learn to take care of patients by living on the wards and apprenticing themselves to experienced doctors became the modern

recruits,”⁵⁸ identifying themselves as “tough and ‘hardened[,]’”⁵⁹ using an array of measures to discipline residents deemed weak.⁶⁰

Egotism among physicians plays an undeniable role in the process. While supervising physicians liken themselves to the military elite,⁶¹ evidence indicates that surgeons perceive themselves as almost godlike, viewing their physiological abilities to be far superior than that of physicians in other medical disciplines and, perhaps, all other human beings.⁶² Richard Reiling, former residency director and former representative of the American College of Surgeons at the American Medical Association, flatly rejects sleep-deprivation research and dismisses complaints about fatigue as “‘whining[,]’”⁶³ suggesting surgeons “‘are built differently’ and learn to become impervious to exhaustion.”⁶⁴ These God complex or superhuman attitudes appear misplaced, given the vast degree of scholarship highlighting the deleterious effects of sleep deprivation recognized by noted professionals,⁶⁵ including the military elite.⁶⁶ As illustrated in the next

residency. “These are smart people, very competitive and driven in a high-stress environment, which requires a certain attitude to get through[. . . .]”; see also Simon Ahtaridis, *When Physicians Ignore the Evidence*, COMMITTEE OF INTERNS AND RESIDENTS NEWS (CIR, nat’l affiliate of SEIU, New York, N.Y.), Sept. 2006, at 2, available at <http://www.cirseiu.org/assets/assetcontent/a96df179-53ca-4706-8a8a-7f3002566263/546bfa9e-94e2-495f-9d30-54cc81f55e47/a5b8e061-97c0-4fe6-a66b-64a88792b604/1/CIR%20News-9-06.pdf> (“[The medical profession’s] culture supports the view that [physicians] are indestructible individuals, immune to the effects of illness and fatigue. . . . Those who claim that long shifts are bad for patient care are thought to be weak, undedicated, or selfish.”).

⁵⁸ Peter Gott, *Long Shifts Hurt Patient Care*, STUART NEWS (Fla.), Feb. 26, 1998, at D3, available at 1998 WLNR 5822505.

⁵⁹ *Id.*

⁶⁰ See M.H. Klaiman, *Medical Education’s Dirtiest Secret*, THE HUMANIST, Nov.-Dec. 2003, at 30-31 (“[T]he ugliest feature of medical education is the draconian methods that medical educators use in disciplining residents. Medical school administrators have been functionally free to resort to actionable or illegal acts such as defamation or physical mistreatment. The latter can include increasing the trainee’s workload, denying leave for illness and even corporal punishment. . . . Denial of sick leave (especially extended sick leave), for example, is common. . . . Hospital administrators engage in abusive discipline because they can. The perpetrators must account to no one and nothing in the typical contract signed by a doctor joining a medical residency places limits on her or his superiors’ disciplinary prerogatives.”); see also Boodman, *supra* note 56 (reporting remarks by Bertrand M. Bell, a professor of medicine at Albert Einstein College of Medicine in New York, who said that resident physicians are “‘taught to hide what [they] don’t know’”). According to Bell, the idea is that the only way the resident is going to remember how to do something right “‘is to make a mistake and then learn from it.’” *Id.* As a result of such cultural norms, “[m]istakes by interns and residents kill more people than medication errors’” *Id.*

⁶¹ See Boodman, *supra* note 56.

⁶² Whetsell, *supra* note 13, at 46 n.125.

⁶³ *Id.*

⁶⁴ *Id.*; see also Lindsay Evans, *Regulatory and Legislative Attempts at Limiting Medical Resident Works Hours*, 23 J. LEGAL MED. 251, 256 (2002) (reiterating same).

⁶⁵ See, e.g., Humphries, *supra* note 22 (citing a study that found “‘interns made 35.9[%] more medical errors considered serious during the traditional [thirty-hour shift], including 20.8[%] more medication errors and

section, the scientific scholarship reveals an undeniable and unforgiving reality regarding sleep deprivation in the resident-physician work environment and prompts questions regarding the ethics and judgment of the practices employed by some residency hospitals.

B. The Link Between Sleep Deprivation and Harm to the Resident Physician

Contrary to the assertions made by some supervising physicians and regardless of a resident physician's effort and dedication, no human being can overcome the physiological need for sleep.⁶⁷ The judiciary and the medical profession alike have recognized the wide body of scholarship indicating that human beings have a biological need for sleep.⁶⁸ Few would deny that sleep deprivation results in decreased "judgment, vigilance, mood, motor coordination, cognitive skills, reaction time, and even the ability to recognize error."⁶⁹ Whether a person forgoes sleep for twenty-four consecutive hours or receives inadequate sleep over an extended period, "the harmful impact on cognitive performance is similar."⁷⁰ In addition to cognitive dysfunctions, resident physicians frequently "feel they are living in a kind of submarine of anguish that no one 'out there' can understand,"⁷¹ which reduces their chances of maintaining healthy personal relationships. This stress and isolation consequently leads to high rates of divorce, emotional difficulties, alcoholism, anger, depression, drug abuse, suicide, pregnancy complications, or some combination of these occurrences.⁷² The

more than five times as many serious diagnostic errors").

⁶⁶ According to a 2008 report commissioned by the Pentagon's Office of Defense Research and Engineering, the "most immediate human performance factor in military effectiveness is degradation of performance" due to sleep deprivation. E. WILLIAMS ET AL., HUMAN PERFORMANCE 1 (2008), available at <http://fas.org/irp/agency/dod/jason/human.pdf>. The report found that "sleep deprivation is known to have significantly harmful impact on physical performance, alertness, and the ability to perform complex cognitive tasks." *Id.* at 20. Therefore, battlefield commanders should "weigh carefully the negative impact" of sleep deprivation on their forces. *Id.* Contrary to the attitudes of many physicians likening themselves to soldiers, the report indicated that sleep deprivation caused a dramatic decrease in the "cognitive function, including vigilance, memory, reaction time and reasoning" of soldiers "in U.S. Army elite units during a combat simulation field exercise." *Id.* at 21. See also ScienceDaily.com, Sleep Deprivation Affects Moral Judgment, Study Finds, <http://www.sciencedaily.com/releases/2007/03/070301081831.htm> (last visited Aug. 17, 2009) (highlighting a study conducted by the Walter Reed Army Institute of Research that found sleep deprivation affects moral judgment).

⁶⁷ *Desmond v. Mukasey*, 530 F.3d 944, 953–55 (D.C. Cir. 2008).

⁶⁸ *Id.* (citing medical studies and textbooks in finding that human beings do indeed need sleep).

⁶⁹ Whetsell, *supra* note 13, at 40.

⁷⁰ Andrew W. Gefell, Note, *Dying to Sleep: Using Federal Legislation and Tort Law to Cure the Effects of Fatigue in Medical Residency Programs*, 11 J.L. & POL'Y 645, 649–50 (2003).

⁷¹ Ethan Bronner, *The Foot Soldiers of Medicine*, BOSTON GLOBE, July 6, 1986, Sunday Magazine, at 16, available at 1986 WLNR 274384.

⁷² See Evans, *supra* note 64, at 255 (citing depression and pregnancy complications); Lucy M. Osborn et al., *Outcome of Pregnancies Experienced During Residency*, 31 J. FAM. PRAC. 618 (1990), available at

debilitating effects of sleep deprivation are, in fact, comparable to the effects of alcohol use.⁷³ Studies have shown that staying awake for nineteen to twenty-eight hours impairs physiological performance to the same degree as having a .10% blood alcohol level, which is well above the legal limit.⁷⁴

C. Sleep Deprivation and Patient Harm

Despite protestations that there is no “rigorous scientific evidence” that links sleep deprivation and patient harm,⁷⁵ strong medical evidence now explains the link between resident-physician sleep deprivation and medical error.⁷⁶ A March 2008 study by researchers at Duke University revealed for the “first time” that sleep deprivation substantially decreases a healthy individual’s brain functioning, including those areas that make sense of visual perceptions.⁷⁷ According to Dr. Michael Chee,⁷⁸ humans “can’t effectively memorize or process what [they] see if [the] brain isn’t capturing that information.”⁷⁹

Dr. Chee’s findings are consistent with the personal claims of resident physicians who contend that their fatigue-related medical errors,⁸⁰ have led

1990 WLNR 4494677 (discussing pregnancy complications among female residents but noting the issue “needs further investigation”); Raymond C. Lackore, Editorial, *Exhausted Doctors in Training Hazardous*, VIRGINIA-PILOT & LEDGER-STAR (Norfolk, Va.), Dec. 3, 1990, at A8, available at 1990 WLNR 1543654 (citing “[d]rug dependence, alcoholism, divorce, and suicide”); see also Joyce Allman, *Bearing the Burden or Baring the Soul: Physicians’ Self-Disclosure and Boundary Management Regarding Medical Mistakes*, 10 HEALTH COMM. 175, 177 (1998) (describing how resident physicians are “precluded” from discussing their medical errors for “three reasons: risk management discourages it, public law inhibits it, and the medical culture denies it”). This workplace arrangement often leads to “self-imposed professional isolation, feelings of remorse, anger at self, inadequacy, guilt, and fear of repercussions.” *Id.*

⁷³ Joshua D. Levine, Note, *A Road to Injustice Paved with Good Intentions: Maggie’s Misguided Crackdown on Drowsy Driving*, 56 HASTINGS L.J. 1297, 1301 (2005).

⁷⁴ Whetsell, *supra* note 13, at 41; see also Levine, *supra* note 73, at 1301 (citing study that indicated individuals “awake for twenty-four hours are as impaired as someone with a blood-alcohol level of .10%”). Not surprisingly, sleep deprivation presents a high risk of exposure to vehicular harm for resident physicians. NAILAH THOMPSON, *DRIVING WHILE DROWSY: THE THREAT TO RESIDENT PHYSICIANS & PUBLIC SAFETY* 4 (2008), available at http://www.cirseiu.org/assets/assetcontent/a96df179-53ca-4706-8a8a-7f3002566263/546bfa9e-94e2-495f-9d30-54cc81f55e47/df3512e6-27d6-431d-9a95-6ad2e8bf4a16/1/IOM_Thompson_testimony_030408.pdf.

⁷⁵ Whetsell, *supra* note 13, at 42.

⁷⁶ See *Sleep Deprivation Affects Ability to Make Sense of What We See*, DRUG WK., June 6, 2008, at 136, available at 2008 WLNR 10145244 [hereinafter, DRUG WK.] (discussing neuroscience study of effects of sleep deprivation).

⁷⁷ *Id.*

⁷⁸ Lead author and professor at the Neurobehavioral Disorders Program at Duke-NUS Graduate Medical School Singapore.

⁷⁹ DRUG WK., *supra* note 76, at 136.

⁸⁰ Whetsell, *supra* note 13, at 38.

to patient physical discomfort, emotional distress, or death.⁸¹ Several incidents involving resident-physician fatigue have drawn national attention because they reveal life-threatening errors.⁸² One resident physician fell asleep with surgical equipment in hand during surgery,⁸³ another neglected to examine test results that revealed a high probability of patient death from arrhythmia,⁸⁴ and another nearly administered a lethal dose of medication to a patient.⁸⁵

Ironically, the approximate number of resident physicians in the United States, 106,000,⁸⁶ corresponds with the approximate number of patient deaths from medical errors, 100,000.⁸⁷ Indeed, within the medical profession, it is a matter of common “folklore” that more patients die during July, when the inexperienced resident physicians begin their residency programs.⁸⁸ Equally telling is a California study indicating that babies born late at night, when resident physicians have almost sole responsibility for providing care, are 16% more likely to die than those born during the day.⁸⁹

While the medical profession’s practice of having medical students perform pelvic exams on anesthetized women without their consent

⁸¹ *Id.*; see also Tara Abraham et al., *Are Resident Work-Hour Limitations Beneficial to the Trauma Profession?*, AM. SURGEON, Jan. 1, 2006, at 35, available at 2006 WLNR 2259433 (stating “more than [one] million patient injuries and up to 98,000 patient deaths can be attributed to medical errors” in which fatigue can play a significant role); Charles Czeisler, *It’s Time to Reform Work Hours for Resident Physicians*, SCIENCE NEWS, 2009 WLNR 21655909, 36 (Oct. 24, 2009) (stating that “[o]ne in 20 [resident physicians] admitted a fatigue-related mistake that resulted in a patient’s death”).

⁸² Antonetti, *supra* note 45, at 880 n.21 (citing Boodman, *supra* note 56).

⁸³ Boodman, *supra* note 56.

⁸⁴ *Id.*

⁸⁵ *Id.*

⁸⁶ AAMC, About the AAMC, <http://www.aamc.org/about/start.htm> (last visited Sept. 7, 2009).

⁸⁷ See Connolly, *supra* note 27 (mentioning that there are about 100,000 medical deaths a year in the United States).

⁸⁸ E-mail from Mimi Klaiman to Brandy Baker (Aug. 28, 2008, 12:23:09 CST) (on file with author); see also John Langone, *Books on Health: Surviving the Healing During a Hospital Stay*, N.Y. TIMES, 2004 WLNR 5451924 (February 17, 2004) (“Dr. Sherer also suggests avoiding elective surgery in July because of the ‘July Syndrome.’ Then, those doctors who have finished training are replaced by ‘fresh faces.’ If you find yourself in a hospital in July, he writes, “and see a young person hovering over you nervously with a needle, you are hereby warned that you, too, could be in for the pincushion treatment.”); Adam Cresswell, “Killing Season” A Dangerous Time to Be in Wards, AUSTRALIAN, 2009 WLNR 20269280 (October 15, 2009) (reporting on “new research from Australia” that proves that “the start of the academic year,” the “August killing Season” in British hospitals, and the “July Syndrome” in U.S. hospitals, is “the most dangerous time to be admitted to hospital, because of the influx of [resident physicians].”).

