1993

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Recommended Citation
Terri D. Keville, Studies of Transfer Trauma in Nursing Home Patients: How the Legal System has Failed to See the Whold Picture, 3 Health Matrix 421 (1993)
Available at: https://scholarlycommons.law.case.edu/healthmatrix/vol3/iss2/5

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STUDIES OF TRANSFER
TRAUMA IN NURSING HOME
PATIENTS: HOW THE
LEGAL SYSTEM HAS
FAILED TO SEE THE WHOLE
PICTURE

Terri D. Keville†

TO FIND OUT the whole truth we must put all the parts
together.¹

I. INTRODUCTION

In an old fable from India, several blind men encounter an ele-
phant, and each examines a separate part in an effort to determine
what the creature is like. Afterwards, each man describes the ele-
phant in radically different terms depending on which part he inves-
tigated. Similarly, by focusing on certain aspects of transfer trauma
data and ignoring others, jurists, legislators, and commentators
have often failed to see the “big picture.”

The term “transfer trauma” was coined in the early 1960s when
gerontologists first became concerned that involuntary relocation of
the elderly—either from private residences to institutions or from
one institution to another—might have adverse health effects and
possibly even hasten death. (This phenomenon has also been re-
ferred to as transplantation shock, relocation stress, and relocation
shock, but transfer trauma is the most commonly used term.) Early
studies seemed to furnish scientific evidence that this fear was justi-
fied.² Some later studies, however, had mixed results, and several

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my sincere appreciation to Deborah Hensler of the Rand Corporation for her comments on
an earlier draft of this Article.

¹ THE BLIND MEN AND THE ELEPHANT (Retold by Lillian Quigley, 1959).
² See, e.g., C. Knight Aldrich & Ethel Mendkoff, Relocation of the Aged and Disabled:
Mortality Study, 11 J. Am. Geriatrics Soc’y 185 (1963); Norman Bourestom & Sandra
Tars, Alterations in Life Patterns Following Nursing Home Relocation, 14 Gerontologist
scientists suggested that the phenomenon was a myth, at least in regard to increased mortality.³

During the twenty-year period in which most research was done on this subject, concerns about the welfare of the elderly were also surfacing in the legal community. As government funding of nursing home care through Medicare and Medicaid became more common, and the administering agencies thus acquired the power to determine the fate of elderly patients, advocates for the rights of nursing home patients seized on the concept of transfer trauma as a means of preventing or forestalling unwanted involuntary transfers.

Legal arguments about transfer trauma appear in numerous cases, including the 1980 U.S. Supreme Court case of O'Bannon v. Town Court Nursing Center.⁴ In O'Bannon the Court held that, notwithstanding possible transfer trauma, nursing home residents do not have a right to a hearing prior to transfer. Nevertheless, because the right to a hearing is not the only legal issue associated with transfer trauma, the phenomenon continues to be a consideration in cases challenging relocation. In addition, transfer trauma has been a rationale for the adoption of various statutory schemes addressing relocation.

As the nation's population ages and the number of nursing home residents increases—the current population of 1.5 million residents is expected to rise to 2.1 million by the year 2000, and to 4.4 million by 2040⁵—issues such as the effect of transfer trauma will undoubtedly assume even greater importance. Thus, it is imperative that courts and legislators have a clear understanding of the transfer trauma phenomenon and its implications for the welfare of nursing home residents. This paper will review and analyze the principal published scientific literature on transfer trauma in an effort to determine what conclusions may legitimately be drawn. The paper will then critically examine how the scientific data has been

⁵06 (1974) (suggesting that a weighty source of the variance in relocation effects is the degree of environmental change involved); Kenneth F. Jasnau, Individualized Versus Mass Transfer of Nonpsychotic Geriatric Patients from Mental Hospitals to Nursing Homes, with Special Reference to the Death Rate, 15 J. AM. GERIATRICS SOC'Y 280 (1967); Eldon C. Killian, The Effect of Geriatric Transfer on Mortality Rate, 15 SOCIAL WORK 19 (1970).


⁵. Note, Don't Make Them Leave Their Rights at the Door: A Recommended Model Statute to Protect the Rights of the Elderly in Nursing Homes, 4 J. CONTEMP. HEALTH L. & POL'Y 321 (1988).
used by courts and legislators, and offer suggestions for a more all-encompassing approach.

