Community Involvement in Combating Abuse, Neglect, and Mistreatment in Nursing Homes

PAMELA DOTY
and ELLEN WAHL SULLIVAN

Health Care Financing Administration, Washington;
Center for Policy Research, New York

Case #1 A patient was hospitalized with serious burns on the legs. The hospital suspected abuse had occurred in the nursing home where the patient had previously resided; the facility denied it.

Case #2 Tranquilizers were prescribed for a nursing home resident whose family felt the drugs were not necessary and were causing disorientation.

Case #3 On one floor of a nursing home, several patients who were physically unable to feed themselves were not being fed.

Case #4 A nursing home patient with a hearing aid was unable to obtain a replacement for a dead battery for a year and a half.

Case #5 The shower stall, shower curtains, and rubber mats in several bathrooms of a nursing home were filthy. Residents' complaints to the administration were repeatedly ignored.

Case #6 A resident was found to be without proper clothing and in need of a haircut.

Case #7 A resident's glasses could not be found. When her son reported this to the nursing staff, he was met with excuses and unhelpful attitudes.

Milbank Memorial Fund Quarterly/*Health and Society,* Vol. 61, No. 2, 1983

0160/1997/83/6102/0222-30 $01.00/0

The above are all real cases selected to illustrate the wide range of problems—everything from garden variety lack of courtesy and helpfulness to outright physical abuse—that are subsumed under the general headings of "patients' rights violations" or "institutional abuse, neglect, and mistreatment." These cases come from the files of two community groups whose volunteers regularly visit and monitor conditions in New York City nursing homes. None of these cases, with the exception of the suspected physical abuse case which the community group reported, ever came to the attention of governmental authorities. As such, they typify the kind of problems that tend to fall between the cracks of the existing system of nursing home regulation which focuses almost exclusively on periodic surveys of facilities to check for compliance with physical plant, record-keeping, staffing, and related standards. (In all but the physical abuse case, the community groups were able to resolve the problems through informal mediation with the nursing home administration.)

This paper will explore the potential benefits—and the limitations—of relying more on community involvement to protect nursing home residents from being treated in ways that are abusive, neglectful, or lacking in dignity and respect for their rights. Five strategies for community involvement will be explored: 1) friends and relatives associations, 2) volunteer ombudsmen, 3) community receiverships, 4) private legal action, and 5) mandatory abuse reporting by licensed professionals. Our discussion of these strategies is based primarily on our own field research (supplemented by other studies and information sources) which focused in depth on projects, programs, and organizational efforts currently underway in New York City and State, though we do make passing reference to similar developments in other parts of the country. The methods used were qualitative—participant/observation, interviews, and examination of case histories in organizational files.

Because of the focus on New York, the question naturally arises: How widespread in the nation as a whole are similar problems of abuse, neglect, and mistreatment of nursing home residents?

The question is an important one because, in the authors' experience, it is not uncommon for problems of patient abuse, neglect, and mistreatment in nursing homes to be dismissed on the grounds that the evidence is anecdotal. The implication is that a journalist or a politician on the make can always go out and uncover a "horror story" or two. Isolated examples of abuse, incompetence, and wrongdoing are to be found in any field, and to label something a "social problem" in need of concerted corrective action, one must be able to document a pattern.

Some national statistics do exist. The federal Medicare/Medicaid "conditions of participation" for skilled nursing facilities (SNFs) contain standards on patients' rights, and statistics are kept on the number of facilities cited by surveyors for patients' rights deficiencies. According to the Health Care Financing Administration's Medicare/Medicaid Automated Certification System (MMACS), as of September 29, 1980, 7 percent of SNFs nationwide (N = 550 facilities with 53,936 beds) had been cited as deficient on the requirement that patients' rights policies and procedures ensure that each patient admitted to the facility is "free from mental and physical abuse and free from chemical and (except in emergencies) physical restraints except as authorized in writing by a physician for a specified and limited period of time, or when necessary to protect the patient from injury to self or to others." In 8 states, 15 percent or more of SNFs were cited as deficient on this requirement. In addition, 7 percent of SNFs nationwide (N = 539 facilities with 57,228 beds) were cited as deficient on the requirement that each patient "is treated with consideration, respect, and full recognition of his or her dignity and individuality, including privacy in treatment and in care for personal needs."

Some more detailed statistics are available for particular geographic areas. For example, the annual report of the Long Term Care Ombudsman Committee for the state of Florida reports 1,229 complaints received during the fiscal year July 1, 1979 through June 30, 1980 and 43.1 percent of complaints concerned direct patient care services. The single most frequent complaint was inattention to patients' needs. Upon investigation, 41.6 percent of complaints were substantiated.

The annual report of the Connecticut Department on Aging's Nursing Home Ombudsman Office tallied 718 complaints consisting of 807 individual problems, between July 1, 1979 and June 30, 1980. Of these, 329 problems concerned the quality of care; 148 were financial; 66 involved food (poor quality or insufficient amounts); 59 were about physical environment (lack of cleanliness, need for repairs, infestation); 41 concerned physical abuse. There were 431 complaints resolved informally; 296 were referred to other state agencies. Of 273 problems initially investigated by the Ombudsman and then referred to the health department, 229 were found to be substantiated by a separate health department investigation.

The 1979 annual report of the Minnesota Department of Health's Office of Health Facility Complaints cites 634 complaints against nursing homes (69 percent of all complaints filed about health facilities). Statistics on complaint validation are not kept separately for nursing homes versus other types of facilities. However, 50 percent of all complaints received in 1979 were substantiated or partially substantiated upon investigation; 34 percent were found invalid; and 9 percent could be neither validated nor invalidated. The Texas Health Department logged 4,217 complaints about nursing homes (excluding intermediate care facilities for the mentally retarded (ICFs/MR)) in 1980; and 1,594 complaints, or 37 percent, were validated. Texas has 1,115 facilities; complaints were logged about 683 or 61 percent of all facilities and complaints were validated concerning 506 or 45 percent of all facilities.

Obviously, the statistics cited are not scientific ones. The prevalence of poor quality care, abuse, neglect, and mistreatment in nursing homes would be extremely difficult if not impossible to measure scientifically. Since the only mechanisms available for uncovering and reporting cases are the grievance mechanisms, cases will come to light only if people with legitimate complaints are aware of grievance mechanisms and believe that, by filing a complaint, they have a reasonable chance of getting action. In A. O. Hirschman's (1970) classic formulation, the consumer dissatisfied with the quality of a product or service has a choice between "exit" and "voice." Since the nursing home resident and family are usually limited in "exit" possibilities, their main recourse must be "voice." In order for "voice" to be an effective redress, however, it must be heard as well as spoken. An analogy can be made with rape: for many years, rape was underreported because victims perceived the police and the courts as unsympathetic. Nursing home residents and families have had a similar perception that government officials did not take complaints about abuse, neglect, and mistreatment in nursing homes seriously. It is striking, for example, that for the first 18 months that Washington State's patient-abuse reporting law was in effect, January 1979 to June 1980, only 13 cases of physical abuse of nursing home patients by staff were reported. Investigation found 8 of these complaints valid, 3 partially valid; the validity of the other 2 could not be determined.