⁸⁹ See *Hernandez v. Overlook Hosp.*, 692 A.2d 971, 978 (N.J. 1997) (recognizing that resident physicians are typically responsible for the night shift at hospitals); Max Alexander, *Night Shift Nightmare*, READER’S DIGEST, June 2007, at 113, 114, available at <http://www.rd.com/living-healthy/night-shift-nightmare/article38715.html> (highlighting a 2005 study in California of 3.3 million child births).

garnered national attention,⁹⁰ not enough has been reported or done regarding the use of resident physicians to perform critical medical procedures and the degree of risk patients unknowingly assume when they seek health care. It comes as no surprise that, according to a study conducted by the National Sleep Foundation, the public overwhelmingly favors duty-hour reductions.⁹¹ Of those polled, 86% “indicated that they would feel anxious about their safety” if they knew that their physician had been working for “twenty-four consecutive hours,” and “[70%] reported that they would request another doctor.”⁹²

The economic and human costs of medical errors are as alarming as the reasoning behind them. Medicare reportedly disburses about \$8 billion a year to residency hospitals for resident-physician clinical training and education.⁹³ However, patient-safety incidents cost the federal Medicare program \$8.8 billion and resulted in 238,337 potentially preventable deaths between 2004 and 2006.⁹⁴ Considering that the social-science value of life estimates “are clustered in the \$4 million to \$10 million range, with an average value of life in the vicinity of \$7 million[.]”⁹⁵ the cost of preventable deaths from medical errors arguably exceeds \$7 trillion a year. In short, the harmful economic, physiological, and moral reality of sleep deprivation weighs in favor of strong legislative action.

⁹⁰ See, e.g., Robin Fretwell Wilson, *Autonomy Suspended: Using Female Patients to Teach Intimate Exams Without Their Knowledge or Consent*, 8 J. HEALTH CARE L. & POL'Y 240, 240–42 (2005).

⁹¹ Joseph H. King, *The Standard of Care For Residents and Other Medical School Graduates in Training*, 55 AM. U. L. REV. 683, 740 n.233 (2006).

⁹² *Id.*

⁹³ Lee, *supra* note 1, at 207; cf. Boodman, *supra* note 56 (“The federal government pays training programs about \$100,000 per resident annually, while most [residents] earn between \$26,000 and \$50,000, depending on specialty and experience.”).

⁹⁴ ScienceDaily, *Medical Errors Cost US \$8.8 Billion, Result in 238,337 Potentially Preventable Deaths, Study Shows*, SCIENCEDAILY.COM, Apr. 8, 2008, <http://www.sciencedaily.com/releases/2008/04/080408085458.htm>.

⁹⁵ Frank Cross & Charles Silver, *In Texas, Life Is Cheap*, 59 VAND. L. REV. 1875, 1885 (2006); see also Associated Press, *How to Value Life? EPA Devalues Its Estimate*, MSNBC.COM, July 10, 2008, <http://www.msnbc.msn.com/id/25626294/> (highlighting the EPA's decision to devalue its estimate of a statistical life by \$900,000).

III. LEGISLATIVE INITIATIVES TO PROTECT RESIDENT PHYSICIANS AND PATIENTS

A. Federal Regulatory Efforts

Despite the efforts of some of the nation's most influential political figures, including Bill and Hillary Clinton and President Barack Obama,⁹⁶ federal efforts to reduce medical errors have been largely unsuccessful.⁹⁷ Attempts to combat the problem of resident-physician sleep deprivation are hampered by gaps that exist in federal regulatory paradigms and unsuccessful efforts to fill those gaps. For instance, the chief legal mechanism designed to protect employees from oppressive working conditions, facilitated by the unequal bargaining power between employers and employees, is the Fair Labor Standards Act (FLSA).⁹⁸ One intended purpose of the FLSA is to regulate labor hours.⁹⁹ However, the Act specifically excludes resident physicians from its protections.¹⁰⁰ A review of the congressional discussions surrounding the enactment of the FLSA fails to reveal a rationale for this exclusion.¹⁰¹ Nonetheless, it is reasonably apparent that a lack of federal protection perpetuates the continuation of oppressive duty-hour demands on resident physicians.¹⁰² Ostensibly aware of the need to fill the gap in legislative coverage regarding resident physicians' work hours—as a means to protect residents and the patients they service—federal legislators attempted to address the safety problem

⁹⁶ See Robert Pear, *A Clinton Order Seeks to Reduce Medical Errors*, N.Y. TIMES, Dec. 7, 1999, at A1 (reporting then-President Bill Clinton's attempt to reduce medical errors); see also Sheryl Gay Stolberg & Robert Pear, *Obama Open to Reining In Medical Suits*, N.Y. TIMES, June 15, 2009, at A1 (reporting then-Senators Barack Obama and Hillary Clinton's proposal of a bill to reduce medical errors).

⁹⁷ See, e.g., National Medical Error Disclosure and Compensation (MEDiC) Act, S. 1784, 109th Cong. (2005). The National MEDiC Act, sponsored by then-Senators Hillary Clinton and Barack Obama, sought "to promote a culture of safety . . ." *Id.* The bill, however, never became law before the expiration of the 109th Congress.

⁹⁸ *Brooklyn Sav. Bank v. O'Neil*, 324 U.S. 697, 706 (1945); *McComb v. Homeworkers' Handicraft Coop.*, 176 F.2d 633, 636 (4th Cir. 1949); Peter D. DeChiara, *Rethinking the Managerial-Professional Exemption of the Fair Labor Standards Act*, 43 AM. U. L. REV. 139, 144–45 (1993) (reasoning that the philosophical underpinnings of the FLSA are that regulation would increase employee welfare, productivity, and encourage a healthy society).

⁹⁹ *Barrentine v. Arkansas-Best Freight Sys., Inc.*, 450 U.S. 728, 739 (1981).

¹⁰⁰ Fair Labor Standards Act, 29 U.S.C. § 213(a)(1) (2006); see also 29 C.F.R. § 541.304(c) (2009) ("Employees engaged in internship or resident programs, whether or not licensed to practice prior to commencement of the program, qualify as exempt professionals if they enter such internship or resident programs after the earning of the appropriate degree required for the general practice of their profession.")

¹⁰¹ *Joint Hearing Before the S. Comm. on Education and Labor and H. Comm. on Labor on S. 2475 and H.R. 7200*, 75th Cong. 45 (1937).

¹⁰² Kaiulani Eileen Sumi Kidani, Comment, *Japanese Corporate Warriors in Pursuit of a Legal Remedy: The Story of Karoshi, or "Death from Overwork" in Japan*, 21 U. HAW. L. REV. 169, 198 (1999).

with the Patient and Physician Safety and Protection Act of 2001,¹⁰³ the Patient and Physician Safety and Protection Act of 2002,¹⁰⁴ and the Patient and Physician Safety and Protection Act of 2005 (PPSPA).¹⁰⁵ Unlike the ACGME standards, the PPSPA would have allowed resident physicians to file anonymous complaints, imposed financial rather than accreditation penalties on residency hospitals found noncompliant, and provided whistleblower protection to resident physicians.¹⁰⁶ However, the Association of American Medical Colleges did not support the measures.¹⁰⁷ Accordingly, the PPSPA never became law.¹⁰⁸

B. State Regulatory Efforts

There appears to be wide concurrence among commentators that there is virtually no state regulation of resident physician duty hours.¹⁰⁹ After the death of Libby Zion, New York became the first state or territory to enact regulations restricting resident work hours in 1989,¹¹⁰ followed by legislative efforts in Massachusetts,¹¹¹ Delaware,¹¹² Puerto Rico,¹¹³ Pennsylvania,¹¹⁴ and New Jersey.¹¹⁵ The states and territories that have enacted legislation have provisions that maintain characteristics similar to the ACGME

¹⁰³ H.R. 3236, 107th Cong. (2001) (introduced by Representative John Conyers in November 2001); *see also Lee, supra* note 1, at 196 (reiterating same).

¹⁰⁴ S. 2614, 107th Cong. (2002) (introduced by Senator Jon Corzine in June 2002); *see also Lee, supra* note 1, at 196 (reiterating same).

¹⁰⁵ H.R. 1228, 109th Cong. (2005) (introduced by Representative John Conyers in March 2005).

¹⁰⁶ *See id.* § 3(c).

¹⁰⁷ AAMC, Conyers Reintroduces Resident Hours Legislation, <http://www.aamc.org/advocacy/library/washhigh/2005/040105/start.htm#2> (last visited Sept. 7, 2009).

¹⁰⁸ *See* H.R. 1228.

¹⁰⁹ *See* Evans, *supra* note 64, at 259 (discussing state efforts to regulate); Lee, *supra* note 1, at 189, 207 (same); Laura Lin & Bryan A. Liang, *Reforming Residency: Modernizing Resident Education and Training to Promote Quality and Safety in Healthcare*, 38 J. HEALTH L. 203, 239–40 (2005) (same); Whetsell, *supra* note 13, at 55 (same).

¹¹⁰ N.Y. COMP. CODES R. & REGS., tit. 10, § 405.4 (2009), Press Release, N.Y. Dep't of Health, State Health Dep't Reports That Majority of Hospitals in N.Y. Are Complying with Resident Working Hour Law (Apr. 19, 2006) (available online at http://www.health.state.ny.us/press/releases/2006/2006-04-19_resident_working_hour.htm); AMSA, The Resident Work Hour Issue: State Efforts, <http://www.amsa.org/rwh/efforts.cfm> (last visited Sept. 11, 2009) [hereinafter State Efforts]. The New York regulations were called the "Bell Regulations" and were passed in 1989. *Id.*

¹¹¹ *E.g.*, Senate No. 1247, 185th Sess. (Mass. 2007).

¹¹² S.B. 133, 142nd Sess. (Del. 2003); *see also* State Efforts, *supra* note 110 (indicating the name of the bill).

¹¹³ H.B. 390, 14th Leg., 4th Sess. (P.R. 2003); *see also* AMSA, Comparison of State and Puerto Rican Legislation, http://www.amsa.org/rwh/compare_pr.cfm (last visited Sept. 11, 2009) [hereinafter Comparison]; State Efforts, *supra* note 110.

¹¹⁴ S.B. 1224, 2007–2008 Reg. Sess. (Pa. 2007); *see also* State Efforts, *supra* note 110 (providing background information).

¹¹⁵ S. 808, 2006–2007 Reg. Sess. (N.J. 2006); *see also* Comparison, *supra* note 113 (showing chart of states that have pursued legislative efforts to enact regulations).

standards but offer resident physicians whistle-blower protection and establish better enforcement safeguards.¹¹⁶ While efforts to establish regulation of resident physician duty hours in some states may increase, given the strong warnings enunciated in the December 2008 Institute of Medicine (IOM) report,¹¹⁷ few states have yet to address the problem of sleep deprivation in medical residency programs.¹¹⁸ Accordingly, the vast majority of patients and resident physicians continue to be at risk because of the debilitating effects of sleep deprivation caused by oppressive duty-hour demands.

IV. THE ROLE OF THE JUDICIARY IN PROTECTING RESIDENT PHYSICIANS AND PATIENTS

Every federal circuit court that has addressed the question of whether sleep qualifies as a major life activity, sufficient to evoke federal legislative protections,¹¹⁹ has answered in the affirmative.¹²⁰ In *Desmond v. Mukasey*, the United States Court of Appeals for the D.C. Circuit recognized that sleep is more central to the life process than “seeing, hearing, and speaking, for one can survive without engaging in these activities, but not without sleeping.”¹²¹ Wide acceptance of the vital role of sleep in facilitating the most basic life activities has led some courts to hold employers liable to third parties for the actions of their obviously fatigued employees, under tort law, when the sleep deprivation arises out of activity over which the employer exercised control.¹²² Efforts to hold residency hospitals accountable for the harm suffered by resident physicians as a result of work-induced sleep

¹¹⁶ See Comparison, *supra* note 113.

¹¹⁷ INST. OF MED., RESIDENT DUTY HOURS: ENHANCING SLEEP, SUPERVISION, AND SAFETY (2008), available at http://books.nap.edu/openbook.php?record_id=12508&page=R1.

¹¹⁸ State Efforts, *supra* note 110.

¹¹⁹ For example, this includes the protections enunciated under the Americans with Disabilities Act of 1990, as amended. See 42 U.S.C. §§ 12101–12213 (2006).

¹²⁰ *Desmond v. Mukasey*, 530 F.3d 944, 953–54 (D.C. Cir. 2008).

¹²¹ *Id.* at 955.

¹²² See *Faverty v. McDonald's Rests. of Or., Inc.*, 892 P.2d 703, 709 (Or. Ct. App. 1995) (holding employer liable after allowing an employee to drive home after working three shifts in a twenty-four-hour period); *Robertson v. LeMaster*, 301 S.E.2d 563, 568–69 (W. Va. 1983) (holding employer could be held liable for requiring its employee to work such long hours “and sending him out on the highway in such an exhausted condition”). But see *Behrens v. Harrah's Ill. Corp.*, 852 N.E.2d 553, 556 (Ill. App. Ct. 2006) (asserting that employers cannot be held liable for accidents caused by fatigued employees while driving home, on ground that “employees are in the best position to determine whether they are sufficiently rested to drive home safely”); *Brewster v. Rush-Presbyterian-St. Luke's Med. Ctr.*, 836 N.E.2d 635, 636 (Ill. App. Ct. 2005) (holding that hospital did not owe a duty to victim killed by accident caused by medical resident who fell asleep behind the wheel after working a thirty-six-hour shift on the ground that the medical resident was off-duty).

deprivation, for which residency hospitals exercise control, face considerable challenge because of the judiciary's reluctance to intercede on behalf of resident physicians.