II. TRANSFER TRAUMA STUDIES

A. STUDIES ASSERTING THE EXISTENCE OF TRANSFER TRAUMA

The earliest studies of the effects of relocation on the elderly involved moves from the community into institutions. In addition, a number of studies have considered the effects of voluntary moves, for example, into housing for active seniors. Because most of the subsequent judicial and legislative attention has focused on involuntary transfers between institutions, I will concentrate on the studies addressing that situation.

The first major study to observe the effects of relocation from one institution to another was that of C. Knight Aldrich and Ethel Mendkoff conducted in 1963. Aldrich and Mendkoff took advantage of the research opportunity presented by the closure of the Chicago Home for Incurables, which necessitated the relocation of all of the home's residents for a reason totally unrelated to the state of their health or family relationships.

The transfers took approximately two years to complete. At the outset of the research project, 233 persons lived in the home. Fifty-five of the patients died before they could be relocated. Of the 182 remaining, 163 were dispersed to fifty-six other nursing homes in the area (all of which were considered equal or superior to the Home for Incurables), four were hospitalized, six went to live with friends or relatives, and nine (all under seventy years old) were able to return to independent living.

Aldrich and Mendkoff determined the death rate within one year of transfer to be thirty-two percent, with a substantial percentage of the deaths occurring in the first three months after transfer. Because all of the patients in the home were transferred, it was not possible to create a control group with which to compare the death rate of the transferred residents. Therefore, Aldrich and Mendkoff utilized the baseline method by comparing the death rates for the

6. See e.g. Nelida A. Ferrari, Freedom of Choice, 8 SOC. WORK 105 (1963) (finding a relationship between the lack of freedom of choice in institutionalization and "unexpected" death); Morton A. Lieberman, Relationship of Mortality Rates to Entrance to a Home for the Aged, 16 GERIATRICS 515 (1961) (finding that first year mortality rates in a home for the aged are related to the impact of institutionalization).

7. Aldrich & Mendkoff, supra note 2, at 187.
transferees (separate rates were calculated for patients in different decades of life) with the death rates at the home for the previous ten years. This comparison indicated that the death rates for all transferred groups except those in the tenth decade of life were "substantially and significantly higher" than the rates that would have been anticipated (in the absence of the move) based on the historical data. In the first three months after transfer, the death rate for all patients was more than three times higher than the expected death rate; after three months it returned to the anticipated level.

In addition to this first comparison of death rates, Aldrich and Mendkoff also attempted to determine the relationship between a patient's level of psychological adjustment to the home and mortality. They found that patients who were classified as psychotic or near-psychotic had by far the highest death rate, sixty-three percent. The death rate for patients described as neurotic or overtly depressed was thirty-seven percent; for angry and demanding patients, seventeen percent; and for satisfactorily adjusted patients, twelve percent. Even after correction for age disparities, these differences were still found to be statistically significant.

Finally, Aldrich and Mendkoff evaluated the relationship between mortality and the patients' responses to the news of relocation (for those who were capable of a discernible reaction). The responses were divided into six categories: philosophical, angry, anxious, regression, depression, and denial. None of the philosophical patients died. The death rates for the other groups were 6% for the angry group 15% for the anxious group; 27% for the regression group; 41% for the depression group; and 71% for the denial group. After correction for age, the differences were still statistically significant.

Although they endeavored to do so, Aldrich and Mendkoff were not able to observe any statistically significant relationship between anticipation of transfer and mortality. Also, they were unable to measure the effect of caseworker assistance, but they believed it to be helpful.

On the basis of their findings, Aldrich and Mendkoff concluded that relocation in and of itself can have social and psychological effects that result in increased mortality. They found the patient's level of psychological adjustment—both prior and subsequent to be-

8. Id.
9. Margin of error less than 2%. Id. at 189.
10. Margin of error less than 5%. Id. at 190.
ing informed of the transfer—to be a significant factor in predicting survival. However, they cautioned that because depression has associated physical symptoms, further study would be needed to determine whether repressed hostility or loss of the will to live can be fatal.\textsuperscript{11} Aldrich and Mendkoff recommended that case work or psychiatric help be provided whenever transfer of elderly patients becomes necessary, and stressed that efforts to facilitate adaptation to new surroundings are especially crucial in the first three months after transfer.