The following year, July 1980 to June 1981, 128 cases of staff-to-patient physical abuse were reported, of which 92 were validated and 3 partially validated. The point is that we will never know the true extent of patient abuse, neglect, and mistreatment until credible grievance mechanisms are widely available. Statistics such as those cited here should be sufficient, however, to refute the allegation that valid complaints of patient abuse, neglect, and mistreatment in nursing homes are rare. Let us turn to look, then, at proposed methods of involving the community in assuring that such complaints will not only be reported but resolved.

As Bruce Vladeck (1980) observes in his book on nursing home policy, "The grand abstractions of public policy must be tied to the concrete needs, problems and aspirations of individual citizens." This suggests that it is important to evaluate grievance mechanisms from the vantage point of an individual with a complaint. Thus, in reviewing each strategy, the following issues will be addressed. How accessible is this mechanism to persons with complaints? What kinds of complaints or problems are handled best? What risks are entailed in making a complaint via this mechanism? How quickly are complaints dealt with and resolved? How likely is it that a complainant using this mechanism would end up feeling that his or her complaint had been satisfactorily resolved?

Friends and Relatives Associations

Friends and Relatives of the Institutionalized Aged (FRIA) is, as its name would imply, an association whose membership is mostly made up of friends and relatives of nursing home residents. Founded in 1976, this New York City based association had approximately 1,200 active members and 2,500 persons on its newsletter mailing list in 1979–1980. The leadership estimated that about 10 percent of members regularly visited relatives and friends in nursing homes and reported to FRIA on conditions in those facilities. (It should be noted that many FRIA members maintain membership in the association but no longer visit a nursing home regularly because their particular friend or relative has died or been discharged.)

In addition to its visitation/monitoring program, FRIA acts on behalf of nursing home residents in two distinctly different ways. On one level, the association helps individuals gain redress for specific complaints and works to improve the quality of care in particular facilities, especially those targeted as among the area's worst. On another level, the association functions as a "consumer lobby" representing the interests of the institutionalized elderly vis-à-vis state agencies and the state legislature.

During the period of study, FRIA's political involvement focused on three main issues: lobbying the state legislature to increase the personal allowance allotted to Medicaid patients in nursing homes (from $28.50 per month) and Supplemental Security Income (SSI) recipients in domiciliary care facilities (from $25 per month); monitoring the enforcement of the state's new regulations on "bed reservation" (which required nursing homes to hold beds open for residents temporarily transferred to hospitals so that they would be able to return to the same facility); and consideration of ways to safeguard domiciliary care patients from eviction as a reprisal for complaining about services. After several years of lobbying by FRIA and the Coalition of Institutionalized Aged and Disabled (a group of nursing and boarding home residents), the New York legislature raised the personal needs allowance for nursing home residents to $60 per month, as of July 1, 1981 (*Collation* 1981c).

FRIA has three strategies for dealing with complaints about particular facilities. First, FRIA staff counsel individuals who ask for advice about how to handle particular problems and refer them to outside sources of help, such as legal services or the appropriate regulatory officials if the situation seems to warrant it. In one home, where a persistent problem of employee theft was not being attended to by the home's administration, FRIA helped residents file a successful claim against the nursing home in small claims court. Second, FRIA's Better Care Committee investigates complaints, especially when numerous complaints occur in a facility, and negotiates with administrators and/or state officials to make improvements in quality of care. For example, FRIA's Better Care Committee successfully negotiated with the administrator of a nursing home to reduce the number of patients subject to physical restraints and modify the facility's written policies to detail more clearly who has authority to apply restraints and how frequently. The home also tightened security procedures to reduce the loss of personal property. In another case where attempts to negotiate with the administrator about problems were met only with denials that there were such problems, FRIA met with state health department officials to discuss what FRIA considered to be serious hazards at the home. The complaints made about the home included insufficient staff, supplies, and equipment; inadequate supervision of disoriented patients to keep them from wandering into the streets; vermin infestation; and inedible food. State officials promised prompt action and three weeks after the meeting they instituted a thorough inspection of the facility.

In homes targeted as requiring urgent action because of especially bad conditions, FRIA may undertake to organize a special FRIA chapter for that home. This was done in connection with King's Harbor, a notoriously poor quality facility owned by one of the major figures in New York State's widely reported 1974–1975 scandals involving Medicaid fraud and abuse in nursing homes. In this instance, FRIA's efforts were successful in speeding up the naming of a court-appointed receiver and ultimate transfer of the home to new ownership and management.

The ability of an association such as FRIA to effectively improve conditions in nursing homes is limited by the fact that it possesses little clout beyond its skill in persuading, cajoling, and "shaming." The most powerful tool available to a friends and relatives association is its ability to threaten a facility with a media exposé. In the case of the King's Harbor nursing home, FRIA did in fact draw newspaper attention to the fact that conditions uncovered several years earlier had still not been remedied (Newfield 1978). Clearly, however, the threat of a media exposé is one that can only be used sparingly and in the worst cases.

Friends and relatives associations do, however, enjoy two important advantages that make them particularly effective in uncovering instances of abuse, neglect, and mistreatment. These are the comparative ease and inconspicuousness of access to facilities, and frequency and continuity of contact with patients. In a number of cases, nursing homes have dealt with persons who complain and whom the homes therefore regard as "troublemakers" by denying them access on the grounds of protecting patients' security and privacy. The *Jane Hoyt* case in Minnesota is the best known example where a nursing home sought to deny visitation rights to a friend who repeatedly complained about the quality of care being given a patient. During a two year court battle, Hoyt was barred from the nursing home. After two lower court defeats, she won her case on appeal to the Minnesota Supreme Court (*Collation* 1981b). Normally, however, it is easier, and more common, for a home to deny access to patient advocates who are unknown to the patient than to friends or family. Moreover, family and friends do not have to explain their presence or declare themselves as "patient advocates."

Moreover, friends and relatives who visit nursing homes regularly are more likely to be trusted by patients than strangers who may never come again. Thus, organized friends and relatives groups probably make their greatest contribution by providing a comparatively protected conduit through which nursing home patients can make their grievances known. By themselves, however, friends and relatives associations lack the clout to resolve many of the grievances they transmit: ultimately, their effectiveness at bettering conditions in nursing homes depends on their ability to tie into a larger network of community resources.

Ombudsman Programs

Amendments to the Older Americans Act passed in 1978 require that every state establish a long-term-care ombudsman program (Administration on Aging 1981). The state may operate the program directly or it may contract with a local government agency or a nonprofit organization so long as the organization is not involved in licensing and certification of facilities, and is not a provider group. Thus, the organization, sponsorship, powers, and other attributes of ombudsman programs vary greatly from state to state. In New York State, the State Office of Aging dispenses the funding, but the actual ombudsman programs are privately run. The New York City program, which was the main focus of our study, operates under the auspices of the Community Council of Greater New York. Paid field supervisors recruit community volunteer ombudsmen, arrange for their training and assignment to facilities, collate and report complaints, meet regularly with the administrations of participating nursing homes, and organize and convene community advisory boards, "Committees of Auspice." As of June 1981, the program had a professional staff of 5 and 1 administrative assistant and counted 75 active volunteers.

