

Guest Editorial

Psychogeriatrics, Nursing Homes, and Lawsuits

Few pieces of American legislation evoke as many raised eyebrows and quizzical looks in non-Americans as does the Omnibus Budget Reconciliation Act of 1987 (OBRA-87). Incorporated into this legislation is the Nursing Home Reform Act, which contains guidelines for establishing a better environment and better care for nursing home residents. Certainly, some of the provisions focusing on nutrition, improved staff education, and the collection and evaluation of data have resulted in improved care, but the provision that regulates the prescription of psychotropic medications has received mixed reviews.

There is general agreement that the behavioral and psychological signs and symptoms of dementia, as well as the existence of depression, schizophrenia, and other mental disorders, are extremely common in the nursing home setting (Rovner et al., 1990; Tariot et al., 1993; Zimmer et al., 1984). Further, many investigators support the view that psychotropic medication has been overutilized with the frailelderly in nursing homes (Burns & Kamerow, 1988; Garrard et al., 1991, 1995; Ray et al., 1980). Increasingly, professional literature and the popular press have underscored the potential dangers of using psychotropic medication, particularly

neuroleptic medication, in treating nursing home elderly, although the only two placebo-controlled, randomly assigned, double-blind studies conducted in the nursing home indicate usefulness for neuroleptic medication in appropriate doses, especially with those most seriously agitated (Barnes et al., 1982; Finkel et al., 1995). Concern about inappropriate physician prescribing of neuroleptic medications in the nursing home became an increasing focus in the United States in the 1980s. Other countries had similar concerns, but their solutions included more education. In Sweden, physicians working in nursing homes receive specialized training in geriatric medicine, including geriatric psychiatry, and must demonstrate proficiency and knowledge in working with the elderly (Bucht & Steen, 1990).

The United States has taken a different route with OBRA-87, for physicians must justify the use of psychotropic medication on the basis of a *Diagnostic and Statistical Manual of Mental Disorders* or *International Classification of Disease* diagnosis. Further, dosages, types of medications used for specific diagnoses, and length of time the patient receives the medication are regulated. Should the physician not comply, it is the nursing home that suffers substantial financial

loss, even to the point of threatened financial viability. Penalties are applied to the nursing home, even if only one nursing home resident receives prescriptions that do not comply with the regulation. In order to enforce the law, the United States Congress mandated that states conduct surveys to ensure that nursing homes comply with the regulations. Typically, reviewers have substantially fewer professional qualifications than those caring for the patient. They are not physicians, yet pass judgment on medical care. No studies and minimal attention are given to those nursing home residents with psychiatric illness who are not treated or who are undertreated, particularly those with agitation, psychotic symptoms, or aggressiveness.

One of the impacts of OBRA-87 has been a reduction of psychotropic medication prescriptions in nursing homes (Burns et al., 1993; Garrard et al., 1995; Semla et al., 1994; Shorr et al., 1994). Moreover, the use of psychotropic medication as "chemical restraints" and its utilization for purposes of convenience or discipline has been reduced or eliminated. Although these results are applauded by many, and indeed needless prescribing or overdosing has been reduced for many, others may be deprived of necessary treatment (Borson et al., 1989; Finkel, 1992; Kashgarian, 1980; Streim & Katz, 1994). Fortunately, some of the original OBRA guidelines, e.g., the elimination of as-needed psychotropic medication, strict adherence to specific doses (which does not give due consideration to the heterogeneity of older people), and the use of only one psychotropic drug to treat certain symptoms, have been ameliorated, as long as sufficient documentation provides justification for such actions.

The OBRA-87 guidelines have also resulted in an atmosphere of opportunities for lawsuits, which are increasing against nursing homes. Unlike medical malpractice lawsuits, nursing homes have been sued without a provision that the lawyer must first receive expert opinion that such a lawsuit is a meritorious and justifiable action. Some law firms specialize in such litigation. Further, nursing homes are responsible for treble damages in the event that they are found guilty. In some situations, law firms have a stable of experts—physicians (who may be retired from clinical practice), clinical nurse managers (who also may be retired or teaching and not involved in clinical work), and nursing home administrators. They are available to travel to different states to provide their expert testimony on the care provided by nursing homes that they perceive is terrible.

One area of litigation has to do with the utilization of psychotropic medication. Although the guidelines use the term "chemical restraint" specifically for psychoactive medications utilized for staff convenience or for punitive purposes, in depositions "chemical restraints" is used as if it were synonymous with psychotropic medication. The following case is an example of such a lawsuit:

Mr. A was an 83-year-old man with a history of coronary artery heart disease, gouty arthritis, and depression. During a 7-week hospitalization in an acute medical setting, he had a urinary tract infection with septicemia, delirium, renal failure requiring dialysis, congestive heart failure, severe anorexia with G-tube insertion, bleeding peptic ulcers, and respiratory failure with tracheostomy. Prognosis was grave, but after 7 weeks he was able to leave the hospital and was transferred to a skilled nursing facility. He was admitted, unable to walk or talk, with a G-tube in place, as well as Foley catheters (tracheostomy had been removed by the time of this admission). On the Medicare unit at the

nursing home, he continued to be delirious with recurrent urinary tract infection and sepsis. His primary care physician prescribed Ativan .5 mg three times a day as needed and later changed to haloperidol .5 mg three times a day as needed. These medications were insufficient to control his behavior during delirious episodes. He continued to suffer from hallucinations and delusions. He often got out of bed, even with rails up and with physical restraints, and he occasionally pulled out his Foley catheter. The children, who were guardians, refused to allow additional medication, indicating that "they cause agitation" and caused too many side effects. In general, they were not proponents of psychiatric consultation and intervention. Nursing staff documented a need for additional medication, but this was not forthcoming.

