

The Law and Older Persons

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Is Geriatric Jurisprudence Therapeutic?

Marshall B. Kapp

Professor, Wright State University
School of Medicine

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Preface

Every law is an experiment of sorts. In the early part of the previous century, Justice Louis Brandeis referred to the individual state legislatures as “social laboratories.” When legislatures enact a statute, or administrative agencies promulgate a new regulation, they begin with a set of both philosophical premises and pragmatic assumptions about the expected impact of that statute or regulation on the conduct of persons or entities to be regulated, as well as about the likely salutary effect of the law on its intended beneficiaries. Besides the selfish political lobbying efforts of interested parties, the fact-finding process to inform legislators or regulators about the merits of proposed bills or regulations generally is limited to, at most, some committee hearings. At best, testimony at such hearings is based mainly on ideologically driven speculation and conjecture about a bill’s or regulation’s probable impact. At worst, legislative and regulatory hearings serve primarily as well-orchestrated media pseudoevents to publicly justify actions on which legislators or regulators have already decided, rather than as legitimate exercises in evidence based policy formulation.¹

Similarly, when courts (particularly at the appellate levels) interpret and apply statutes or regulations or set common law precedents, they must consider the expected future effects of the rules they are enunciating, as well as the dictates of existing legal precedent (*stare decisis*) and concepts of justice for the individual litigants in the particular case then before the court for adjudication. It is rare indeed that a court has the opportunity, let alone the inclination, to base its decisions on reliable information rather than unspoken philosophical biases or guesses about the likely future social impact of its present holding in a lawsuit.

A prospective lack of real knowledge about a law’s effects is sometimes understandable and even unavoidable, especially in the litigation context. More distressing, though, is that missing from the law-making experiment almost always is any serious testing phase after legislation

has been enacted, regulation promulgated, or judicial decision announced to determine the law's actual, as compared with its expected, outcomes and impacts. Only recently have we started to hear credible calls for a real examination of the tangible effects of legal rules on identifiable — rather than abstract — persons, calls for a careful study of the empirical reality of legal requirements.² Mental health scholars have paved the way over the past decade through development of the concept of “therapeutic jurisprudence,” which (as will be discussed in the first chapter) supports rigorous examination of the actual impact of legal rules on providers and funders of health and human services and on the real and potential persons whose quality of care and quality of life those legal rules were intended to improve.³ What these scholars largely have found is that, despite a tremendous amount of legislative and judicial law “reform” over the past four decades in areas such as involuntary hospitalization, liability of professionals for the violent acts of their patients, and the patient's right to refuse treatment, the actual changes in professional practice, the quality of intended beneficiaries' lives, and social welfare resulting from legal reform have amounted to something less than a revolution.⁴

Older persons, as a group and individually, frequently are the intended beneficiaries of legal initiatives and rulings. The purpose of this volume is to extend earlier inquiries in Therapeutic Jurisprudence (TJ) to the areas of geriatrics and gerontology, in order to ask whether, in specific contexts, legal involvement and intervention in the lives of older persons is a good thing for both the intended beneficiaries and society as a whole. Put differently, do legislative enactments, regulatory actions, and judicial decisions purportedly justified by advocates and elected and appointed officials always work in practice to achieve their promised benefits? Or, does the law sometimes exert counterproductive or even harmful effects? Public policy making and political and legal advocacy for older persons ought to be a continuous, iterative process for which improvement in content depends — or ought to depend — on accurate feedback in response to these kinds of inquiry.