Volunteers are asked to make at least a six month commitment and to spend 4 to 6 hours per week at the facility to which they are assigned. The program's target ratio is 1 volunteer to no more than 100 patients. Ombudsman volunteers are recruited through advertisements in newspapers, radio, church bulletins, local group newsletters, and by word of mouth. Recruitment has posed less of a problem than the staff initially expected. The local Committees of Auspice proved quite helpful in recruiting volunteers. The staff consider the caliber of the volunteers to be high and are pleased with the variety in age, education, and social class background. Volunteers are initially given 30 hours of training and then follow-up training at regular intervals. The Monk and Kaye (1981) study of the New York City Ombudsman Program found, however, that long-term-care-facility staff, Committee of Auspice members, and volunteer ombudsmen all tend to view the training being given to ombudsmen as insufficient and cite this as the major weakness of the program. When it began in 1978, the New York City program had a budget of $68,000 and covered 17 nursing homes in 2 boroughs. As of fiscal year 1981 (July 1980–June 1981) the annual budget was $148,000 and the program covered 40 nursing homes in 4 boroughs (about 20 percent of New York City nursing homes). During fiscal year 1981, the program logged upwards of 2,600 complaints.

On the basis of our research, we concluded that volunteer ombudsman programs fill a definite need. The New York City program seems to be particularly effective in mediating a whole range of small grievances that involve residents' quality of life but, unless they are part of an overall, more serious pattern, do not warrant the involvement of an investigatory agency with sanctioning powers. Thus, we found that the New York City program, with its reliance on volunteers assigned to particular facilities, dealt with more complaints of a wider variety, and, on average, of a generally less serious nature than those dealt with by ombudsman programs in neighboring states where the ombudsman's office is a governmental agency staffed by paid investigators who have greater authority but who are not regular visitors to particular homes and generally take complaints over the phone. Of course, the converse is also true: because they lack official powers, volunteer ombudsmen are less likely to receive complaints about serious problems (e.g., physical abuse) that residents and staff may be afraid to report. The case of the resident whose glasses were lost and could not get help from nursing home staff to find or replace them is an example of the kind of complaint no government agency will ever have sufficient paid personnel to handle, but which volunteer ombudsman programs are particularly good at resolving. Complaints of this sort may seem trivial when compared to reports of physical abuse or neglect resulting in patients developing bedsores, infected catheters, or dehydration; but having to wait a long time to have lost or broken glasses, dentures, and hearing aids repaired seems to be a common problem for nursing home residents and one that obviously would encourage feelings of isolation, helplessness, and depression.

There is evidence, however, that nursing home residents hesitate to voice their grievances to ombudsmen. In the Monk and Kaye (1981) study of the New York City Ombudsman program, 68 percent of the volunteer ombudsmen surveyed said that patients "often" expressed fear of reprisal by long-term-care staff when making complaints. An additional 28 percent claimed this was "sometimes" the case. Among the sample of patients surveyed, 1 in 5 who were aware of the ombudsman program admitted feeling concern that facility staff would be angry if they made a complaint to the ombudsman (despite the fact that patients generally perceived staff to be mildly positive or, at worst, indifferent rather than hostile to the ombudsman program). Over half (56 percent) of the patients interviewed in the Monk and Kaye study indicated that at one time or another they had held back from telling anyone about a particular complaint or problem bothering them, typically because they felt that to make a complaint would do no good because they feared retaliation, or because they did not trust staff enough. Even so, most patients said that the best person to complain to is a nursing home staff member—a nurse (37 percent), the social worker (26 percent), or the administrator (16 percent). Only 1 percent of patients said they would turn first to an ombudsman, and only 9 percent reported having actually made complaints to an ombudsman. The Monk and Kaye findings suggest that a kind of "catch 22" situation affects the reporting of complaints to ombudsmen; when nursing home residents trust nursing home staff they prefer to report problems to them; when residents distrust or fear staff they are inclined to tell their problems to no one.

Among the advantages of volunteer ombudsmen programs is that potentially they can field greater numbers of ombudsmen than programs relying solely on paid governmental employees. This is an important point in an era of fiscal retrenchment in which government is widely viewed as having grown too large. Moreover, by having sufficient numbers of ombudsmen to assign to particular facilities on a regular basis, these programs are able to develop personal relationships between ombudsmen and residents. Such relationships have value in and of themselves and certainly contribute to the quality of life of institutionalized persons. In addition, the regular contact may create a sense of security sufficient to overcome residents' fears about voicing complaints. Further, it can bring to light minor grievances that may make a resident's life miserable but that are not serious enough to be phoned in to an unknown state official or "saved up" to be told to someone who only visits the facility every few months or even less frequently. Finally, volunteer ombudsmen programs break down the barriers of isolation that keep a nursing home that is physically located in a community from being a real part of the community. Research suggests that community contact is one of the best forms of preventive medicine against the development of a pattern of poor care, abuse, and neglect in a nursing home (Barney 1974).

The biggest problem ombudsmen programs face is lack of guaranteed access to nursing homes. As a result, they may be barred entry to the facilities with the worst conditions. Moreover, where entry has to be negotiated and can be revoked at any time, ombudsmen become timid about presenting complaints. Access was a problem for the New York City program prior to June 30, 1980, when the legislature granted liberal access rights to ombudsmen programs authorized by the State Office of Aging (*Collation* 1980c). Before this law was passed, the New York City program had a case where a nursing home barred an ombudsman upon learning that she was a trained nurse. Roughly half the states (22) currently guarantee access to nursing homes by ombudsmen programs (Administration on Aging 1981).

In early January 1981, the outgoing Carter administration Secretary of Health and Human Services (HHS), Patricia Roberts Harris, sought to issue a strengthened set of patient's rights regulations that included a regulation specifically guaranteeing 24 hour access to federally certified nursing homes by any federally mandated ombudsman or advocacy program. The regulations were withdrawn, however, shortly after the Reagan administration took office (Demkovitch 1982). The Health Care Financing Administration then established a Deregulation Task Force to review all federal nursing home regulations. In March 1982, the Secretary of HHS, Richard Schweiker, announced that it was his final decision to leave the 1974 federal nursing home standards unchanged

(*Washington Post* 1982). This decision meant that for the foreseeable future HHS would neither weaken existing standards nor issue any of the new or strengthened rules that the Carter Administration had planned to promulgate—including guaranteed access for ombudsmen.

Because volunteer ombudsmen programs lack the legal authority to impose sanctions, they, like friends and relatives associations, are best viewed primarily as mechanisms for uncovering problems that would otherwise go unnoticed. Although many problems can be remedied through informal mediation, the likelihood that this will work is heightened where there is an implicit threat that stronger sanctions might be imposed. The next three strategies to be discussed—community receiverships, private and class action lawsuits, and patient abuse reporting laws—address the issue of sanctions that can be applied against abuse, neglect, and mistreatment in long-term-care institutions.