A. Medical Deferentialism

Medical deferentialism has led to an impracticable, if not myth-based, conception of the resident physician–residency hospital relationship that underlies the reluctance of some courts to enforce or define minimal standards of decency necessary to safeguard resident physicians and patients for at least two reasons. First, some courts do not recognize resident physicians as employees.¹²³ Second, the judiciary has “traditionally accorded great deference” to the decisions of residency-hospital officials regarding their evaluation and treatment of resident physicians.¹²⁴ Some courts are unwilling even to question the decisions of residency-hospital officials on the ground that it would be inappropriate for a court to substitute its judgment for that of hospital officials.¹²⁵ This reasoning is based on a claim that residency hospitals, as academic institutions, are in the best position to decide academic matters, rather than the judiciary.¹²⁶ For example, in *Hernandez v. Overlook Hospital*, the court reasoned that a decision to dismiss a resident physician from the residency program was solely up to the hospital.¹²⁷ The *Hernandez* court believed that judicial intervention would hinder academic freedom by infringing upon the residency hospital's ability to set and enforce performance levels.¹²⁸ It wished to avoid forcing supervising physicians to act like judges rather than academics, thereby hampering candid evaluations of resident physicians for fear of judicial scrutiny.¹²⁹

Prior to the *Hernandez* court's use of the medical-deference approach, the Fifth Circuit, in *Davis v. Mann*, endorsed medical deferentialism on the ground that the main purpose of a residency program is to provide academic training and professional certification.¹³⁰ In the minds of the

¹²³ See, e.g., *Davis v. Mann*, 882 F.2d 967, 974 (5th Cir. 1989).

¹²⁴ *Navato v. Sletten*, 560 F.2d 340, 345 (8th Cir. 1977).

¹²⁵ *Garibaldi v. Applebaum*, 742 N.E.2d 279, 286 (Ill. 2000).

¹²⁶ Colleen F. Walsh, *A Hospital Resident Is Not Entitled to Counsel During a Residency Termination Proceeding and Is Not Entitled to Have the Proceeding Transcribed*—*Hernandez v. Overlook Hosp.*, 27 SETON HALL L. REV. 1733, 1735–36 (1997).

¹²⁷ 692 A.2d 971, 975 (N.J. 1997).

¹²⁸ *Id.* at 975–76.

¹²⁹ *Id.* at 976.

¹³⁰ 882 F.2d 967, 974 (5th Cir. 1989).

Davis court, the fact that residency physicians are compensated for their labor is not enough to overcome the program's academic characteristic and justify the court's interference with what it perceives to be a pedagogical process.¹³¹ However, recognizing a resident physician's contractual right to appropriate duty-hour standards and adequate safeguards would not constitute judicial interference, as medical deferentialists might have us believe, because courts have an obligation to (1) hear and decide cases that meet its jurisdictional and procedural requirements, particularly when the legislature has snubbed its constitutional authority,¹³² and (2) balance "privacy rights against the state's legitimate interest in protecting the public's health, safety, welfare, and morals."¹³³ Therefore, courts have a fundamental obligation to act on behalf of resident physicians and patients for at least several reasons. First, the lack of legal intervention has perpetuated a culture wherein medical-residency administrators and supervising physicians freely abuse resident physicians and impose excessive labor requirements.¹³⁴ Despite the growing number of studies highlighting the adverse effects of sleep deprivation on resident physicians and patients due to medical errors, the ACGME reported an increase in the number of noncompliant residency hospitals from 2006 to 2007.¹³⁵

Second, the underlying justification for the medical-deference approach—that the primary purpose of the residency is to educate—is at odds with the stances taken by medical professionals in the best position to know the nuances of residency programs. In response to claims that resident physicians are primarily students, the Association of American Medical Colleges (AAMC) pointed out that resident physicians spend 80% of their time "in direct patient care activities."¹³⁶ The substantial amount

¹³¹ *Id.*; see also *Phila. Ass'n of Interns and Residents v. Albert Einstein Med. Ctr.*, 369 A.2d 711, 714 (1976) (deciding that resident physicians should be viewed as students); *St. Clare's Hosp. and Health Ctr.*, 229 N.L.R.B. 1000, 1003 (1977) (reasoning that resident physicians are "primarily students" as opposed to employees because they are providing services as part of their educational development); *Cedars-Sinai Med. Ctr.*, 223 N.L.R.B. 251, 253 (1976) (reasoning that hospitals do not provide residency programs for the purpose of meeting staffing requirements but rather to allow students to develop the clinical skills necessary to practice medicine).

¹³² EDWARD KEYNES & RANDALL K. MILLER, *THE COURT VS. CONGRESS: PRAYER, BUSING, AND ABORTION* 96 (1989).

¹³³ *Id.* at 250.

¹³⁴ Klaiman, *supra* note 17, at 375.

¹³⁵ ACGME, *THE ACGME'S APPROACH TO LIMIT RESIDENT DUTY HOURS 2006-07: A SUMMARY OF ACHIEVEMENTS FOR THE FOURTH YEAR UNDER THE COMMON REQUIREMENTS 1-2* (2007), available at http://www.acgme.org/acWebsite/dutyHours/dh_achieveSum0607.pdf.

¹³⁶ Jack E. Karns, *The National Labor Relations Board Redefines "Medical Employee" Under the Wagner Act Regarding Residents and Interns, Thereby Opening the Door to Unionization and Collective Bargaining Demands*, 77 N.D. L. REV. 53, 64 (2001) (quoting *Cedars-Sinai Med. Ctr.*, 223 N.L.R.B. 251, 256 (1976)).

of time resident physicians spend with patients is consistent with the ACGME's position that one of the core goals of the residency program is to provide "safe and effective patient care."¹³⁷

Third, it cannot be denied that there are few legal relationships in which one party (the resident physician) places more reliance upon the other (residency hospital), is more dependent upon the other, is more vulnerable to abuse by the other, or is more tasked by the other to perform vital services for a third party (patient) than that between the resident physician and residency hospital.¹³⁸ Therefore, there is a huge disparity in bargaining power between the resident physician and the residency hospital. As one justice put it, "[t]he hospital has virtually limitless resources—including administrators, physicians, and lawyers—at its disposal[,]” whereas “[t]he resident stands alone.”¹³⁹ The resident physician's status relative to the residency hospital is one of dependence and lowliness.

Finally, resident physicians perform critical tasks in exchange for compensation and training but lack a safe work environment and opportunity to provide proper patient care because of enforced disruption of the medical resident's ability to function and learn due to sleep deprivation.¹⁴⁰ Residency hospitals that require resident physicians to work past their physiological limits are not only preventing the resident physicians from learning they are also exposing the resident physician and patients to great risk. Succinctly put, the reluctance of some courts to protect patients and resident physicians from the harmful working conditions to which they are subjected in the name of medical deferentialism leaves the resident physician in a perpetual state of worker's duress and virtually exempt from judicial protection. This is a dangerous arrangement for a society in which there is strong reliance on resident-physician labor. It comes as no surprise that some courts have declined to adopt medical deferentialism.¹⁴¹

¹³⁷ ACGME, ACGME Highlights Its Standards on Resident Duty Hours—May 2001, http://www.acgme.org/acWebsite/positionpapers/pp_oshareponse.asp (last visited Sept. 11, 2009).

¹³⁸ See *Foley v. Interactive Data Corp.*, 765 P.2d 373, 414–15 (Cal. 1988) (Kaufman, J., dissenting) (making the same claim with respect to the employee-employer relationship).

¹³⁹ *Hernandez v. Overlook Hosp.*, 692 A.2d 971, 979 (N.J. 1997) (Pollock, J., dissenting).

¹⁴⁰ See *Study: Brain Connections Strengthen During Waking Hours, Weaken During Sleep*, OBESITY, FITNESS & WELLNESS WK., Feb. 9, 2008, at 3906, available at 2008 WLNR 1858039 (citing research by the University of Wisconsin indicating that lack of sleep affects the brain's ability to learn).

¹⁴¹ See *infra* Part IV.B.

B. Medical Realism

Some courts have adopted a view stemming from medical realism, which recognizes the educational component of the residency as subordinate to the critical medical services resident physicians provide for patients—and, by extension, for society in general.¹⁴² Medical realists embrace the reality that resident physicians are often the only physicians “present in the hospital during evening hours, on weekends, and on holidays.”¹⁴³ “To a patient or visitor at a hospital, a resident in his or her white coat is indistinguishable from any other physician.”¹⁴⁴ “In many hospitals, they respond to patient emergencies[,] such as cardiac arrest, arrhythmia, and bleeding.”¹⁴⁵ They also provide direct patient care, handle childbirths, run respirators, draw blood, and place catheters.¹⁴⁶ Resident physicians sometimes change medications, adjust intravenous fluids, and enter orders on patient charts that significantly affect patient care.¹⁴⁷ Although these procedures are subject to examination by an attending physician and medical faculty, such a review typically occurs after the resident physician has already performed the tasks.¹⁴⁸

In addition to receiving compensation (albeit minimal) for these services, resident physicians pay federal and state taxes, make Social Security contributions, and receive benefits, such as health insurance, vacations, and sick leave.¹⁴⁹ Residency hospitals are certainly responsible for resident physicians’ negligence while on duty.¹⁵⁰ Moreover, American Medical Association guidelines refer to residency contracts as “employment agreements.”¹⁵¹ In keeping with these medical realities, some courts have recognized that the employment facet of the medical-residency program is an “integral and mandatory component[,] . . . rather than an incidental feature[,]” of the medical residency experience.¹⁵² For instance, the United

¹⁴² See *Regents of Univ. of Cal. v. Pub. Employment Relations Bd.*, 715 P.2d 590, 605 (Cal. 1986).

¹⁴³ *Hernandez*, 692 A.2d at 978.

¹⁴⁴ *Id.*

¹⁴⁵ *Id.*

¹⁴⁶ *Regents of Univ. of Cal.*, 715 P.2d at 601–02.

¹⁴⁷ *Hernandez*, 692 A.2d at 978.

¹⁴⁸ *Id.*

¹⁴⁹ See *Navato v. St. Luke’s Hosp. of Kan. City*, No. 90-0068-CV-W-6, 1991 U.S. Dist. LEXIS 18456, at *5–*6 (W.D. Mo. Dec. 9, 1991) (recognizing that the United States Equal Employment Opportunity Commission considers resident physicians to be employees).

¹⁵⁰ See *id.* at *6–*7 (recognizing the “potential for liability on the part of the hospital for the interns’ negligence” exists, if the right facts are presented).

¹⁵¹ *Karns*, *supra* note 136, at 64 & nn.99–102.

¹⁵² *Navato*, 1991 U.S. Dist. LEXIS 18456, at *6.

States Court of Appeals for the First Circuit, in *Lipsett v. University of Puerto Rico*, held that a resident physician was an employee and a student.¹⁵³ For other medical realists, the distinction between student and employee is virtually immaterial. In *Zaklana v. Mt. Sinai Medical Center*, the United States Court of Appeals for the Eleventh Circuit reasoned that although the work status of resident physicians does not resemble that of traditional employees, because abusive work practices may negatively affect their future employment opportunities, judicial relief from such practices is appropriate.¹⁵⁴

To date, the Connecticut Supreme Court may have constructed the best attempt to reconcile the problems caused by the apparent dual nature of the resident-physician identity by combining the medical-deferentialist and medical-realist approaches.¹⁵⁵ In *Gupta v. New Britain General Hospital*, a dismissed resident physician sued the residency hospital.¹⁵⁶ The hospital administrators claimed that his dismissal was due to several poor performance evaluations based on the resident physician's alleged "inability to make decisions in the operating room, his unwillingness to accept responsibility for errors," and gaps in his "knowledge base."¹⁵⁷ The *Gupta* court reasoned that if the alleged breach concerns educational issues, the court should consider the resident physician a student and defer to the decisions of the residency hospital;¹⁵⁸ however, if the alleged breach concerns employment issues, the court should consider the resident an employee and apply the appropriate judicial scrutiny.¹⁵⁹ The court refused

¹⁵³ 864 F.2d 881, 897 (1st Cir. 1988) (finding, for purposes of Title VII, that a medical resident is a student and an employee); see also *Smith v. St. Louis Univ.*, 109 F.3d 1261, 1264 (8th Cir. 1997) (reasoning that residents are employees, for Title VII purposes); *Regents of Univ. of Mich. v. Mich. Employment Relations Comm.*, 204 N.W.2d 218, 226 (Mich. 1973) (reasoning that resident physicians are no less "employees" than new lawyers employed by law firms who are, undoubtedly, continually "acquiring new skills"); *House Officers Ass'n v. Univ. of Neb. Med. Ctr.*, 255 N.W.2d 258, 261-62 (Neb. 1977) (holding resident physicians are both students and employees, but in the context of the Nebraska statute resident physicians are employees); *Ryan v. Univ. of N.C. Hosps.*, 494 S.E.2d 789, 790 (N.C. Ct. App. 1998) (reasoning that resident physicians are both graduate medical students and employees because they perform services in exchange for compensation and training). *But see Bd. of Curators of Univ. of Mo. v. Horowitz*, 435 U.S. 78, 82-83 & n.1 (1978) (assuming that medical resident was a student for purposes of procedural due process).

¹⁵⁴ 842 F.2d 291, 294-95 (11th Cir. 1988) (deciding that even though resident physicians are students rather than employees, they may bring Title VII claims because termination of medical residency interferes with employment opportunities).

¹⁵⁵ See *Gupta v. New Britain Gen. Hosp.*, 687 A.2d 111, 116 n.10, 117 (Conn. 1996).