Regulation is not (other than, perhaps, for some mindless bureaucrats) an end in itself, but rather serves as a necessary means to achieve specific desirable goals. The exact nature and extent of the regulatory and litigation climate intended to protect and promote both the rights and the well-being of older persons should be formulated and constantly fine-tuned on the basis of credible evidence about the impact of various governmental interventions on the lives of older persons and

other intended beneficiaries (e.g., families of older individuals), not as a response to political ideology, administrative convenience, or the economic interests of the professional regulators and litigators. Complaints by regulated parties, such as health and human service providers, that “We don’t like regulation” should carry no more automatic weight in the process of developing public policy than should the imploring of often self-anointed groups⁵ whose innate distrust of the marketplace leads them to advocate against anyone ever being allowed to do anything in an insufficiently regulated manner. An antidogmatic approach⁶ to the wisdom of particular details of elder law will keep the debate going and the inquiry open. The ultimate policy objective ought to be to pair, as exactly as possible, specific regulatory requirements with desired, beneficial outcomes, while allowing everyone involved the greatest feasible amount of flexibility to pursue the public’s goals.⁷

This book is not intended as a libertarian diatribe against the involvement of law, in all its various forms, in the lives of older persons. As the ensuing chapters make clear, the context and content of particular statutes, regulations, and judicial holdings matter a great deal; in some situations, expected positive impacts have been achieved and in others the results have not been favorable. In most areas, the data base on which an honest, helpful, comprehensive evaluation of the law’s effect might be predicated is sorely lacking, and the best we can do at this point is to urge more careful and extensive study.

While I did not begin this writing project with any fundamental antipathy to regulation generally or regarding older persons specifically, I must be clear that my therapeutic jurisprudence analysis is heavily influenced by the belief that, far too frequently, regulation in the United States (and in other countries as well)⁸ is driven by a vision of regulation that focuses on catching wrongdoers and punishing them for their transgressions—a deterrence and enforcement model—rather than a vision of law and its agencies chiefly as an instrument for solving individual and social problems.⁹ I agree with much of the recent criticism that the prevalent enforcement paradigm has caused us in large part to sacrifice “common sense” and to neglect the tangible effects of our laws on real people in favor of enactment and adherence to laws reflecting rigid ideology and, often, simple animosity toward the perceived “bad guys.”¹⁰ In this prevailing model, we figuratively “bite off our nose to spite our face” and the intended beneficiaries are the ones who suffer the most.

Relying too heavily and routinely on regulatory approaches to solving social problems is a flawed strategy, but so too is stubborn denial of

the necessity of government intervention in some situations. I agree with Francis Fukuyama:

Regulation brings with it many inefficiencies and even pathologies that are well understood. Research has shown, for example, how government regulators develop a self-interest in promoting their own power and position, even as they make claims to speak in the public interest. Poorly thought out regulation can drive up the costs of doing business enormously, stifle innovation, and lead to the misallocation of resources as businesses seek to avoid burdensome rules. [The same may be said for not-for-profit organizations.] . . . The inefficiency of any scheme of regulation is a fact of life. We can try to minimize it by designing institutions that seek to streamline the regulatory process and make it more responsive to changes in technology and social needs, but in the end there are certain types of social problems that can only be addressed through formal government control.¹¹

The Guiding Principles enunciated by the Department of Health and Human Services (DHHS) Secretary's Advisory Committee on Regulatory Reform seem to me an excellent starting point:

- Regulations should be uniform and streamlined to avoid conflict and duplication.
- Regulations should have a clearly articulated purpose that advances an appropriate regulatory function.
- Regulations should be written clearly to promote easy understanding by all concerned parties.
- Regulations should be based on evidence from research and peer-reviewed literature, wherever possible, not on anecdotes or interest group politics.
- Regulations should be based on the premise that value is added for consumers (in terms of better service, access, and affordability) and other entities (in terms of such achievements as improved ability to serve patients or clients without excessive operational costs to comply with regulatory requirements). Regulations that do not meet such a cost-benefit analysis should not be adopted.
- Regulations should avoid micromanaging the process by which entities operate and instead should focus broadly on improving performance in the areas of quality, solvency, accessibility, and affordability.
- Regulations should assure consumers that the professionals and suppliers with whom they deal will be held accountable for pro-

viding the benefits, services, and products they promise and, where appropriate, for achieving targets for improved performance. By the same token, those professionals and suppliers should be given greater flexibility to achieve the goals set for them.¹²