Community Receiverships

The usual remedies suggested for dealing with chronic-problem nursing homes are fines and decertification. Both have such serious drawbacks that they are rarely used. Fines levied against the nursing home as a corporate entity are likely to be paid out of operating revenues and can have the effect of penalizing patient care rather than profits. Decertification means forced closure of the facility. In most states, the demand for nursing home beds exceeds the supply, and certificate of need programs and tight money limit new construction. As a result, state officials feel they cannot afford to lose beds. In addition, closure of a home means that patients will have to be moved with the resultant danger that some will deteriorate or die due to "transfer trauma." Concern about transfer trauma and the desirability of having patients remain in a facility that has become "home" to them has, in a number of cases, led to consumer groups making common cause with nursing home owners to try to prevent decertification and closure of seriously substandard homes. The *O'Bannon versus Town Court Nursing Center* case which went all the way to the Supreme Court is the best known such example (*Collation* 1980a). Finally, the forced closing of a nursing home represents a significant capital investment not easily converted to another use. Although most facilities are privately owned, their capital costs have been heavily subsidized with public funds, via the

Department of Housing and Urban Development's (HUD's) loan program or tax-exempt small issue Industrial Development Bonds (U.S. Dept. of Health and Human Services. Office of the Assistant Secretary for Planning and Evaluation 1981; *Medicine and Health/Perspectives* 1982). In fact, closure of facilities is wasteful and seldom really necessary, except in the limited case of firetraps that are structurally irreparable or would cost more to fix than replace. Obviously, it is not buildings but the people who staff them who perpetrate poor quality care, patient abuse, neglect, and mistreatment. Instead of removing the patients and closing the facility, it would appear to make greater sense to improve the quality of the ownership, administration, and staff.

In recent years, a number of states have enacted receivership statutes that empower the state to replace the management of a facility where conditions are deemed to pose a health and safety hazard to residents, pending sale of the facility to a new owner. Community groups can become involved in this process in several ways. Pressure can be exerted on the state to opt for receivership rather than decertification and closure as the remedy of first choice in dealing with chronic violators. The New York City Ombudsman program and the Brooklyn Legal Society successfully exerted such pressure, via the courts, in the case of the Haym Salomon Home in Brooklyn (*Collation* 1980b). Community groups can also volunteer to take over and run nursing homes threatened with decertification, either on a temporary receivership basis or permanently by purchasing the facility. In New York City, both the Village Nursing Home in Manhattan and the Cobble Hill Nursing Home in Brooklyn, formerly under proprietary ownership, were purchased by neighborhood coalitions of local churches, civic and social services groups, and other community organizations (*Collation* 1979, 1981a). There is, however, a major barrier to such purchases of nursing homes by community groups: the ability of nursing home owners to hold out for the most favorable terms of sale. Frequently, the sale of the facility may be delayed for a considerable period of time because of the excessive demands of the owner. In the end, the home may be sold to proprietary interests rather than to a community group because the latter cannot meet the purchase price. Moreover, many nursing homes threatened with closure for failure to meet standards require large infusions of capital to come into compliance. Community groups should be able to use the funds they raise to improve the facility, rather than pay a former owner who may well have brought the facility to a condition where it is financially almost unsalvageable.

As of April 1981, 27 convicted felons continued to operate or receive revenues from 43 New York State nursing homes. Sixteen individuals involved with 24 homes were still litigating the state's attempts to revoke their operating certificates. Seven others had had their licenses revoked but continued to operate 15 homes pending the finding of new operators. Four had had their licenses revoked and had been replaced by new operators but continued to receive rents as property owners (*New York Times* 1981).

Later in 1981, the New York State legislature enacted legislation making it somewhat easier to get convicted felons out of the nursing home business (*Collation* 1981c). Legislation to create a receivership fund to provide interest-free loans to receivers who take over homes belonging to convicted felons was enacted in the fall of 1981 (*AHCA Notes* 1981).

Mandatory Abuse Reporting

New York State's Patient Abuse Reporting Law, otherwise known as "Chapter 900," was enacted in 1977. It was patterned on a statute enacted several years earlier requiring medical personnel to report suspected cases of child abuse. Those initially required to make a report included: any nursing home administrator, physician, medical examiner, coroner, physician's associate, specialist's assistant, osteopath, chiropractor, physical therapist, occupational therapist, registered professional nurse, licensed practical nurse, dentist, podiatrist, optometrist, pharmacist, psychologist, certified social worker, speech pathologist, and audiologist. Effective September 1, 1980, the reporting requirement was expanded to include nonlicensed nursing home employees as well.

The law requires the reporting of "physical abuse" (defined in regulations as "inappropriate physical contact, contact . . . which harms or is likely to harm the patient or resident"); "mistreatment" (inappropriate use of medications, inappropriate isolation or inappropriate use of physical and chemical restraints); and "neglect" (failure to provide timely, consistent, safe, adequate and appropriate services, treatment and care, including, but not limited to nutrition, medication, therapies, sanitary clothing and surroundings, and activities of daily living). Complaints filed under the law are handled by the Patient Advocates Office (which is located in the Office of Health Systems Management of the Health Department). There are six regional Patient Advocates offices, including one in New York City.

The Patient Advocates Office maintains a 24 hour toll-free hotline to take Chapter 900 complaints. An onsite investigation must be conducted within 48 hours. The report is then sent to Albany where the Commissioner of Health's designee rules as to whether or not the complaint has been sustained. (All complaints are also referred to the Special Prosecutor for Nursing Homes—recently renamed Special Prosecutor for Medicaid Fraud—for investigation.) If the report is unsustained, whether because the evidence suggests innocence or the evidence is inconclusive, or the evidence suggests guilt but is not considered credible or sufficient to sustain the charge, the record must be "expunged," that is, destroyed. If the charge is sustained, and it is determined that a professional who should have been aware of the offense ought to have filed a report but did not, the matter is referred to the appropriate committee on professional conduct, board of examiners (for nursing home administrators), or the state board of professional medical conduct (for doctors). If it is determined that abuse, neglect, or mistreatment has occurred, the accused person is so informed, and the information is passed on to the appropriate licensing agency. The accused is entitled to a fair hearing after those agencies make their final determination. The complainant whose complaint is not sustained does not have the right to a fair hearing. The identity of both reporter and victim need not be exposed until the investigation is completed. The law prohibits facilities from retaliating against employees who report abuses, but there are no specific protective mechanisms or penalties provided.