¹⁵⁶ *Id.* at 112-14.

¹⁵⁷ *Id.* at 114.

¹⁵⁸ *Id.* at 119-20.

¹⁵⁹ *Id.* at 120.

to render judgment on the merits of the dismissal, on the ground that the dismissal was due to deficient clinical performance, a decision the court deemed related to academics, rather than employment.¹⁶⁰

The *Gupta* court reasoned that unlike decisions regarding salary and benefits, a resident physician's evaluation is akin to a medical-school professor's grade.¹⁶¹ In its appeal to medical deferentialism, the court posited that judges are not qualified to render opinions as to the attainments of a medical student.¹⁶² However, it also made an attempt to hew to the medical-realist approach, reasoning that when an educational program fails to offer any of the courses or training necessary to obtain certification in a particular field or fails to fulfill "a specific contractual promise distinct from any overall obligation to offer a reasonable program," breach-of-contract claims may be had against the residency hospital.¹⁶³ The court thereby acknowledged the viability of a claim for breach of the implied covenant of good faith and fair dealing.¹⁶⁴

Despite limited judicial application of the implied covenant of good faith to employment arrangements, the *Gupta* court's posture supports the assertion that conduct on the part of a residency hospital may be inimical to the implied good-faith duty of performance. Given the unregulated nature of the relationship between residency hospital and resident physician, application of common-law formulations is appropriate, since the court has not been tasked with assessing the general quality of the education.¹⁶⁵ Nevertheless, research has not revealed any cases holding that a residency hospital's imposition of arduous duty hours that cause severe sleep deprivation upon resident physicians breaches the implied duty of good-faith performance applicable to contractual arrangements. Equally notable is the lack of any decision or even dicta indicating that the abuse of such discretion does not represent a breach of the duty of good-faith performance.

Logic dictates that disregard of the duty of good faith essentially authorizes residency hospitals to circumvent obligations demanded by the implied covenant of good faith and fair dealing under the guise of

¹⁶⁰ *Id.* at 117–18.

¹⁶¹ *Id.*

¹⁶² *Id.* at 119–20.

¹⁶³ *Id.* at 120. *But see* *Ross v. Univ. of Minn.*, 439 N.W.2d 28, 33 (Minn. Ct. App. 1989) (refusing to apply the implied doctrine of good faith because hospitals have autonomy in deciding whether to dismiss residents for academic reasons).

¹⁶⁴ *Gupta*, 687 A.2d at 122–23.

¹⁶⁵ *See id.* at 116–18 (supporting a functional analysis not based on rigid labels).

educational autonomy, which essentially denies resident physicians the right to challenge certain categories of improper conduct in all fifty states. The absence of relevant case law, inconsistency within the federal judiciary regarding the work status of resident physicians, and the increasing degree of harm and economic losses associated with patients deaths caused by resident-physician sleep deprivation all weigh strongly in favor of the application of the implied covenant of good faith and fair dealing as a juridical tool against abusive duty-hour requirements. The next section delineates the extent to which the implied covenant of good faith and fair dealing requires a court to infer, from the residency agreement, a residency hospital's obligation to limit resident physician duty hours.

V. THE IMPLIED COVENANT OF GOOD-FAITH PERFORMANCE AS A JUDICIAL SOLUTION

The law of contracts governs the relationship between the residency hospital and the resident physician. The Restatement (Second) of Contracts states that every contract contains an implied covenant of good faith and fair dealing.¹⁶⁶ Charles Fried, in his influential book *Contract as Promise*,¹⁶⁷ asserted long ago that one of “[t]he most direct challenge[s] to the conception of contract law as a coherent expression of the principle of autonomy is thought to come from the doctrine[] of good faith.”¹⁶⁸ The implied duty of good faith authorizes courts to revise arrangements or overturn them “in the name of fairness.”¹⁶⁹ It challenges the concept of contract as promise by providing that a promise, alone, is insufficient to define the duties between contracting parties.¹⁷⁰ The doctrine holds that even when there is an explicit agreement, the parties' rights are affected by what the courts and society judge to be a fair distribution of the advantages and burdens between the parties, in addition to—or possibly in contravention of—the express terms of the agreement.¹⁷¹

¹⁶⁶ RESTATEMENT (SECOND) OF CONTRACTS § 205 (1981); *see also* Anthony's Pier Four, Inc. v. HBC Assocs., 583 N.E.2d 806, 820 (Mass. 1991); Kirke La Shelle Co. v. Paul Armstrong Co., 188 N.E. 163, 167 (N.Y. 1933). By use of the term “good faith” in this Article, the author intends to limit the discussion to good-faith performance rather than enforcement, negotiations, or interactions between fiduciaries. Of the three texts relevant to the doctrine of good faith—the Restatement (Second) of Contracts, the Uniform Commercial Code, and the United Nations Convention on Contracts for the International Sale of Goods—this Article focuses on the common-law doctrine found in the Restatement (Second) of Contracts.

¹⁶⁷ CHARLES FRIED, *CONTRACT AS PROMISE: A THEORY OF CONTRACTUAL OBLIGATION* (1981).

¹⁶⁸ *Id.* at 74.

¹⁶⁹ *Id.*

¹⁷⁰ *Id.* at 75.

¹⁷¹ *Id.*

Despite widespread commentary on the subject and after more than seventy years of litigation in the wake of the first recognition of an implied good-faith contractual obligation by American common law, academics and courts have not articulated any single or universal concept of contractual good faith.¹⁷² Ideas about what satisfies the good-faith duty of performance are not concretely defined but rather are shaped by the needs of society in general and determined by repeated resort to community standards and social benefits that would be forfeited but for the court's intervention.¹⁷³ Because it is a function of continually emerging standards of decency, the adaptability and elasticity of this concept make it well adept for a wide range of applications.

Whereas some observers have applauded the tool as “an indispensable measure of contractual morality,”¹⁷⁴ others have criticized its use because of its reliance on moral idealism or public morality, which arguably makes its application problematic and ill-suited for contractual formulations. Professor Clayton Gillette, for instance, argues in favor of a narrow application of the implied duty of good faith on the ground that it hinders the ability of businesspeople and their attorneys “to predict the legal consequences of voluntary transactions.”¹⁷⁵ Professor Gillette posits that the realization of such a prediction “requires precision of definition and certainty of the effects of performance and nonperformance.”¹⁷⁶ In line with Gillette's view, Professor Michael Bridge also rejects the role of judicial opinion in determining what is just or fair under a good-faith analysis.¹⁷⁷ For Professor Bridge, the implied covenant of good faith and fair dealing is the intellectual equivalent of uncertainty because it is “tantamount to saying that the good[-]faith duty is breached whenever a judge decides that it has been breached. . . . [which] hardly advances the cause of intellectual inquiry[,] and it provides absolutely no guide to the disposition of future cases.”¹⁷⁸ Similarly, Professor Steven Burton, whose contributions to the

¹⁷² The *Kirke La Shelle* court was recognized in *Centronics Corp. v. Genicom Corp.* for providing the “first explicit recognition of an implied good faith contractual obligation.” 562 A.2d 187, 191 (N.H. 1989).

¹⁷³ Neil G. Williams, *Offer, Acceptance, and Improper Considerations: A Common-Law Model for the Prohibition of Racial Discrimination in the Contracting Process*, 62 GEO. WASH. L. REV. 183, 206–07 (1993).

¹⁷⁴ See *Christensen v. Kingston Sch. Comm.*, 360 F. Supp. 2d 212, 225 (D. Mass. 2005) (quoting Tory A. Weigand, *The Duty of Good Faith and Fair Dealing in Commercial Contracts in Massachusetts*, 88 MASS. L. REV. 174, 174 (2004)).

¹⁷⁵ Clayton P. Gillette, *Limitations on the Obligation of Good Faith*, 1981 DUKE L.J. 619, 621 (1981).

¹⁷⁶ *Id.*

¹⁷⁷ Michael G. Bridge, *Does Anglo-Canadian Contract Law Need a Doctrine of Good Faith?*, 9 CAN. BUS. L.J. 385, 398 (1984).

¹⁷⁸ *Id.*; see also E. Allan Farnsworth, *Good Faith in Contract Performance*, in GOOD FAITH AND FAULT IN CONTRACT LAW 153, 162 (Jack Beatson & Daniel Friedmann eds., 2002) (quoting Bridge, *supra* note 177, at

body of scholarship on good-faith performance cannot be ignored, states that the doctrine of the duty of good-faith performance acts “as a license for the exercise of judicial or juror intuition” and leads to unpredictable results and inconsistent applications.¹⁷⁹

Common to each of these objections to the implied covenant of good faith is the insistence on prediction as a normative character of law. By extension, these objections denounce the infusion of moral principle when deciding the outcome of contractual arrangements because of its perceived ruinous effect on predictability.¹⁸⁰ Although an exhaustive defense of moral theory goes beyond the scope of this Article, the aforementioned claim that a court’s appeal to moral principle facilitates the weakening of contractual arrangements and therefore warrants a separation of law and morality requires some attention to the extent that these sentiments qualify as meritorious objections to the application of the implied covenant of good faith.

A. The Implied Duty of Good Faith and the Separatists’ Theory of Good

The separatist argument for predictability bears the imprint of allegiance to nineteenth-century positivism, during which “the destinies of American commerce, industry[,] and finance” were a primary concern guiding jurists.¹⁸¹ It extends from the “latent social ideal of the nineteenth-century law of contract [that] embodies a libertarian state, in which the law maximize[d] the liberty of individual citizens, encourage[d] self-reliance,

398).

¹⁷⁹ Steven J. Burton, *Breach of Contract and the Common Law Duty to Perform in Good Faith*, 94 HARV. L. REV. 369, 369–70 (1980).

¹⁸⁰ Professor Summers, perhaps one of the most influential writers on the implied covenant of good faith, took a defensive posture in response to criticisms that the implied covenant of good faith is a creature of moral idealism. See Robert S. Summers, *The General Duty of Good Faith—Its Recognition and Conceptualization*, 67 CORNELL L. REV. 810, 834–35 (1982). Summers denied the presence of empirical evidence indicating that courts have resolved good faith cases by resorting to moral doctrine and asserted that moral imperatives have had a *de minimis* impact on good-faith applications. *Id.* Commentators have frequently expressed strong concern that application of the good faith duty is flawed because of its reliance on public morality, but

the extensive case law to date does not reveal any significant tendency of this kind. . . .

The risk of overextension is inherent in any doctrine. Experience to date indicates that the risk is not great with regard to [the implied covenant of good faith and fair dealing]. Our contract law has been relatively free of moralism, especially any forms legitimately describable as “Good Samaritanism” or the like. Moreover, legal good faith is not identical with moral good faith. . . . In addition, [the implied covenant of good faith and fair dealing] incorporate[s] safeguards. And the determinations of trial judges and jurors are subject to various forms of review.

The ultimate question is whether the gain is worth the risk.

Id. at 834–35 (footnotes omitted).

¹⁸¹ EDWIN W. PATTERSON, JURISPRUDENCE: MEN AND IDEAS OF THE LAW 121 (1953).

and adopt[ed] an avowedly neutral stance with regard to permissible patterns of social life.”¹⁸² For separatist adherents, the law of contracts is not only “a convenient way of understanding the social relations of a market economy” but also representative of the state’s limitation of its authority in the name of respecting individual autonomy.¹⁸³ Faith in individual autonomy and rationality undergird the separatist’s confidence in the fairness of the distributive outcomes of a relatively uninhibited market.

The idea of faith in individual preferences that is so deeply rooted in separatism begets a belief that when parties contract each party is made better off by the exchange.¹⁸⁴ “The claim that individuals know what is best for themselves” metamorphoses into a claim that what they are contracting for is “eo ipso right for them.”¹⁸⁵ As a result, the separatist approach accepts that two parties should have the right to contract and perform their obligations without interference so that they can achieve better outcomes for themselves by acting on their individual specific knowledge and in their own interest.¹⁸⁶ In this way, the separatist theory of contractarianism catapults free choice into the realm of moral rightness,¹⁸⁷ facilitating a presumption that contracts are inherently just and that they enhance well-being.¹⁸⁸ In so doing, this theory accepts law and morality as separate domains, simultaneously viewing (1) the law of contracts as the foundation for a maximally efficient system of exchange and (2) the moral demands that regulate behavior as both an individual responsibility and a threat to the certainty of outcome believed necessary for contractual arrangements to flourish.¹⁸⁹ Separatism encourages a belief that the law should overrule only those agreements that are not truly voluntary.¹⁹⁰ Hence, judicial revision of contracts on the ground of fairness is perceived as undermining the role of the uninhibited market in determining the distribution of wealth.¹⁹¹

There are several drawbacks to the separatist theory of good. First, its acceptance of contracts as intrinsically just provides a vehicle for avoiding an evaluation of the substantive merits of each party’s choices, which could

¹⁸² HUGH COLLINS, *THE LAW OF CONTRACT* 4–5 (2d ed. 1993).

¹⁸³ *Id.* at 5.

¹⁸⁴ RUSSELL HARDIN, *MORALITY WITHIN THE LIMITS OF REASON* 113 (1988).

¹⁸⁵ *Id.*

¹⁸⁶ *Id.*

¹⁸⁷ *Id.* at 114.

¹⁸⁸ *Id.* at 113–14.

¹⁸⁹ Seana Valentine Shiffrin, *The Divergence of Contract and Promise*, 120 HARV. L. REV. 708, 713–14 (2007).

¹⁹⁰ See COLLINS, *supra* note 182, at 5.