Nevertheless, with intensive nursing involvement, and with his other medical problems increasingly ameliorated, and after several brief hospitalizations for urinary tract infection and/or syncopal episodes, he was medically and psychiatrically stabilized. By the fourth month, he was walking, talking, and no longer in restraints, although he was talking about suicide and was obviously depressed. There was also evidence of persistent cognitive impairment. He was started on antidepressant therapy, and the suicidal ideation and depressive ruminations disappeared, though evidence of dementia persisted.

Though his background led him to not be interested in other residents or nursing home activities, he did have a girlfriend who visited him almost daily and his family visited on a regular basis. He enjoyed his contact with the staff, entered a physical therapy program, and walked extensively with one of the staff members on an almost daily basis.

As he became physically stronger, he began to leave the facility in an attempt to go home. Although staff kept a careful lookout for him, he would sometimes become very agitated. At times he would physically strike out, once injuring a pregnant woman, and causing property damage on another occasion. He could be charming, but also obstreperous and confrontational. Although he left the nursing home on several occasions, there was no significant injury, and he was apprehended and returned on all occasions. Because of the concern of his wandering off the premises, the nursing home installed an alarm system that generally proved effective, but that failed on a couple of occasions.

Near the end of the first year, he again became depressed and again required antidepressant medication. In the meantime, the family had not paid their bill for him, even though there were adequate funds to do so. The reasons why they did not pay are debatable, but there is no question that the financial problems and nonpayment for the better part of the year resulted in the nursing home asking the family to find another facility, which they did, and promptly the small amounts of psychotropics that Mr. A was on (thioridazine 20 to 30 mg a day, bupropion 75 to 150 mg) were discontinued at the new nursing home. Shortly thereafter, his psychiatric and medical condition deteriorated and, after several months, he died.

The first nursing home brought suit for collection of money owed for services, which they felt were lifesaving. Administrative and staff comments included the belief that Mr. A required and obtained more of the nursing home's resources than any other resident. After the lawsuit was instituted, a countersuit from the family accused the nursing home of destroying his dignity, resulting in his permanent deterioration from lax care, including inappropriate use of psychotropic medications and inappropriate physical restraints (when he was delirious during the early part of his nursing home stay).

The law firm, which specialized in such litigation, had among its witnesses a geriatrician who had not practiced medicine for 14 years, a nonpracticing clinical nurse manager with limited understanding related to psychopathology of later life and its role in the nursing home, and a nursing home administrator/consultant. All were critical of the nursing home care and minimized the positive impact of the staff and Mr. A's incredible recovery. Although Mr. A had dementia, delirium, and depression, the physician expert maintained that Mr. A's symptoms were a result of the medications and physical restraints and other environmental contributors, but not due to brain disease. The nurse "confirmed" these observations. Although the physician expert witness was discredited at trial, and the case was resolved to the satisfaction of the nursing home, literally hundreds of thousands of dollars were lost by the nursing home on lawyers, expert witnesses, and court costs, as well as to try to collect the overdue revenue from Mr. A.

Mr. A's case is an example of a phenomenon that is occurring with greater frequency, namely lawsuits against nursing homes for "poor care and lack of compliance with OBRA regulations," including inappropriate use of psychotropic medications. Of great interest is that the physicians were not sued, even though it was the physician, not the nursing home, who was responsible for prescribing the psychotropic medication and, moreover, the guardian (children) refused to allow appropriate doses of medication. With greater regulation and clearer demand for documentation mandated by the government, we may see improved care, but among the costs are decreased clinical staff-patient contact (as a result of greater need for documentation) and an increase in lawsuits in a society noted for its litigious propensities. Of course, nursing homes that provide obviously inappropriate or poor care that harms individuals must be liable for harm done to residents due to the actions or inactions of the nursing home. However, there must also be provisions to protect nursing homes and other providers who are delivering appropriate care to very difficult patients. At the least, there must be expert review by a qualified clinician in active practice before a lawsuit can be instituted. Meanwhile, non-Americans must hope that this American state of affairs is not exported.

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- International Psychogeriatrics*, 9(2), June 1997

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Sanford I. Finkel, MD

Department of Psychiatry
and Behavioral Sciences

Division of Geriatric Psychiatry
Division of Psychiatry and Law

Northwestern University Medical School
Chicago, IL USA



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