As interpreted by the Patient Advocate, the law applies both to individuals and to entire facilities. In practice, however, complaints are nearly always lodged against individuals (sometimes several individuals in connection with a single incident). Thus, unlike other regulatory sanctions imposed on the nursing home as a corporate entity, Chapter 900 holds individuals personally accountable. For calendar year 1978, 529 cases of alleged patient abuse, neglect, or mistreatment were reported. As of April 15, 1979, decisions had been rendered in 384 of these cases; 237 cases (60 percent) were sustained. In calendar year

1979, 1,295 cases were reported. As of April 15, 1980, 520 decisions had been rendered; 240 (46 percent) were sustained. In calendar year 1980, 1,986 cases were reported; of the 1,536 decisions rendered during the year, some of which concerned cases remaining from prior years, 689 or 45 percent were sustained. The most frequent source of reports is registered nurses, followed by nursing home administrators. Physicians are the least likely of licensed professionals to report (typically two or three cases decided per four-month reporting period were reported by physicians). Indeed, though reports of abuse, neglect, and mistreatment by physicians are not numerous, the allegations against physicians that have been sustained typically outnumber the allegations reported by physicians.

Patients seldom report cases of abuse, neglect, or mistreatment. Families report allegations more frequently but their reports have a lower rate of being sustained than do cases reported by licensed personnel. The most frequent objects of allegations are aides and orderlies, followed by other patients. Allegations against licensed personnel (administrators, registered nurses, licensed practical nurses, and physicians) are comparatively much less frequent but the rate of sustained allegations is typically as high or higher than the rate of sustained allegations against unlicensed personnel (New York State Office of Health Systems Management 1979–1981).

Initially, there were no specific penalties provided under the law for dealing with substantiated complaints. Chapter 900 provided only for sanctions against professionals who failed to report abuses, the sanction being a hearing for removal of license before the relevant licensing board. The law did not authorize the Department of Health to take any action beyond notification and consultation with the facility against employees found to have abused, neglected, or mistreated patients. In theory, the Special Prosecutor for Nursing Homes, to whom Chapter 900 complaints must be reported, could decide to file criminal charges. In practice, however, the burden of proof in a criminal case is so difficult to meet that, as of 1979 in New York City, for example, only 1 percent (6 out of 600) allegations of patient abuse reported to the Special Prosecutor resulted in indictments being sought. Effective September 1, 1980, the New York legislature amended the patient abuse reporting law to provide for a civil penalty of up to $1,000, after hearing, for committing patient abuse, neglect, or mistreatment, or for failure to report such incidents (*Collation* 1981d).

Private and Class Action Lawsuits

Our interest in the legal remedies directly available to patients and families was initially sparked by curiosity concerning the effectiveness of New York's private right of action legislation, enacted in the aftermath of the 1974–75 nursing home scandals, at the recommendation of the governor's investigatory commission specially appointed under the terms of the Moreland Act. The law's intent was to provide a legal basis broader than the traditional common law of torts by which nursing home residents, or others such as families acting on their behalf, could bring suit for poor quality care, abuse, neglect, or mistreatment. Specifically, the law was intended to ensure "standing" for private parties to bring suit for violation of Medicare/Medicaid standards or other contractual rights created by virtue of state and federal laws and regulations. The statute permits the defense that the facility exercised all care reasonably necessary to prevent injury, but expressly prohibits the defense of exhaustion of administrative remedies. The idea is that nursing home residents ought not be dependent on the will (which in the past has been both fickle and feeble) of state regulatory agencies to enforce the law; if need be they can go "over the heads" of the bureaucrats. New York's private right of action statute sets a minimum level of damages recoverable in such an action at 25 percent of the daily Medicaid reimbursement rate and it prohibits premiums for liability insurance to cover private action awards from being allowable costs reimbursable to facilities under Medicaid (Butler 1979). The Moreland Commission believed this law to be one of the two most significant reforms in its entire sixteen bill legislative package. In May 1975, when the private right of action bill was before the legislature, nursing home lobbyists had characterized it as the "most horrendous" of the Moreland Commission's proposals because, they said, Medicaid would wind up paying huge liability insurance rates. "This package of bills is a nursing home lawyer's pension plan," argued Mr. Aronowitz, a nursing home lawyer, "because there is going to be an awful lot of litigation" (*New York Times* 1975). In the course of our research we found, however, that five years after this legislation's passage no such suits had as yet been brought. The same appears to be true in the other eight states with private right of action statutes, most of whose laws are, however, of more recent vintage than New York's (Butler 1979; Doty 1980; American Bar

Association Commission on Legal Problems of the Elderly 1981). In investigating the reasons why the law has been so little used, we found that the barriers to effective use of this remedy go far beyond the specific weaknesses of individual statutes.

The reasons nursing home residents do not bring suit under private right of action statutes are much the same as the reasons there are also so few negligence or malpractice suits filed. Pat Butler's review of tort claims against nursing homes over the period 1950 to 1978 uncovered only 35 reported cases, all of which were individual personal injury cases (Butler 1980). Thus, in the discussion to follow, we will discuss the feasibility of privately instigated suits generally.

Among the most serious barriers to bringing suit is the patient's and their relatives' fear of reprisal by nursing home owners and operators. This problem is not specific to the use of legal remedies but tends to keep residents from making their complaints known to ombudsmen and patients' advocates and even to relatives, friends, and physicians as well. Other difficulties, however, are more specifically associated with adjudication of complaints via the courts. The lengthy process is a disincentive for all plaintiffs in lawsuits; however, it is a special problem for elderly nursing home residents who quite literally may not live long enough to see their cases come up. In addition, the kinds of complaints and grievances nursing home residents most commonly have about institutional care are different from those involved in the typical lawsuit. In most lawsuits, there is seldom an issue of ongoing harm; rather, the plaintiff is seeking a monetary settlement for a one-time "wrong" or "injury" allegedly done to him by the defendant. In contrast, the most likely objective of a nursing home resident or a "class" of residents bringing suit against a nursing home would be simply to put a stop to a continuing pattern of abuse, neglect, or mistreatment. Thus, the dependency of a nursing home plaintiff creates a situation more analogous to that of a victim of child abuse rather than a victim of a negligent accident. Moreover, for the elderly victim, the prospect of a financial award in and of itself, particularly if it comes after the customary several years of litigation, is not a strong incentive to bring suit. Many prospective plaintiffs would have legitimate reason to question whether they would survive long enough to receive the award. In addition, an institutionalized person has little use for a large financial settlement except to apply it against his or her bill for nursing home care. (As David Barton

Smith [1981] has observed, it is sheer fantasy to picture former nursing home patients lolling in deck chairs sipping pina coladas as they cruise around the world on monies awarded in private right of action suits.)

Indeed, in the case of a patient whose nursing home care is Medicaid financed, the patient might well be forced by Medicaid regulations to use the money to pay for nursing home care. New York's private right of action statute specifically exempts court judgments from Medicaid financial-eligibility calculations. Of the other eight states with private right of action statutes only two contain similar provisions. For different reasons, there is little financial incentive to lawyers to take such cases. A review of cases found that damages awarded in nursing home tort cases tend to be small. This is because of the way damage awards have traditionally been computed, that is, with a heavy stress on compensation for lost earnings, of which there obviously are none in the case of an elderly nursing home resident (Butler 1979).