¹⁹¹ See *id.*

facilitate harmful consequences.¹⁹² That is, by limiting our concern to whether a contract was entered into voluntarily, we fail to consider that performance of its explicit terms may produce an outcome that, while predictable, frustrates the purpose of the agreement or harms society in a variety of ways.¹⁹³ Also, it further assumes a connection between the choices explicitly stated in the agreement and the outcome flowing from those terms when such a relation may not be present.¹⁹⁴ Few would claim that Libby Zion's death was naturally related to her choice to seek medical attention for an earache or an intended outcome of the contractual arrangement between the resident physicians treating her and New York Hospital. Performance of their agreement, as it was presumably set out, led to predictable-but-dire consequences.

What the Libby Zion case more tellingly indicates is that, depending on the ordering of performance, contractual arrangements may have substantial utilitarian value or none at all. For this reason, objections to incorporating considerations of the desired outcome and public welfare when ordering performance under contractual arrangement represent nothing more than refusal to let moral concepts play their appropriate role in the legal process.¹⁹⁵

According to Friedrich Nietzsche, “[i]t is in the sphere of contracts and legal obligations that the moral universe of guilt, conscience, and duty . . .

¹⁹² DON HERZOG, *HAPPY SLAVES: A CRITIQUE OF CONSENT THEORY* 222 (1989); HARDIN, *supra* note 184, at 114.

¹⁹³ Parties to contracts, particularly relational contracts, are incapable of predicting all of the events and conditions that may affect their transactions in the future. *See* COLLINS, *supra* note 182, at 272. Also, the transaction costs of making contracts limit the resources that the parties are willing to devote to the contracting process and thus restrict the parties' ability to arrive at a contract that perfectly reflects their agreement. *Id.* Even when the parties have the requisite foresight and resources to draft a contract reflecting their agreement in all its present and future dimensions, a judge or arbiter may be unable to apply that contract accurately or inexpensively. *See* Kent Greenawalt, *A Pluralist Approach to Interpretation: Wills and Contracts*, 42 *SAN DIEGO L. REV.* 533, 572–74 (2005). The parties involved may have had different understandings of what the contract terms signified or different perceptions of what terms the contract contained. One party may realistically have authored more terms than the other. *Id.* at 573. Parties may believe that their relations will not be governed by the terms of the written contract, but rather by principles of fairness. *Id.* Even a party aware of an unfavorable term may not believe that the contracting partner will rely upon it or the various contractual provisions point in different directions. A contract may contain a clause that one or neither of the parties sufficiently understood could produce onerous results that neither party foresaw. *See* P.S. ATIYAH, *PROMISES, MORALS, AND LAW* 149–50 (1981) (giving example of variable mortgage rate contract); *see also* FRIED, *supra* note 167, at 87 (recognizing that one “may not know what is included in a system until the question arises”).

¹⁹⁴ HERZOG, *supra* note 192, at 223–24.

¹⁹⁵ Mathias Reimann, *Horrible Holmes*, 100 *MICH. L. REV.* 1676, 1679 (2002) (criticizing Oliver Wendell Holmes, Jr., because of his perceived attempt to separate law from morality).

took its inception.”¹⁹⁶ Few obligations are more recognized than the moral requirements arising from voluntary promises in contract.¹⁹⁷ By the act of promising, a party morally and legally obligates itself to obey the commands and restrictions of that agreement.¹⁹⁸ Even criminals, warring states, or armies, which may largely dismiss or disregard all other moral duties, will often regard themselves as bound by their agreements.¹⁹⁹

The undertaking makes what was once morally indifferent or optional for a particular person into something he or she must do.²⁰⁰ Therefore, when parties enter into contracts, the exchange involves simultaneous participation in a moral and legal relationship.²⁰¹ This requires negotiation of two distinct sets of norms. For the contractual arrangement to possess legal authority, “the content and normative justification” for the exchange “must be acceptable to a reasonable moral agent with a coherent, stable, and unified personality.”²⁰² The justification for law cannot depend upon the law being opaque or amoral because its ability to constrain behavior is limited or subject to override by moral demands.²⁰³ If it is to command authority, the law cannot require moral agents to do or refrain from doing something inconsistent with leading a life of at least minimal moral virtue.²⁰⁴ Here, the practices promoted or facilitated by the law of contracts should be compatible with a culture that supports morally virtuous character. For this reason, the utilitarian value of contracts relies on a theory of good that encompasses evaluation of the strictures of public morality.

My claim is not that the law of contracts should aim to enforce interpersonal morality per se. Rather, the postulation is that its doctrinal structures and formulations should be compatible with conditions necessary

¹⁹⁶ FRIEDRICH NIETZSCHE, ON THE GENEALOGY OF MORALITY, in CLASSICAL READINGS IN CULTURE AND CIVILIZATION 95, 99 (John Rundell & Stephen Mennell eds., 1998).

¹⁹⁷ See, e.g., CHRISTOPHER HEATH WELLMAN & A. JOHN SIMMONS, IS THERE A DUTY TO OBEY THE LAW? 115 (2005).

¹⁹⁸ *Id.* at 116.

¹⁹⁹ *Id.* at 115–16.

²⁰⁰ JULES STEINBERG, LOCKE, ROUSSEAU, AND THE IDEA OF CONSENT: AN INQUIRY INTO THE LIBERAL-DEMOCRATIC THEORY OF POLITICAL OBLIGATION 12 (1978).

²⁰¹ *Id.*

²⁰² Shiffrin, *supra* note, 189, at 717; see also Samuel Vincent Jones, *Has Conduct in Iraq Confirmed the Moral Inadequacy of International Humanitarian Law? Examining the Confluence Between Contract Theory and the Scope of Civilian Immunity During Armed Conflict*, 16 DUKE J. COMP. & INT’L L. 249, 259 (2006) (stating that “implicit obligations and rights can be inferred ‘from the values underlying the explicit rules only if the explicit rules are coherent’” (quoting Ken Kress, *Coherence and Formalism*, 16 HARV. J.L. & PUB. POL’Y 639, 646 (1993))).

²⁰³ Samuel Vincent Jones, *Daifur, the Authority of Law, and Unilateral Humanitarian Intervention*, 39 U. TOL. L. REV. 97, 111 (2007) (discussing the authority of law and its vulnerability to moral objection).

²⁰⁴ Shiffrin, *supra* note 189, at 709.

for morally desired outcomes to surface.²⁰⁵ In essence, a theory of good relative to the law of contracts is without support absent some evaluation of the moral consequences promoted or likely to be so by performance or nonperformance of a contractual act.²⁰⁶ Objections to the role of standards of morality in ascribing rights and duties in contractual arrangements, as an affront to certainty of outcome, stand at odds with the utility of using moral principles within the sphere of contractual arrangements.

Implied promises, for instance, are well-established juridical tools used to make words and conduct binding on a person when circumstances make such inferences morally appropriate.²⁰⁷ What makes such implications appropriate is the recognition that a particular promise will produce more utility amongst society, rather than exclusively for one or both of the parties. P.S. Atiyah graphically illustrates the point that when one orders a meal in a restaurant, the patron does not say, “‘I promise’ [to pay for this meal] or anything remotely resembling it.”²⁰⁸ Jurists would agree, nevertheless, that a legal obligation to pay for the meal plainly arises.²⁰⁹ Jurists would assert that the implied promise is derived from the patron’s conduct.²¹⁰ Atiyah notes, however, that “there are difficulties with this traditional explanation. What of the person who does not intend to pay . . . for the meal supplied to him in the restaurant?”²¹¹ If a person who does not intend to pay for a restaurant meal is said to have communicated a promise in exactly the same way as the person who actually does intend to pay, it seems odd to say that an actual promise creates the liability in both cases.²¹² Some brush aside this difficulty based on an “‘objective test’ of promise or assent[.]” thereby creating a means to construe the appearance of a promise from the person’s conduct rather than his or her intent.²¹³ This response, though reasonable, dismisses the deeply entrenched conception that the central requirement of a promise is a voluntary undertaking.²¹⁴

To imply a promise suggests that the person is bound—that is, the person is obligated to pay for the meal because the person promised to pay

²⁰⁵ *See id.* at 710.

²⁰⁶ STEINBERG, *supra* note 200, at 13.

²⁰⁷ *See* Cotnam v. Wisdom, 104 S.W. 164, 165 (Ark. 1907).

²⁰⁸ ATIYAH, *supra* note 193, at 173.

²⁰⁹ *Id.*

²¹⁰ *Id.* at 173–74.

²¹¹ *Id.* at 173.

²¹² *Id.*

²¹³ *Id.*

²¹⁴ *Id.*

for it.²¹⁵ It seems equally plausible to assert, as Atiyah observes, that the person is obligated because society naturally feels impelled to infer a promise to pay in such circumstances.²¹⁶ In one instance, there may be an actual promise. In the other instance, the promise is *theoretical*. It can be said that the person to whom the theoretical promise is ascribed is replaced by an “idealized version of ourselves . . . purged of obvious defects,” who rightly perceives and appreciates true virtue and goodness.²¹⁷ The source of obligation lies not in a voluntary action but rather in the socio-moral and utilitarian value of requiring those who order and eat meals to pay for those meals.²¹⁸ In other words, the promise to pay is implied by a reciprocal theory that obligates citizens to reciprocate for benefits they accept or receive from others.²¹⁹ Because the outcome of the exchange turns on society’s objective reaction to conduct, rather than the autonomous habits of the parties, a consistent outcome to the contractual exchange is ensured. Viewed in this fashion, implied promises or duties can be viewed as indispensable inventions designed to legitimate the consistent imposition of obligations in contractual arrangements. These obligations, born of reasons of fairness and social policy, might appropriately be called morality²²⁰ or what Professor Eisenberg describes as “social morality.”²²¹

Given the needs of social morality, the obligations that flow from the duty of good faith and fair dealing are more nonconsensual than consensual in origin.²²² These obligations are rooted in a theory of fairness that presumes a moral obligation on the part of a party who benefits from the cooperative sacrifices of others, made in support of a mutually beneficial exchange, to bear its “own fair share of the burdens assigned within that scheme.”²²³ Although the nature of the implied obligations depends on the purpose of the contract and the expectations of the parties, the parties do not expressly agree upon these obligations in the contract.²²⁴ Instead, the

²¹⁵ *Id.*

²¹⁶ *Id.* at 173–74.

²¹⁷ WELLMAN & SIMMONS, *supra* note 197, at 117.

²¹⁸ ATYIAH, *supra* note 193, at 174.

²¹⁹ WELLMAN & SIMMONS, *supra* note 197, at 116.

²²⁰ ATYIAH, *supra* note 193, at 176.

²²¹ Melvin A. Eisenberg, *The Disengagement Interest in Contract Law*, 105 MICH. L. REV. 559, 579–80 (2006); see also Shiffrin, *supra* note 189, at 716 (“[I]f contract law’s aim were to protect against harm suffered from breach of promise, measured in terms of reasonable reliance, what counts as a reasonable form of reliance might depend on the cultural context and the degree to which easy trust is encouraged; the degree to which trust is encouraged might, in turn, be a matter settled partly by the norms of morality and not merely by cultural customs.”).

²²² *Koehrer v. Superior Court*, 226 Cal. Rptr. 820, 828 (Cal. Ct. App. 1986).

²²³ WELLMAN & SIMMONS, *supra* note 197, at 119.

²²⁴ *Id.* at 117.

law imposes them so that the agreement reflects the normative character of moral virtues or the collective social voice.²²⁵

In this way, the source of the implied promise is somewhat Kantian in nature;²²⁶ the premise being that contracts require interaction between parties. Each party approaches the arrangement with a variety of motives and interests that have the propensity to conflict with one another.²²⁷ One party may actively seek control over the other or they may be competing for limited resources or freedoms.²²⁸ These opposing interests “set the stage for conflict. Lack of power and neutrality, along with . . . coordination and assurance problems, prevent persons from solving” matters amongst themselves.²²⁹ Without some coercion to do what was promised and deter or control those who would introduce conflict into the transaction, the contractual arrangement would inevitably produce the constant threat of upheaval, economic impasse, or anarchy.²³⁰ Great insecurity would result because each party would represent a potential threat to the other.²³¹ The law mediates such tensions. Seen this way, the notion that the implied duty of good faith and fair dealing is designed to preserve and protect is not limited to partisan interest in having mutual promises performed but rather extends to society’s interest in protecting the public from harm and safeguarding the utilitarian value of contracts.²³² By consistently implying duties based on individual and societal theories of good, rather than autonomous and voluntary urges, we are in a better position to predict the outcome of contractual relations without compromising the utilitarian value of contractarianism.

²²⁵ *Id.*

²²⁶ *See id.* at 122–24 (articulating Immanuel Kant’s natural duty theory of law argument).

²²⁷ *Id.* at 122–23.

²²⁸ *Id.*

²²⁹ *Id.* at 123.

²³⁰ *Id.*

²³¹ *Id.*

²³² The potentially harmful nature of contracting has been recognized by society’s need to protect certain groups of people from the harshness of agreements they might otherwise be free to enter into. *See Kiefer v. Fred Howe Motors, Inc.*, 158 N.W.2d 288, 290 (Wis. 1968) (acknowledging the “commendable and just” nature of the “infancy doctrine”). Harm may arise because (1) one or both parties may be unaware of what is truly in their best interest, *see id.*; (2) there may be an underlying denial of the normative character of labor-protective statutes that facilitate unacceptable exploitation, *see Marc Linder, Closing the Gap Between Reich and Poor: Which Side Is the Department of Labor On?*, 21 N.Y.U. REV. L. & SOC. CHANGE 1, 4–5 (1993); or (3) the employer may find it more profitable to expose its employees and the public to unreasonable risk of harm, *see Debra McCloskey Barnhart, The Dual Capacity Doctrine: Piercing the Exclusive Remedy of Workers’ Compensation*, 43 U. PITT. L. REV. 1013, 1032 (1982).