Thus, I readily admit that I am seeking a difficult and elusive balance here. I am engaging in a therapeutic jurisprudence inquiry in areas of geriatrics and gerontology in the definite hope that by doing so I may help move the agenda of law and aging closer towards a positive, problem solving paradigm. “Sometimes progress in matters of social policy occurs when the moralizers step back and the tinkerers step forward.”¹³ It is only through the often laborious generation and objective analysis of credible information about the law’s actual effects that we can best enhance the process and content of social experiments conducted by our legislatures, regulatory agencies, and judicial bodies in the name of our older citizens.

Abbreviations Used in Text

AAHRPP	Association for the Accreditation of Human Research Protection Programs
AAHSA	American Association of Homes and Services for the Aging
ABA	American Bar Association
AD	Advance directive
ADA	Americans With Disabilities Act
ADL	Activity of daily living
ALF	Assisted living facility
ANH	Artificial nutrition and hydration
APS	Adult Protective Services
BBA	Balanced Budget Act
BBRA	Balanced Budget Refinement Act
CARF	Commission on Accreditation of Rehabilitation Facilities
CBO	Congressional Budget Office
CFR	Code of Federal Regulations
CHAP	Community Health Accreditation Program
CMS	Centers for Medicare and Medicaid Services
CMP	Competitive Medical Plan
CNA	Certified nursing assistant
CoPs	Conditions of Participation
CPR	Cardiopulmonary resuscitation
DALTCP	Office of Disability, Aging, and Long-Term Care Policy
DEA	Drug Enforcement Agency

DHEW	Department of Health, Education, and Welfare
DHHS	Department of Health and Human Services
DNR	Do not resuscitate
EOL	End of life
ESRD	End-Stage Renal Disease
FBI	Federal Bureau of Investigation
FDA	Food and Drug Administration
FFS	Fee for service
FWA	Federal-Wide Assurance
GAO	General Accounting Office
HCB	Home and community based
HCFA	Health Care Financing Administration
HHA	Home health agency
HI	Hospital Insurance (Medicare Part A)
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health maintenance organization
IL	Independent Living
IoM	Institute of Medicine
IP	Independent provider
IRB	Institutional Review Board
ISO	Intermediary Service Organization
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
LSMT	Life-sustaining medical treatment
LTC	Long term care
MCO	Managed care organizations
MCP	Medicare+Choice Program (Medicare Part C)
MDS	Minimum Data Set
MSA	Medical Savings Account
NAELA	National Academy of Elder Law Attorneys
NAMI	National Alliance for the Mentally Ill
NASUA	National Association of State Units on Aging

NBAC	National Bioethics Advisory Commission
NCOA	National Council on the Aging
NCQA	National Committee for Quality Assurance
NRC	National Research Council
PAS	Personal Assistance Services
PHS	Public Health Service
PPS	Prospective Pricing System/Prospective Payment System
PSDA	Patient Self-Determination Act
OASIS	Outcomes and Assessment Information Set
OBRA	Omnibus Budget Reconciliation Act
OBQI	Outcome-Based Quality Improvement
OHRP	Office of Human Research Protections
OIG	Office of Inspector General
OPRR	Office of Protection from Research Risks
OSCAR	On-Line Survey and Certification Assessment Reporting
PPO	Preferred provider organization
PRO	Peer Review Organization
PSO	Provider-Sponsored Organization
QA	Quality assurance
RAI	Resident Assessment Instrument
RAP	Resident Assessment Protocol
RWJF	Robert Wood Johnson Foundation
SAQIP	State Agency Quality Improvement Program
SMQT	Surveyor Minimum Qualifications Test
SOM	State Operations Manual
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982
TJ	Therapeutic jurisprudence
UGPPA	Uniform Guardianship and Protective Procedures Act
U.S.	United States
U.S.C.	United States Code
V.A.	Veterans Affairs