Finally, our research revealed that many of the complaints and grievances that nursing home residents would be likely to have, particularly in respect to quality of care, do not fit well into existing legal doctrines and statutes. For example, a plaintiff in a negligence suit must normally be able to prove not only "negligent action" in the ordinary sense of careless, thoughtless, or irresponsible behavior, but that such behavior directly caused personal or property damage to the plaintiff. Proof of "actual damages" must also be sustained in suits brought under New York's private right of action law. Generally speaking, the requirement for proof of actual damages in a negligence suit makes excellent sense. In the nursing home context, however, a wide range of staff behavior that is clearly "negligent" in the ordinary nonlegal sense of the term would not constitute sufficient legal grounds for a "negligence" suit unless, or until, actual physical injury could be proved to have resulted. Examples include persistent failure to respond to patient requests for help, disabled and fragile patients left unattended and unassisted in the bathroom, incontinent patients left lying in their urine and feces for hours on end, unauthorized use of physical restraints, etc. Moreover, even if clearcut physical injury did result from the kinds of behavior just listed, the patient's medical record, normally among the major sources of documentation of personal injury in a lawsuit, would be under the control of the defendants. Indeed, because of the unusually high degree of control the defendant is likely to have over the available evidence (such as the fact that any witnesses to the incident or incidents are likely to be either other employees of the home or other patients who may be too frightened for their own safety to speak out) the burden of proof is likely to be especially difficult to sustain.

Despite these problems, some attorneys are optimistic about the potential for private legal actions against nursing homes and believe such suits will become more common. Eldon Rosenthal, a private attorney in Portland, Oregon, who has had success with such cases, points out that private actions are not as subject to the vagaries of politics as public remedies may be. Andrew Zweban, a former New York City legal services attorney now in private practice, recently filed a tort claim in New York against a nursing home asking for $25 million in damages for a class of present and former residents of the facility (*Iushiuewitz et al. v. DeWitt Nursing Home et al.*). Zweban believes that tort actions can result in malpractice insurers exerting significant pressure on facilities to improve conditions (*Nursing Home Law Letter* 1980).

In our research we were particularly interested in exploring the role of legal services agencies in bringing suit on behalf of nursing home residents. Although legal services corporations have been quite active and highly successful in defending patients' rights in involuntary transfer cases, we found only three cases nationwide in which legal service corporations filed suit on behalf of clients with complaints about poor quality care, abuse, neglect, or mistreatment. This is partly because legal services agencies are prohibited from taking any fee generating cases (which means they cannot file traditional tort claims). Two of the three cases were filed in Ohio by the same legal services agency. Both were class action suits filed on behalf of Medicaid residents charging that the facilities in question violated federal standards for medical attendance and direction, nursing and dental care, nutrition, resident privacy, resident activities, housekeeping, and resident finances. In the *Jane Resident v. Emmanuel Training Center* case, the court appointed a three-person panel of experts to investigate the allegations. The panel's report substantiated plaintiff's claims, and the court appointed a receiver to bring the facility into compliance with the standards. The second case, *A.P. v. Abbey Nursing Home,* was settled by consent decree when the defendants agreed to make various staffing as well as other changes the implementation of which would be monitored regularly by a court appointed supervisor. Two aspects of these cases are especially noteworthy. One is the use of pseudonyms to protect complainants residing in nursing homes from possible reprisal. The other is that nursing home residents with quality of care complaints can be successful in seeking a court to appoint a receiver under its inherent equitable powers even in the absence of a specific state nursing home receivership or private right of action statutes. (As of 1980, Ohio had neither.)

The third class-action suit involving legal services is the *Smith v. O'Halloran* case in Colorado. The action began when Smith, a bedridden 25-year-old victim of brain damage from a car accident, had to spend a month in the hospital. During this time, his SSI (personal needs allowance) check came to the nursing home where it was signed with an X and cashed. When Smith returned from the hospital and asked for his money he was told the bookkeeper was not in. Smith finally got a former employee who knew what had happened to telephone Legal Aid. When the home's administrator, O'Halloran, learned of this he screamed at Smith and told him he wanted him out in a week. Smith then telephoned Legal Aid concerning his fear of eviction. That night Smith's requests for nursing assistance were not answered. The following day the administrator met with an assistant attorney general of Colorado and admitted that he had both forged Smith's name with an X on the check and had circulated a memo warning residents of the home not to seek legal assistance for problems concerning the home. Smith and another disabled resident filed suit on behalf of all Medicaid residents charging that the home denied them rights secured under the First, Fifth, and Fourteenth Amendments of the Constitution as well as under Medicaid regulations (including the Patient's Bill of Rights). It is worth noting here that commingling, illegal charges applied to patient's personal funds, and outright theft of personal funds are frequent complaints brought to nursing home ombudsmen. State and federal regulatory agencies were also cited in the suit for failure to safeguard these rights.

The *Smith* case began in May 1975; an injunction guaranteeing residents their rights was secured in July 1975. Plaintiffs' lawyers then began an extensive data collection effort on the home which continued for two years. In 1978, however, Colorado joined the plaintiffs in suing the U.S. Dept. of Health, Education, and Welfare, and the focus of the case shifted from the individual nursing home to the role of the federal government in regulating nursing home care. Colorado's position was that the state could not effectively enforce patient rights because it must survey and certify facilities based on the federal "Conditions of Participation" for Medicare and Medicaid, which emphasize physical plant characteristics, staffing, and other structural measures of a facility's "capability to provide care" rather than assessing the actual quality of care or respect for patient's rights.

It appeared for a time during 1980 that the suit against the federal government would be settled out of court. The Department of Health and Human Services had published proposed new regulations strengthening the patient rights and patient care assessment components of the federal conditions of participation. Plaintiffs agreed that publication of these new regulations as final rules would improve the regulatory process sufficiently to satisfy their major concerns. Following the 1980 Presidential election, however, it began to appear more and more uncertain that these or substantially similar final rules would be promulgated. In March 1982, Health and Human Services Secretary Richard Schweiker announced that he would leave the 1974 rules unchanged. In May 1982 the *Smith v. O'Halloran* case went to trial; in February 1983, the judge ruled that though a patient care management system might well be feasible and desirable, the failure of the federal government to regulate such systems did not constitute a violation of duty.

In addition to these few suits brought by legal services agencies on behalf of Medicaid patients for implied breach of contract for failure of a nursing home to comply with state and federal quality-related regulations, an equally small number of suits have been brought by state attorneys general charging misrepresentation under state consumer protection or deceptive trade practices statutes. In one Texas case (*State v. Southwest Mediplex*) the court issued a restraining order against further violations, assessed civil penalties, and ordered the appointment of a compliance officer to monitor conditions in the home and report periodically to the court. In another Texas case (*State v. Forest Manor Nursing Home*) the court appointed a receiver and mandated the sale of the home to new owners (Bragg 1980). In a Massachusetts case (*Bellotti v. Heritage Hill*) brought under a progressive consumer protection statute containing specific provisions concerning nursing homes, the court appointed a receiver within two days.