Indeed, long before the recognized establishment of the implied covenant of good faith and fair dealing, judicial adoptions of moral principles, whether avowed or covert, “brought about a good many elevations of legal standards” in a wide array of contractual arrangements in the interests of social morality.²³³ In *Cotnam v. Wisdom*, the defendant received emergency medical attention after a vehicle accident rendered him unconscious.²³⁴ The defendant denied the existence of a contractual obligation to pay for the services, on the ground that he could not have consented to receive medical attention while incapacitated.²³⁵ The Arkansas Supreme Court disagreed, reasoning that although there was no evidence of an actual promise, the circumstances dictated “it shall be taken that there was a promise”²³⁶

Similarly, in *Chicago, St. Paul, Minneapolis & Omaha Railway Co. v. Belliwitth*, the court’s strong reliance on “public policy”²³⁷ led it to hold that an illiterate was bound by the terms of an agreement, despite the individual’s lack of consent or understanding of the terms.²³⁸ The United States Court of Appeals for the Eighth Circuit reasoned that a party to a contract not only owes a duty to the other contracting party but the party also owes a duty to the public because of the role that written contracts play in society.²³⁹ Because contracts do not inherently enhance well-being, the law of contracts has always maintained a role for morality for purposes of revising, rescinding, or modifying duties when it becomes morally required to do so. These decisions illustrate how the judiciary weighs what parties have an obligation to do against the consequences promoted by, or likely to result by, performing or not performing an act.²⁴⁰ Seen that way, they are indicative of how the enforcement and implication of promises and duties

²³³ PATTERSON, *supra* note 181, at 234.

²³⁴ 104 S.W. 164, 165 (Ark. 1907).

²³⁵ *Id.*

²³⁶ *Id.* at 165–66 (quoting *Sceva v. True*, 53 N.H. 627, 632 (1873)); see also *K.A.L. v. S. Med. Bus. Servs.*, 854 So. 2d 106, 108–09 (Ala. Civ. App. 2003) (holding, under an implied contract theory, that hospital was entitled to reasonable fees for services rendered while plaintiff was unconscious and in critical condition); *In re Crisan Estate*, 107 N.W.2d 907, 910 (Mich. 1961) (discussing an implied promise to pay hospital upon rendering care); *Allen Twp. Ambulance Corps v. Renoll*, 45 Pa. D. & C.3d 732, 733–34 (1987) (using implied contract theory to hold that an ambulance service that renders emergency services to an unconscious accident victim is entitled to compensation).

²³⁷ 83 F. 437, 440 (8th Cir. 1897).

²³⁸ *Id.* at 441–42.

²³⁹ *Id.* at 440.

²⁴⁰ See STEINBERG, *supra* note 200, at 13 (discussing “teleological theories of moral obligation,” which claim that what individuals are obligated to do “is a function of the consequences promoted by, or likely to be promoted by, performing or not performing an act, where the idea of consequences refers to the values promoted by an act”).

reflect the degree of morality necessary for the utilitarian value of contracting to flourish, while remaining loyal to our appreciation and desire for predictable outcomes. Infused properly, moral standards will enhance, rather than detract from, outcome predictability and certainty. For this reason, moral principle, via the adoption of Section 205 of the Restatement (Second) of Contracts, has moved “along the spectrum from a covert application” to contractual principles of law.²⁴¹ The doctrine of good faith represents a twentieth-century attempt to formally “instill morality into contract law.”²⁴² The development of this doctrine symbolizes commitment to the fundamental objective of fairness through a “new spirit of contracts” in satisfaction of “the normative urge of contract law to seek justice in the individual case.”²⁴³ Although my claim here may strike some positivists as oversimplified, my claim regarding the viability of implied covenant of good faith and fair dealing does not rest solely on moral imperatives. Accepting the role of morality merely provides an additional mean to fully appreciate the full-range of duties that may be implied in the interest of the public welfare. Whether public interest is considered or not, it cannot be ignored that the duties arising from the contractual arrangement between the resident physician and residency hospital also include duties both expressly and implicitly assumed by each party,²⁴⁴ which are critical to a court’s ability to articulate the proper distributive outcome.²⁴⁵

B. The Resident Physician’s Duty-Hour Obligations Under the Residency Agreement

Residency agreements are generally adhesive in nature and likely include a provision stating something much like the following:

(1) *The Program.*

The general objectives of the Program are to provide to the Physician a proper educational experience . . . while simultaneously providing to the

²⁴¹ LARRY A. DIMATTEO, *EQUITABLE LAW OF CONTRACTS: STANDARDS AND PRINCIPLES* 113 (2001).

²⁴² *Id.*

²⁴³ *Id.* at 113–14.

²⁴⁴ See *In re Hannaford Bros. Co. Customer Data Sec. Breach Litig.*, 613 F. Supp. 2d 108, 118 (D. Me. 2009) (stating that contracts contain “not only the promises set forth in express words, but, in addition, all such implied provisions as are indispensable to effectuate the intention of the parties and as arise from the language of the contract and the circumstances under which it was made” (quoting *Seashore Performing Arts Ctr., Inc. v. Town of Old Orchard Beach*, 676 A.2d 482, 484 (Me. 1996))); see also FRIED, *supra* note 167, at 75 (“[D]uties not explicitly assumed by the parties may be imposed if required by good faith.”).

²⁴⁵ FRIED, *supra* note 167, at 75.

Hospital's patients a high quality of health care. The Hospital represents that the Program is, and will continue to be, properly accredited by all necessary accrediting authorities. The Hospital will maintain its staffing and facilities so as to maintain such accreditation. . . . The Physician's *duty time* in the Program *will be scheduled* by the Program Director with due regard for *the needs of Hospital patients* and the educational interests of the Physician.

. . . .

(2) *Obligations of the Physician.*

The Physician agrees to fulfill all educational requirements of the Program and further *to provide safe, effective[,] and compassionate health care to Hospital patients* during the Program period. Furthermore, the Physician shall comply with all laws, bylaws, rules, regulations[,] and policies to which the Hospital is subject The Physician shall comply with all proper directives and instructions of the Program Director.²⁴⁶

The residency agreement encompasses basic principles universal to every contract. The expressed representations are not merely expressions of intent but binding commitments.²⁴⁷ The representations convey the parties' objective intent at the time the agreement is made to carry out that which they have represented that they will or will not do.²⁴⁸ The representations obligate or commit the residency hospital and resident physicians to perform their duties regardless of whether they later regret having made the agreement, change their mind,²⁴⁹ or lose resources. Put simply, the law of contracts limits each party's freedom and creates in each party the right to enforce the promised obligations that are expressed in or can be implied from the agreement.²⁵⁰

The residency agreement is also unique. Because of the fluid nature of the residency training process, the extended duration of the residency program, and the sporadic and unpredictable nature of the residency-hospital environment, the expressed terms of a typical residency agreement neither encompass or detail all the obligations between the physician and the hospital nor delineate a specific formula of duties and tasks. While, on its face, the expressed terms of the residency agreement authorizes the

²⁴⁶ *Gupta v. New Britain Gen. Hosp.*, 687 A.2d 111, 112 n.3 (Conn. 1996) (emphasis added).

²⁴⁷ See E. Allan Farnsworth, *Decisions, Decisions: Some Binding, Some Not*, 28 SUFFOLK U. L. REV. 17, 19–20 (1994) [hereinafter *Decisions*] (analyzing when an expression is a promise).

²⁴⁸ *Id.* at 19.

²⁴⁹ *Id.* at 19–20.

²⁵⁰ *Id.*

residency hospital to set the amount of resident physician duty hours, it is completely silent regarding any obligation on the residency hospital's part to limit the resident physician duty hours to some specific amount. Despite the contract's silence regarding critical rights and obligations, the agreement is still enforceable.²⁵¹

The question is whether the implied covenant of good-faith performance permits the hospital to exercise absolute discretion to set boundless duty hours, in light of each party's knowledge of the medical profession's long history of requiring resident physicians to work extremely harsh hours at their employer's discretion. Alternatively, does the implied duty of good-faith performance require the residency hospital to limit duty hours according to a specific standard? If so, to what amount or degree? The answer requires multidimensional consideration. On the one hand, the distribution of rights and duties should bear some relation to the parties' intent.²⁵² Despite the standardized nature of the residency agreement, the clause that empowers the residency hospital with the discretion to set the number of resident physician hours should be given great weight. On the other hand, although resident physicians must adhere to the standardized contract terms, "they are not bound to [accept] unknown terms which are beyond the range of reasonable expectation."²⁵³ The benefits exchanged under the agreement and the reasonable expectations of the parties, therefore, must inform our analysis.

²⁵¹ See *Wood v. Lucy, Lady Duff-Gordon*, 118 N.E. 214, 214 (N.Y. 1917) (reasoning that a contract was enforceable because one party was legally bound to use "reasonable efforts" to secure endorsements for the other party, even though the express terms did not enunciate such an obligation).

²⁵² See, e.g., *The Winterton, LLC v. Winterton Investors, LLC*, 900 N.E.2d 754, 759 (Ind. Ct. App. 2009) ("When interpreting a contract, we attempt to determine the intent of the parties at the time the contract was made by examining the language used in the instrument to express their rights and duties." (citing *Whitaker v. Brunner*, 814 N.E.2d 288, 294 (Ind. Ct. App. 2004))).

²⁵³ RESTATEMENT (SECOND) OF CONTRACTS § 211 cmt. f (1981). The comment explains that [a]lthough customers typically adhere to standardized agreements and are bound by them without even appearing to know the standard terms in detail, they are not bound to unknown terms which are beyond the range of reasonable expectation. A debtor who delivers a check to his creditor with the amount blank does not authorize the insertion of an infinite figure. Similarly, a party who adheres to the other party's standard terms does not assent to a term if the other party has reason to believe that the adhering party would not have accepted the agreement if he had known that the agreement contained the particular term. Such a belief or assumption may be shown by the prior negotiations or inferred from the circumstances. Reason to believe may be inferred from the fact that the term is *bizarre or oppressive*, from the fact that it eviscerates the non-standard terms explicitly agreed to, or from the fact that it eliminates the dominant purpose of the transaction. . . . This rule is closely related to the policy against unconscionable terms and the rule of interpretation against the draftsman.

Id. (emphasis added).

Under the terms of the residency agreement, the residency hospital agrees to provide the resident physician with several benefits, including clinical training, educational instruction, patient-care experience, and, ultimately, a certification from an accredited residency hospital.²⁵⁴ Because of the problem of severe sleep deprivation, one of the most obvious factors within the residency hospital's control that could hinder the resident physician's receipt of contractual benefits is the number of duty hours the resident physician is required to work. If the residency hospital imposes unreasonable work demands that deprive the resident physician of critically needed sleep necessary for the resident physician to care properly for patients, the residency hospital prevents the resident physician from participating in the educational and clinical training components of the residency program. Thus, the residency hospital's contractual obligation to provide the resident physician with specialized training and opportunities to properly care for patients and its right to set resident duty hours are interrelated. Resident physicians who are left incapacitated by sleep deprivation are no less a threat to themselves or to their patients than an intoxicated resident physician and no more capable of benefiting from the residency agreement than a resident who has been denied access to the specialized training sessions and opportunities to care for patients.

As noted earlier, the ACGME imposed duty-hour guidelines for residency hospitals in an effort to solve the problem of sleep deprivation.²⁵⁵ Armed with this knowledge, the resident physician enters the residency program in order to obtain specialized training and certification from an ACGME-accredited residency program. According to the express terms of the agreement, the hospital promises to "maintain such accreditation" and provide the resident physician with the requisite specialized training necessary to earn the certification.²⁵⁶ Regardless of the residency hospital's conduct prior to making the promise or whether the resident physician relies on the promise, by promising to comport with the accreditation requirements, the residency hospital communicates to the resident physician its intent to comply and commits itself to comply with the accreditation requirements.²⁵⁷ Surely, if at the time the residency hospital promised to

²⁵⁴ See *Gupta v. New Britain Gen. Hosp.*, 687 A.2d 111, 112 n.3 (Conn. 1996) (exemplifying a typical resident agreement).

²⁵⁵ See *supra* Part I.B.

²⁵⁶ *Gupta*, 687 A.2d at 112 n.3.

²⁵⁷ See E. ALLAN FARNSWORTH, *CHANGING YOUR MIND: THE LAW OF REGRETTED DECISIONS* 55 (1998) (stating that the law of contracts does not require proof of a promisee's reliance in order for a promise to be binding or fully enforceable).

comply with the accreditation standards it lacked the intent to do so, such action would subject the residency hospital to claims of misrepresentation.²⁵⁸ Hence, the residency hospital, by its promise, gives up certain freedoms or opportunities that an unaccredited program may enjoy and creates in the resident physician a reasonable expectation and right to enforce the obligations taken on by the hospital in exchange for the resident physician's labor.

Given that the representations enunciated under the agreement are not only statements of intent but also commitments, one freedom that the residency hospital relinquishes is its freedom to engage in conduct that materially fails to comply with the ACGME accreditation standards. This constraint on the residency hospital's freedom precludes any opportunity to use the resident physician in a manner inconsistent with the spirit and letter of the duty-hour parameters established by the ACGME. If the residency hospital attempts to use or does use the resident physician in a manner inconsistent with the ACGME duty-hour limits, the residency hospital thereby attempts to recapture a degree of control (i.e., unlimited use of its human capital) that it has already relinquished under the terms of the residency agreement. This recapturing of opportunities foregone by the terms of the agreement frustrates the reasonable expectation of the resident physician and places the residency hospital squarely within the sphere of bad faith.²⁵⁹

Some may assert that such a finding is indefensible because the residency agreement explicitly authorizes the residency hospital to set duty hours. The rationale behind such a claim is that the residency hospital cannot breach the implied covenant of good faith for doing what the residency agreement explicitly authorizes it to do. This contention is rooted in the idea that although a court may fill gaps in a contract, it cannot use the implied covenant of good faith to vary, overrule, or preclude conduct unambiguously permitted by the express terms²⁶⁰ or to impose obligations inconsistent with other express terms appearing in the contract.²⁶¹ For

²⁵⁸ See *Decisions*, *supra* note 247, at 19 ("The law thus treats a promise made without the intention of performing it as a fraudulent misrepresentation of the fact that the promisor has made the initial decision announced by the promise.")

²⁵⁹ See *Burton*, *supra* note 179, at 388-89 (asserting that a "quantity-controlling party" acts in bad faith when they attempt to recapture opportunities that the other party reasonably expected had been forgone).

²⁶⁰ See *Sons of Thunder, Inc. v. Borden, Inc.*, 690 A.2d 575, 586 (N.J. 1997) ("[T]he implied covenant of good faith and fair dealing cannot override" an express contract provision).

²⁶¹ *Dalton v. Educ. Testing Serv.*, 663 N.E.2d 289, 291-92 (N.Y. 1995); see also *Guz v. Bechtel Nat'l, Inc.*, 8 P.3d 1089, 1110 (Cal. 2000) (reiterating same).

some, because the agreement does not expressly indicate that the resident physician has a right to have duty limited to a specific number of hours or that the residency hospital has an obligation to limit duty hours, a breach cannot be identified.²⁶² Well-established precedent and several other considerations, however, weigh heavily against the expected merit of such a claim.

The law requires that we read contracts so that every provision is given some degree of deference.²⁶³ This requires that the law respect the duties implied by the residency hospital's commitment to maintain accreditation and the resident physician's ethical and expressed obligations to provide effective and safe health care to patients. Respecting those implied duties compels consideration of the great weight of modern sleep-deprivation scholarship, which militates against the recognition of an absolute and unlimited right to set resident physician duty hours.

Secondly, although parties may intend to leave absolute discretion to only one party without limits and make the issue of good-faith performance irrelevant, we must ask whether the residency agreement has been so drafted.²⁶⁴ Contrary to what some may assert, a residency agreement's mere recitation of the residency hospital's express right to set resident physician duty hours does not answer the question.²⁶⁵ To read every contractual right expressly conferred as an absolute and unlimited right is "to read the doctrine of good faith . . . out of existence."²⁶⁶ A residency

²⁶² See, e.g., *Los Angeles Equestrian Ctr., Inc. v. City of Los Angeles*, 21 Cal. Rptr. 2d 313, 323 (Cal. Ct. App. 1993) ("[T]he implied covenant [of good faith and fair dealing] . . . 'cannot be extended to create obligations not contemplated in the contract.'" (quoting *Racine & Laramie, Ltd. v. Dep't of Parks & Recreation*, 14 Cal. Rptr. 2d 335, 339 (Cal. Ct. App. 1992))).

²⁶³ See RESTATEMENT (SECOND) OF CONTRACTS § 202(2) (1981) ("A writing is interpreted as a whole, and all writings that are part of the same transaction are interpreted together."); *id.* § 203(a) ("[A]n interpretation which gives a reasonable, lawful, and effective meaning to all the terms is preferred to an interpretation which leaves a part unreasonable, unlawful, or of no effect . . .").

²⁶⁴ See *Tymshare, Inc. v. Covell*, 727 F.2d 1145, 1153 (D.C. Cir. 1984) (disregarding the issue of whether or not a contract was pursued under "the rubric of 'good faith'" and noting that the object of the court's inquiry was "whether it was reasonably understood by the parties" that the contract had certain limitations).

²⁶⁵ *Id.*

²⁶⁶ *Id.* at 1153-54. This is to say that compliance with specific provisions of the contract does not shield the residency hospital from violating the implied covenant of good faith if, in its performance, it violates implied obligations. See *Marsu, B.V. v. Walt Disney Co.*, 185 F.3d 932, 937 (9th Cir. 1999) (holding that a "breach of a specific provision of the contract is not a necessary prerequisite" to a breach of an implied covenant of good faith and fair dealing" (quoting *Carma Developers (Cal.), Inc. v. Marathon Dev. Cal., Inc.*, 826 P.2d 710, 727 (Cal. 1992))); see also *Pearce v. Manhattan Ensemble Theater, Inc.*, 528 F. Supp. 2d 175, 180-81 (S.D.N.Y. 2007) (reasoning that a breach of good faith may be alleged "where one party's conduct, though not breaching the terms of the contract in a technical sense, nonetheless deprive[s] the other party of the benefit of its bargain" (quoting *Sauer v. Xerox*

hospital, therefore, may be liable for breaching the implied duty of good-faith performance simply by doing what the expressed contract terms permit it to do, if its performance does not comply with implicit demands of the agreement.²⁶⁷ That is, by exercising its discretion to set resident physician duty hours—a right expressly permitted by the terms of the residency agreement—a residency hospital may breach the implied covenant of good faith.²⁶⁸

The rationale is that while certain express rights, “even without an expansive modifier, are implicitly absolute . . . others are not.”²⁶⁹ The implied covenant of good faith acts as an implied modifier to prevent a contracting party from engaging in conduct that “while not technically transgressing the express covenants[,] frustrates the other party’s rights to the benefits of the contract”²⁷⁰ and the reasonable expectations of the parties.²⁷¹ The way in which the implied duty of good faith constrains each party’s freedom depends on the nature of the agreement.²⁷²

Given the unique potential for residency hospitals to prey on or take advantage of the dependent resident physician while simultaneously

Corp., 95 F. Supp. 2d 125, 132 (W.D.N.Y. 2000)).

²⁶⁷ See *United Roasters, Inc. v. Colgate-Palmolive Co.*, 649 F.2d 985, 990 (4th Cir. 1981) (“What is wrong with Colgate’s conduct in this case is not its failure to communicate a decision to terminate arrived at before the end of March, but its cessation of performance. Clearly it had an obligation of good faith performance up until its right of termination was actually effective. The contract expressly obliged it to use its best efforts in the promotion of Bambeanos. Instead of doing that, it simply ceased its performance. It stopped manufacturing Bambeanos. It ended its advertising campaign in Boston and in Syracuse and sold its inventory. Quite simply, it broke its contract when it terminated its performance, which was United Roasters’ contractual due.”).

²⁶⁸ In *United Roasters*, the plaintiff gave Colgate the contractual right to manufacture and distribute Bambeanos, its roasted soybean snack. *Id.* at 987. The contract allowed Colgate to terminate its performance at any time during the test-marketing period so long as it gave United Roasters thirty-days notice. *Id.* After almost three years, Colgate terminated the contract. *Id.* at 988. The U.S. Court of Appeals for the Fourth Circuit concluded that the question was not whether there was a good-faith limitation on Colgate’s unconditional right to terminate the contract but, instead, whether Colgate breached the covenant of good faith and fair dealing when it exercised the express right to terminate the contract. *Id.* at 990. In finding Colgate’s performance inconsistent with the implied covenant of good faith, the court held that a party to a contract may breach the implied covenant of good faith and fair dealing in performing its obligations simply by exercising rights expressly conferred in the contract. See *id.* at 989–90; see also *Bak-A-Lum Corp. of Am. v. Alcoa Bldg. Products, Inc.*, 351 A.2d 349, 352 (N.J. 1976) (finding a breach of an implied term when one party exercised a right permitted under the express terms of the agreement).

²⁶⁹ *Tymshare, Inc.*, 727 F.2d at 1154.

²⁷⁰ *Los Angeles Equestrian Ctr., Inc. v. City of Los Angeles*, 21 Cal. Rptr. 2d 313, 323 (Cal. Ct. App. 1993) (quoting *Racine & Laramie, Ltd. v. Dep’t of Parks & Recreation*, 14 Cal. Rptr. 2d 335, 338 (Cal. Ct. App. 1992)).

²⁷¹ See *E. Shore Mkts., Inc. v. J.D. Assoc. Ltd. P’ship*, 213 F.3d 175, 184 (4th Cir. 2000) (reasoning that the implied duty of good faith creates an obligation to recognize conditions inherent in the express terms of the agreement).

²⁷² *Tymshare, Inc.*, 727 F.2d at 1153–54.

complying with the express terms of the residency agreement, the duty of good-faith performance is implicated.²⁷³ When the contract confers on the residency hospital the discretionary right to affect the obligations of resident physicians by controlling the implementation of express terms, the implied covenant of good faith requires the residency hospital to remain mindful of the purpose for contracting “in accordance with fair dealing.”²⁷⁴ This requirement is heightened in circumstances where a huge disparity in bargaining positions exists, where one party is in a position to take advantage of the other, or where the nature of the agreement makes it impractical to detail every aspect of performance necessary to effect the purpose of the contract.²⁷⁵

In *Scarborough v. Delaware*, the Supreme Court of Delaware considered the legality of the state’s conduct relative to a plea agreement.²⁷⁶ The court emphasized that breach of the duty of good faith occurs when one party’s “conduct frustrates the overarching purpose of the contract by taking advantage of [its] position to control implementation of the agreement’s terms.”²⁷⁷ Since the state was “always . . . in a position to take advantage of its superior ability to control implementation of the agreement’s terms,”²⁷⁸ the court viewed itself as having a heightened duty to protect the weaker party.²⁷⁹ The covenant of good faith and fair dealing required the state “to refrain from . . . unreasonable conduct [that had the] effect of preventing” the other party to the plea agreement “from receiving the fruits of the bargain.”²⁸⁰

²⁷³ See *Sons of Thunder, Inc. v. Borden, Inc.*, 690 A.2d 575, 588–89 (N.J. 1997) (examining “the independence of the implied duty to act in good faith and the express terms of the contract” and affirming the trial court’s finding of a breach of the obligation of good faith); *Wood v. Lucy, Lady Duff-Gordon*, 118 N.E. 214, 214 (N.Y. 1917) (implying a promise of exclusive agency).

²⁷⁴ See *Perdue v. Crocker Nat’l Bank*, 702 P.2d 503, 510 (Cal. 1985) (“If there are reciprocal promises . . . the fact that the contract permits one party to set or change the price charged for goods or services does not render the contract illusory. . . . The buyer did not have arbitrary power . . . because ‘where a contract confers on one party a discretionary power affecting the rights of the other, a duty is imposed to exercise that discretion in good faith and in accordance with fair dealing.’” (quoting *Cal. Lettuce Growers, Inc. v. Union Sugar Co.*, 289 P.2d 785, 791 (Cal. 1955))); see also *Schell v. LifeMark Hosps. of Mo.*, 92 S.W.3d 222, 231 (Mo. Ct. App. 2002) (discussing the implied obligation to exercise reasonableness when contracted terms leave discretion to one party over another).

²⁷⁵ *Pizza Mgmt., Inc. v. Pizza Hut, Inc.*, 737 F. Supp. 1154, 1178–79 (D. Kan. 1990).

²⁷⁶ 938 A.2d 644, 652 (Del. 2007).

²⁷⁷ *Id.* (quoting *Cole v. Delaware*, 922 A.2d 354, 359–60 (Del. 2005)).

²⁷⁸ *Id.* (quoting *Cole*, 922 A.2d at 359–60).

²⁷⁹ *Id.*

²⁸⁰ *Id.* (quoting *Cole*, 922 A.2d at 359).

Given that the residency hospital is always in a position to take advantage of the resident physician when the residency contract, by its terms or its silence, grants the hospital the discretion to set or determine resident physician duty hours, an obligation arises not to deprive the resident physician of the value of the contract. A corollary of the hospital's duty to resist depriving the resident physician of the benefits of the contract is an obligation "to observe reasonable limits in exercising that discretion, consistent with the parties' . . . purposes in contracting."²⁸¹ The question thus becomes, what are reasonable resident physician duty hours within the context of a good-faith analysis?

C. What Is a "Reasonable" Limit on Resident Physician Duty Hours?

Justice David Souter, then a justice on the Supreme Court of New Hampshire, considered the issue of reasonableness for purposes of good-faith performance in *Centronics Corp. v. Genicom Corp.*²⁸² He asserted that whether the exercise of discretion exceeds the bounds of reasonableness for purposes of good-faith performance depends on (1) the "common purpose or purposes of the contract, against which" (2) the reasonable expectations of the complaining party "may be measured" and to which (3) "community standards of honesty, decency[,] and reasonableness can be applied."²⁸³ This framework provides an important normative dimension to the process of determining reasonableness. It focuses on the intrinsic quality of the act of contracting as well as the desired consequences of that performance. Thus, any construction of reasonable limits on the residency hospital's exercise of discretion includes not only elucidation of the parties' reasonable expectations but also deliberation of public identity of the contractual arrangement. As a methodology, this is distinct from the traditional—and perilous—libertarian narrow focus on efficiency and individual intent.²⁸⁴

²⁸¹ *Centronics Corp. v. Genicom Corp.*, 562 A.2d 187, 193 (N.H. 1989).

²⁸² *Id.* at 193–96.

²⁸³ *Id.* at 193–94. Justice Souter's analysis recognizes Professor Robert Summers' "view that the obligation of good[-]faith performance is better understood . . . as excluding behavior inconsistent with common standards of decency, . . . reasonableness, and with the parties' agreed-upon common purposes and justified expectations." *Id.* at 191 (citing Summers, *supra* note 180, at 820, 826); see also *Pizza Mgmt., Inc. v. Pizza Hut, Inc.*, 737 F. Supp. 1154, 1180 (D. Kan. 1990) (determining reasonableness by looking, first, at whether a contract condition is reasonable and, second, at whether it is reasonably applied under the circumstances).