It is striking how much more quickly the cases brought by state attorneys general were concluded as compared to privately instigated suits. As Phillip Gassel, a New York City legal services attorney familiar with the Massachusetts case, observed: "This demonstrates what an advantage the government has when it does its homework" (Sullivan 1980). He was referring to the fact that a state attorney general's office has broad investigatory powers. The government can, for example, send licensing and certification inspectors into a facility at any time, day or night, to investigate allegations of poor quality care, abuse, neglect, and mistreatment. The government also has ready access to any evidence of such violations contained in patient and other facility records. Thus, in the Massachusetts case, the availability of documentation provided by the health department enabled the attorney general's office to go into court and obtain an injunction based on two days' legal preparation. In contrast, in the Colorado case, the Legal Aid Society spent two years documenting its case via the use of undercover informants hired as employees of the facility. Those who look to private and legal services attorneys to make up for the reluctance of government to invoke sanctions for abuse, neglect, or mistreatment of nursing home residents need to bear in mind that private parties will never be accorded the kind of broad investigatory authority that is available to government to substantiate these difficult-to-prove cases.

Conclusions and Policy Recommendations

Analytically, an effective procedure for resolving complaints of poor quality care, abuse, neglect, mistreatment, or violations of patients' rights is a three part process. The first phase involves identifying and reporting apparent problems. Phase two entails investigating cases to determine the validity of a complaint, who was responsible, and why the problem occurred. Finally, of course, corrective action needs to be taken to resolve validated complaints and, if possible, prevent recurrence of similar problems. Depending on the nature and seriousness of the complaint, corrective action might involve mediation, the imposition of punitive sanctions, or structural reform that seeks to eliminate underlying causes. Each of the five strategies reviewed here is particularly well-suited to address aspects of one or more of these three phases, but none covers all of them. Accordingly, none of the five strategies reviewed constitutes an effective procedure for complaint resolution in and of itself alone.

Briefly, we have seen that community involvement strategies are strong on outreach ("case finding") and on cooperative complaint resolution (mediation). On these two counts, they seem quite superior to reliance on government regulation alone. Community strategies are weak, however, in coercive elements such as investigatory authority (where voluntary cooperation is not given) and punitive enforcement powers (e.g., the ability to impose fines, remove licenses, etc.). Although the investigatory authority given to community groups can be strengthened somewhat (e.g., some states grant volunteer ombudsmen legal right of access to medical records provided there is written consent by the patient), there is a limit to the extent to which government can delegate coercive investigatory and enforcement powers to private groups (note that this limitation applies equally well to professional peer review bodies as to citizen watchdog groups) without risking the infringement of due process.

What is required to more effectively combat patient abuse, neglect, mistreatment, and violation of patients' rights are strategies that combine the special strengths of community involvement with the special powers of government that government cannot responsibly delegate. Patient abuse reporting laws are a start in this direction; they rely on community outreach (ombudsmen, friends and relatives, and mandatory professional reporting) to bring complaints to light. Often complaints are resolved informally, e.g., as when a facility fires an abusive employee without any formal charges being brought. Investigation and enforcement, however, remain the responsibility of government officials.

The chief defects of patient abuse reporting to date are, first, that it has been long on investigation and short on enforcement, perhaps, in part, because enforcement has been a purely bureaucratic process, insulated from public view and participation. Second, patient abuse reporting has been concerned primarily with a relatively narrow band of complaints—those involving physical abuse and gross neglect.

The following policy proposal is thus intended primarily to suggest mechanisms for assuring that patient abuse reporting results more frequently in meaningful sanctions being imposed on the individuals and/or facilities responsible for patient abuse, neglect, and mistreatment.

We also recommend that the range of complaints subject to the adjudication process being proposed here be expanded to include patients' rights issues in general. Indirectly, the role of the ombudsman as mediator might well be strengthened since this would create incentives for nursing homes to resolve complaints informally. Finally, our proposal seeks to demonstrate how community involvement can be incorporated in the sanctioning as well as the reporting and investigative phases of the complaint process, without jeopardizing due process.

The Institutionalized Persons Protection Board

The proposal is to create a new type of judicial entity—tentatively named the Institutionalized Persons Protection Board—that would adjudicate complaints of abuse, neglect, and mistreatment, as well as lesser types of patient rights violations. A comparatively incremental means of implementing this proposal is to locate such a board in the state health department. In New York, the logical spot would be the Patient Advocates' Office. A broader, more ambitious approach would be to create a free-standing board whose authority would be extended to protect *all* institutionalized persons, that is, persons in all publicly funded mental hospitals, drug and alcohol treatment facilities, homes for the retarded, domiciliary care and halfway houses, as well as nursing homes.

The members of the Protection Board would for the most part be community representatives. The idea is to extend the jury principle into the realm of administrative law. If, as studies suggest, social isolation is an essential condition of patient abuse, neglect, and mistreatment, and greater public visibility is therefore the means to eliminate these problems, then it is vital that ordinary citizens be involved in the enforcement of residents' rights rather than allowing this to be a wholly bureaucratic activity. The citizen members might be chosen as a jury is chosen, or appointed by the governor, or allotted to representatives of organized community groups that have shown interest in the issue (as is often the case with consumer seats on health planning boards). In addition to the community representatives on the Protection Board, one seat apiece should be allotted to representatives of the nursing home industry and nursing home employees' unions.

Union representation is advisable because one of the powers we recommend the board be given is the power to require dismissal of abusive employees.

The board would have two types of mechanisms at its disposal: 1) a mediation mechanism that would permit resolution of grievances in a "no fault" manner; and 2) a more formal hearing process that would be concerned with establishing whether or not a sanctionable rights violation has been committed, and then deciding the nature of the sanction to be applied.

The principal sanctioning authority that we recommend be given to the Protection Board is the authority to determine whether or not a patient's rights violation has been committed, to "grade" the seriousness of the violation on a point scale, and to inform the relevant licensing authorities of the violation and its point score. Once a facility or an individual licensed employee accumulated a certain number of points due to patients' rights violations, the licensing authority would be required to suspend the facility's or employee's license. The model is a simple one; indeed, it is patterned on how most states deal with traffic violations. An automobile driver can be caught going through a red light or exceeding the speed limit and not lose his or her license immediately. Each time, however, points are accumulated such that, eventually, one too many moving violations will cause the driver's license to be suspended.

Since so many complaints under New York's abuse reporting law are made against aides and orderlies, consideration ought perhaps be given to licensing such lower level personnel. The purpose of such licensure would be to provide a mechanism to prevent aides and orderlies who are found to have engaged in patient abuse and been dismissed from their jobs from simply getting a job in another facility. An alternative and perhaps simpler, less bureaucratic method for dealing with this problem would be to prohibit facilities from hiring any individual against whom a complaint of patient abuse has been sustained. In addition, the Protection Board would be empowered to levy fines up to $1000 and issue rulings akin to injunctions and restraining orders requiring nursing homes to cease practices that are considered to violate patient rights or take specific positive steps to safeguard patient rights. Information about sustained complaints should be a matter of public record.