²⁸⁴ See *Greenfield v. Philles Records, Inc.*, 780 N.E.2d 166, 170 (N.Y. 2002) ("The fundamental, neutral precept of contract interpretation is that agreements are construed in accord with the parties' intent.").

When attempting to honor the mutually agreed-upon duties the parties voluntarily assume under the residency contract, the law imposes a duty to consider medical-community standards of decency and the reciprocal nature of the cooperation essential to successful performance of the residency contract.²⁸⁵ The doctrinal expansion of the duty of good faith as the normative core of the contractual relationship ensures that these important dimensions are both recognized by the parties and enforced by the courts. Hence, finding an appropriate definitional standard of reasonableness relative to resident physician duty-hour limits requires more than evaluation of the particular dimensions of the individual transaction; it also involves an examination of the institutional roles of the residency hospital and resident physician as defined by the prescriptions of public morality.²⁸⁶

In fashioning a definitional standard, one must remain mindful of the appeal for some level of medical deferentialism. A trier of fact's freedom to determine whether the residency hospital's decisions are sound could seriously compromise the residency hospital's ability to exercise its own expertise and professional judgment in setting resident physician duty hours. Nevertheless, one cannot ignore the substantive merits of medical realism. The residency hospital's representations that it will provide the resident physician with educational and clinical benefits are promises. The obligations extending from those promises include a duty to act in a manner consistent with the residency hospital's institutional role to provide proper care to patients. Consequently, part of this role includes considering the undeniable harmful consequences of sleep deprivation.

To reconcile this tension, the affirmative duties incorporated in the duty of good faith require one to look no further for guidance than medical community standards. Indeed, judges may derive concepts of public decency and fairness from their own experience in living in the community or consult an industry in determining whether performance comports with community standards.²⁸⁷ The implied covenant of good faith imposes obligations like those of tort law by recognizing duties that emanate from social policy rather than from the private intentions of the parties.²⁸⁸

²⁸⁵ See RESTATEMENT (SECOND) OF CONTRACTS § 205 cmt. a (1981) (explaining the duty of good faith and fair dealing); see also Williams, *supra* note 173, at 206 (discussing duty of good faith and fair dealing).

²⁸⁶ See Timothy Davis, *An Absence of Good Faith: Defining a University's Educational Obligation to Student-Athletes*, 28 HOUS. L. REV. 743, 779 (1991) (acknowledging a duty among colleges and universities to assist student-athletes in acquiring an education).

²⁸⁷ See PATTERSON, *supra* note 181, at 239-41.

²⁸⁸ Tort law generally allows for recovery under negligence for breaches of contractual duties in

Indeed, “one who performs or fails to perform her contractual obligations in bad faith is not only liable for breach of contract, but may also be liable in tort.”²⁸⁹ Tort cases, therefore, can be instructive as to how a court might turn to community standards or social policy when deciding reasonableness in good faith cases.

In *Kelty v. Wiseman Construction Co.*, for instance, the plaintiff alleged that the defendant was negligent in failing to provide its employee, a carpenter, with a reasonably safe place to work and violated its duty when it failed to institute certain safety measures to prevent its carpenters from falling, as the plaintiff did, while working.²⁹⁰ The plaintiff’s expert witness testified that “there was an established set of safety standards applicable to the construction industry,” commonly referred to as “consensus standards,” that were not followed.²⁹¹

The construction company, conversely, introduced evidence showing that some of the consensus standards were not, in fact, the custom and usage of the construction industry.²⁹² The *Kelty* court held that “[a]lthough there was substantial evidence that it was not the custom in the trade to employ safety nets, rails, or lines for carpenters constructing external walls at the edge of the second floor deck, such custom is not conclusive as to the required standard of care.”²⁹³ In recognition of the risk of potential harm at issue in the case, the court reasoned that “[c]ourts must in the end say what is required; there are precautions so imperative that even their universal disregard will not excuse their omission.”²⁹⁴ As in *Kelty*, the court is required to say or confirm what each party knows or should know is required by public morality because of the implied covenant of good faith.

Considering the analytical framework applied in *Kelty* and the complexities of the resident physician-residency hospital relationship, one

instances where the breach rises to the level of constituting misfeasance (e.g., affirmative acts of negligence) on the defendant’s part, as compared to mere nonfeasance. *E.g.*, DAN B. DOBBS, *THE LAW OF TORTS* § 321, at 870 (2000). Thus, when a defendant promises to act under a contract and simply fails to do anything (e.g., nonperformance), the contract action in many instances is the only remedy available to the plaintiff, and no tort recovery is allowed. *See, e.g.*, *Newton v. Brook*, 32 So. 722, 723–24 (Ala. 1902) (holding that only the contract action would lie when the defendants contracted to prepare a body for shipment on a certain train and then failed to perform the promise).

²⁸⁹ DIMATTEO, *supra* note 241, at 114; *see also* DOBBS, *supra* note 288, § 321, at 870 (discussing same). Some commentators, however, have asserted that tort law is ill-suited for addressing the problem of resident-physician sleep deprivation. *E.g.*, *Lee*, *supra* note 1, at 210.

²⁹⁰ 349 N.E.2d 108, 109–11 (Ill. App. Ct. 1976).

²⁹¹ *Id.* at 112.

²⁹² *Id.*

²⁹³ *Id.* at 113.

²⁹⁴ *Id.* (quoting *The T.J. Hooper*, 60 F.2d 737, 740 (2d Cir. 1932)).

need not look any further than the duty-hour standards enunciated in the ACGME guidelines to resolve the question of reasonableness. Like the construction company in *Kelby*, the residency hospital owes a duty of care to its resident physicians and patients. ACGME standards, like the consensus standards in *Kelby*, are designed to safeguard and protect. Regardless of whether the residency hospital accepts the ACGME guidelines as customary within the medical industry or lacks the intent to frustrate the purpose of the residency contract,²⁹⁵ society as a whole, via the implied covenant of good faith, imposes a duty to comply with the ACGME guidelines.

In addition to facilitating compatibility within a culture that supports morally virtuous character and reasonable expectations of the parties, recognition of a good-faith obligation to adhere to ACGME duty-hour limits has several other advantages. First, given that ACGME sponsors the residency hospital, recognizing ACGME standards as reasonable standards within the medical industry is analogous to the usage of trade evidence typically referred to in commercial exchanges. Reference to (and reliance on) the ACGME guidelines on the question of reasonableness is, therefore, completely defensible. Second, an implied contractual duty to limit duty

²⁹⁵ In *Northern Crossarm, Inc. v. Chemical Specialties, Inc.*, the court considered a marketing support agreement between the plaintiff, a wood-treating company, and the defendant, a chemical company. 332 F. Supp. 2d 1181, 1185–86 (W.D. Wis. 2004). The defendant agreed to pay the plaintiff a specified amount for every pound of wood-treating chemical sold in the plaintiff's region. *Id.* at 1187. The defendants sublicensed the wood-treating technology to one of the plaintiff's competitors, who began selling the chemical in the plaintiff's region. *Id.* at 1187. When the plaintiff sought payment under the marketing support agreement, the defendant claimed that it did not owe the plaintiff a royalty because enabling another company to make sales was not the equivalent of selling wood-treating chemical in the plaintiff's region. *Id.* The court found that while the defendant may have technically complied with the terms of the contract, the defendant breached the implied covenant of good faith and fair dealing by repudiating the purpose of the contract. *Id.* at 1189–90. The reasoning was that the plaintiff's expected benefit was to be compensated for its labor in promoting the wood-treating chemical. *Id.* By sublicensing to a competitor and refusing to give the plaintiff royalties, the defendant breached an *implicit* obligation of the agreement, which prevented the plaintiff from reaping the benefits of the contract, increased the plaintiff's competition in its market, denied the plaintiff its contractual right to royalties, and frustrated the purpose of the agreement. *Id.* at 1188–90. The *Northern Crossarm* court rejected the contention that a party can breach its duty of good faith only by intentional bad-faith acts. *Id.*

Similarly, in *Zig v. Prentice-Hall, Inc.*, the United States Court of Appeals for the Second Circuit held that although a publishing contract with an author contained no restriction on the publisher's discretion to expend resources in promoting the author's book, the publisher was bound in good faith to make an effort that would give the book a reasonable chance of success. 717 F.2d 671, 679–80 (2d Cir. 1983). The rationale is that, in such circumstances, parties are "forced to confer control of a contract term, or discretionary authority, upon one another, leaving each to depend on the good faith of the other." *Pizza Mgmt., Inc. v. Pizza Hut, Inc.*, 737 F. Supp. 1154, 1178 (D. Kan. 1990) (citing *Boone v. Kerr-McGee Oil Indus.*, 217 F.2d 63, 65 (10th Cir. 1954)). That conduct is actionable when a party's performance becomes unreasonable as it relates to a term of the contract. *Id.* at 1178–79.

hours to ACGME standards comports with the residency hospital's societal function to provide quality health care to patients and its obligation to adhere to the agreed common purpose of the resident physician-hospital relationship.²⁹⁶ Third, a definitional limit of resident physician duty hours comports with the universal public policy favoring the protection of hospital patients.²⁹⁷ Fourth, it also helps the court prevent or quell opportunistic behavior on the part of the residency hospital, without overreaching or substituting its exercise of judicial discretion in areas that may properly lie within the expertise of medical professionals.²⁹⁸ Fifth, it also precludes the residency hospital from recapturing opportunities objectively inferable from the express terms of the residency agreement that the hospital bargained away at the time of contracting²⁹⁹ and permits the court to carry out its heightened duty to protect basic principles of contract law. Lastly, a party pursuing a breach-of-contract claim, whether it is a resident physician or patient that is an intended third-party beneficiary of the resident-physician agreement, allows for a longer statute of limitations than does tort claims.³⁰⁰ In addition, the breach-of-contract claim alleviates the need to prove reliance or the scienter attendant to misrepresentation claims or hospital negligence.³⁰¹ In short, the lack of legislative oversight and judicial uniformity, coupled with the significant risk of public harm due to resident-physician sleep deprivation, weighs in favor of courts permitting an additional legal means to address and reduce the degree of medical errors related to resident-physician sleep deprivation.

²⁹⁶ See *Garland Cmty. Hosp. v. Rose*, 156 S.W.3d 541, 545 (Tex. 2004) (stating that a hospital's primary function is to provide a place in which doctors can provide health-care services to patients).

²⁹⁷ See *Insinga v. LaBella*, 543 So. 2d 209, 214 (Fla. 1989) (recognizing public policy of hospitals to protect patients); *Highlands Hosp. and Health Ctr. v. Am. Fed'n of State, County and Mun. Employees*, No. CIV. A. 95-170, 1996 WL 163947, at *4 (W.D. Pa. Feb. 16, 1996) (recognizing the dominant public policy to protect patients from harm).

²⁹⁸ See *Mann Farms, Inc. v. Traders State Bank of Poplar, Mont.*, 801 P.2d 73, 73-77 (Mont. 1990) (in deciding whether bank breached covenant of good faith, court restricted itself to looking at the parties' performance and obligations within the context of the creditor-debtor relationship).

²⁹⁹ See *Burton*, *supra* note 179, at 389-91 (discussing breach of contract due to a party failing to perform in good faith).

³⁰⁰ See, e.g., *Douglas R. Richmond, Liability Issues in the Sale of Life Insurance*, 40 TORT TRIAL & INS. PRAC. L.J. 877, 908 (2005) ("The advantages to alleging a breach of contract to a plaintiff are the longer statutes of limitations for contract claims than for tort claims, and the lack of need to prove reliance or scienter attending an alleged misrepresentation.").

³⁰¹ See, e.g., *id.*

CONCLUSION

As discussed, every year, approximately 100,000 patients die because of medical errors,³⁰² some of which are linked to sleep-deprived resident physicians.³⁰³ This Article has examined and evaluated legislative and judicial treatment of the problem of sleep deprivation within residency hospitals and the social costs of leaving the problem unabated. The penchant of the judiciary to decline evaluation of the performance obligations enunciated under residency agreements because of appeals to medical deferentialism has facilitated a perpetual state of worker duress among resident physicians, essentially rendering them exempt from traditional judicial and legislative protections. This juridical gap has facilitated an economic and humanitarian state of emergency. As illustrated, the law of contracts is properly suited to respond to the moral urge to resolve the problem of sleep deprivation without encroaching upon the libertarian strictures that prioritize efficiency and certainty of contractual outcomes over the demands of social welfare.

The doctrinal expansion of the implied covenant of good faith and fair dealing as the normative core of the contractual relationship requires that a residency hospital adhere to the resident physicians' reasonable expectations and align its discretionary acts with contractual purposes and community standards of decency, so as not to deprive the resident physician of promised benefits. Because the directives of contract law and morality may constrain or regulate the same behavior, its subjects have to negotiate two distinct sets of norms, both of which are interrelated. The methodological approach to construction advanced here considers not only the intrinsic quality of the act of contracting between the resident physician and residency hospital, but also the morally desired consequences of the promised acts in the distribution process when deciding rights and duties. By so doing, the construction prompts a finding that residency hospitals have committed to limit resident physician duty hours commensurate with the guidelines promulgated by the Accreditation Council for Graduate Medical Education.

³⁰² See *Connolly*, *supra* note 27 (“[T]here are about 100,000 medical[-]error deaths a year in this country, and many of them can be prevented.”); see also *Klevens et al.*, *supra* note 27, at 160, 163 (reiterating same); President Barack Obama, *supra* note 25 (reiterating same).

³⁰³ *Lee*, *supra* note 1, at 162 (“In recent years, there has been an increase in the public’s awareness of medical errors committed by hospital interns and residents who have been acutely and chronically sleep-deprived as a result of extremely long work hours.”); see also *Parker-Pope*, *supra* note 16, at A23 (national publication drawing the public’s attention to the problem).