To carry out its functions the board would require a small professional staff of persons trained in social work or nursing with physician consultants on call. Use of retired professionals who volunteer their time or agree to work for small stipends that supplement but do not jeopardize Social Security and pension benefits would hold down the Protection Board's administrative costs and might be particularly appropriate here. Investigators would be needed to research the facts of each complaint and decide whether or not a given complaint should go to mediation or to the board for a formal hearing.

Investigators would also have the job of presenting cases to the board. Unlike prosecutors under the adversary court system their job would not be to represent the complaining patient's "case" but rather to present the facts, as he/she found them to be, and the statements and points of view of both parties to the case. It would thus be the job of the investigator to research and represent the evidence on both sides objectively. The parties to the complaint would also have the right to make a personal statement to the board. In principle, the process should be designed, like small claims and traffic courts, so that individuals could represent themselves, without requiring lawyers. The Protection Board staff would also act as dispute mediators and caseworkers. We assume that many cases would, in fact, be settled through mediation, but the possibility that a case could go to a formal hearing before the Board would serve as an incentive for mediation.

As a final note, we recommend that Institutionalized Persons Protection Boards be granted "positive" as well as "negative" sanctioning authority. In other words, they should be empowered to recognize and reward special efforts by nursing home staff to assure residents' rights and enhance quality of life in the nursing home. Nominations for outstanding performance by nursing home personnel in safeguarding residents' rights or improving the quality of nursing home life could be made by friends and relatives associations, ombudsmen programs, and other advocacy groups. Besides purely symbolic awards such as certificates of achievement, the Protection Board ought also to have funds available so that cash bonuses and scholarships for further training could be awarded as well. In his book *Nursing Home Life: What It Is and What It Could Be,* nursing home administrator Clifford Bennett (1980) reiterates the industry's perennial complaint that too much publicity given to nursing homes concerns abusive incidents and "as a consequence, people think of nursing homes as bad and evil places." Yet Bennett's book is by no means a defensive denial of problems; it is a highly personal account of what it felt like for him to "go undercover," posing as a patient in a friend's nursing home where he experienced firsthand the sense of powerlessness and deprivation of freedom that the typical patient experiences even in a high quality facility. He then goes on to describe how he has tried as a nursing home administrator to apply what he learned to better safeguard the dignity and expand the personal freedom of residents in his facility. This is precisely the kind of innovative and pragmatic effort by nursing home personnel that a body such as the Protection Board should be able to recognize and reward.

References

Administration on Aging. 1981. The Long Term Care Ombudsman Program, Development from 1975–1980. Mimeo.

American Bar Association. Commission on Legal Problems of the Elderly. 1981. Model Recommendations: Intermediate Sanctions for Enforcement of Quality of Care in Nursing Homes. Mimeo.

AHCA Notes. 1981. (Newsletter of the American Health Care Association). November 27.

Barney, J. 1974. Community Presence as a Key to Quality of Life in Nursing Homes. *American Journal of Public Health* 64 (March):265–68.

Bennett, C. 1980. *Nursing Home Life: What It Is and What It Could Be*. New York: Tiresias Press.

Bragg, D.F. 1980. *Nursing Homes and Consumer Protection*. Austin: Texas State Attorney General's Office, Consumer Protection Division.

Butler, P. 1979. Assuring the Quality of Care and Life in Nursing Homes: The Dilemma of Enforcement. *National Clearinghouse Law Review* 57:1317.

———. 1980. A Long Term Health Care Strategy for Legal Services, Nursing Home Quality of Care Enforcement. Part I: Litigation by Private Parties. Washington, Legal Services Corporation Research Institute.

Collation (Newsletter of the National Citizens Coalition for Nursing Home Reform, Washington, D.C.). 1979. Coalition of New York Citizen Groups Discusses Community-run Nursing Homes. 7, 8 (April):13–14.

———. 1980a. Supreme Court Rules against Residents in Town Court Case. 16 (July):75.

———. 1980b. New York District Court Arranges for Resident Involvement in Operation of Home. 16 (July):79.

———. 1980c. New York Enacts Access and Abuse Reporting Laws. 18 (December):65–66.

———. 1981a. Village Nursing Home Celebrates Success of Its Community Ownership. 19 (February):35–37.

———. 1981b. Minnesota Supreme Court Upholds Advocate's Right of Access to Nursing Home Resident. 20 (April):2A.

———. 1981c. New York Raises Personal Needs Allowance. 22 (August):18.

———. 1981d. New York Revises Inspection and Enforcement Systems. 22 (August):19.

Demkovich, L.E. 1982. Nobody's Happy over Administration's Attempt to Change Nursing Home Rules. *National Journal* 11 (March 20):508–10.

Doty, P. 1980. *Guided Change of the American Health System. Where the Levers Are.* New York: Human Sciences Press.

Hirschman, A.O. 1970. *Exit, Voice and Loyalty.* Cambridge: Harvard University Press.

Medicine and Health/Perspectives (McGraw-Hill Health Newsletter). 1982. March 29.

Monk, A., and L.W. Kaye. 1981. *Ombudsman Services for the Aged in Long-Term Care Facilities.* New York: Columbia University, Brookdale Institute on Aging and Human Development.

Newfield, J. 1978. The Last Unspeakable Nursing Home. *The Village Voice,* September 11.

New York State Office of Health Systems Management. 1979–1981. *Patient Abuse Reporting Statistical Analyses. Quarterly Reports.* Albany: New York State Department of Health.

New York Times. 1975. Program of Nursing Home Reform Backed by N.Y. State Is Attacked at Assembly Hearing. May 17

———. 1981. 27 Felons Involved with Nursing Homes. April 23.

Nursing Home Law Letter. 1980. 45 (October-November).

Smith, D.B. 1981. *Long Term Care in Transition: The Regulation of Nursing Homes.* Chicago: Health Administration Press.

Sullivan, E.W. 1980. *Senior Citizen Participation in Corrective Mechanisms.* New York: Center for Policy Research.

U.S. Dept. of Health and Human Services. Office of the Assistant Secretary for Planning and Evaluation. 1981. *Working Papers on Long Term Care.* Appendix 3-B. Washington.

Vladeck, B. 1980. *Unloving Care.* New York: Basic Books.

Washington Post. 1982. Administration Will Not Relax Nursing Home Safety Rules. March 21.

Acknowledgments: Research for this paper was supported by a grant to the Center for Policy Research from the Florence V. Burden Foundation. The authors are grateful to Stephanie Horn-Barbour and Amitai Etzioni, Center for Policy Research; Madilyn Pennachio, New York State Patient Advocate's office; and Patricia Belanger, New York City Ombudsman Program, for comments on previous drafts. Findings and recommendations, however, are the sole responsibility of the authors. In particular, this article should not be construed as representing the opinions or policy of the Health Care Financing Administration.

Address correspondence to: Pamela Doty, Ph.D., Office of Legislation and Policy, Health Care Financing Administration, Dept. of Health and Human Services, Room 341H Humphrey Building, 200 Independence Ave. S.W., Washington, DC 20201.