In 1967, Aldrich and Mendkoff's study was praised by another researcher, Margaret Blenkner, as being the best investigation of relocation effects to date.\textsuperscript{12} However, Blenkner cautioned that "[b]ecause each study tends to use different measures and classifications for psychological data it is very difficult to arrive at any conclusive summary."\textsuperscript{13} She then expressed a deeper concern that "such knowledge as we think we have rests on very insecure foundations. . . . We have cited each other until the evidence sometimes appears of a better quality than it really is."\textsuperscript{14} She called for further research.

The next significant published study of geriatric transfers appeared in 1970. Psychiatric social worker Eldon Killian documented the effects of involuntary transfer on geriatric psychiatric patients who were moved from Stockton (California) State Hospital to other facilities.\textsuperscript{15} At the time of the study, the hospital facilities were divided into two separate locations. The North Area had at one time been operated as a farm that supplied food for the hospital, and many of the patients housed in the North Area had worked on the farm. When the acreage on which the farm was located increased substantially in value, it was sold by the state, leaving only the patient dormitories. Eventually the state decided to sell the remaining North Area land and relocate the patients. During the first

\textsuperscript{11} Id. at 193. In an effort to shed further light on this question, Aldrich examined the data further by comparing the twenty-six patients who died in the first three months with a group of surviving patients matched for sex, age, and physical condition (defined by primary diagnosis, since many patients had multiple disabilities). The results of this analysis were published the following year. Aldrich concluded that psychological adjustment was a greater determinant of survival than physical condition. C. Knight Aldrich, \textit{Personality Factors and Mortality in the Relocation of the Aged}, 4 \textit{Gerontologist} 92 (1964).

\textsuperscript{12} Margaret Blenkner, \textit{Environmental Change and the Aging Individual}, 7 \textit{Gerontologist} 101, 102 (1967).

\textsuperscript{13} Id. at 103.

\textsuperscript{14} Id. at 104-05.

three months of 1968, 144 of the North Area patients were transferred to different state hospitals or other facilities.\textsuperscript{16}

Killian studied three groups of patients: two groups of transferees and one group of patients who remained at Stockton during the study period. All of the subjects were age sixty or older. Group I consisted of seventy-one men and eight women who were transported by bus to other state hospitals. Group II included twenty-one male and forty-four female patients who were transferred to nursing homes, boarding houses, and "family care homes" (private homes licensed by the state to care for up to six patients). Forty percent of the Group II patients were nonambulatory and were transported by ambulance. The others were taken by automobile. Group III was comprised of fifty-two men and fifty-seven women who remained at Stockton during the study period, although some of them were transferred to other locations within the hospital. Data was collected on six variables: age, sex, race, organic or functional diagnosis, length of hospitalization since most recent admission, and whether the patient was ambulatory.\textsuperscript{17}

Three matched control groups were created using hospital census data. For each experimental subject there was a control subject who shared comparable characteristics based on the six variables.\textsuperscript{18} A random sample group was also selected from the hospital geriatric census. Mortality data gathered four months after the transfer revealed that the mortality rate for Group I was 4.98 times higher than for its matched control group. The Group II mortality rate was 8.99 times that of its control group. Among the nonambulatory Group II patients, nearly 27% died; this finding was statistically significant at the .023 level. A Chi-square test applied to the combined data from Groups I and II indicated that the probability of these deaths occurring by chance was .0005. By contrast, there was no significant difference in mortality between the Group III patients and their matched controls.\textsuperscript{19}

Age was the only variable, other than the move itself and

\textsuperscript{16} Id. at 20.
\textsuperscript{17} Id. at 21.
\textsuperscript{18} Ages were matched using five-year ranges, and length-of-stay was divided into intervals of less than one year, one to four years, five to ten years, to nineteen years, and twenty years and over. Because of the specific characteristics used, the relatively small size of the pool, and the blind matching procedure used, there were eleven patients (4.35%) who turned out to be both experimental and control subjects. These patients were included in the study even though they could not properly serve as controls because they were relocated. Id. at 24-25.
\textsuperscript{19} Id. at 25.
whether the patient was ambulatory, that showed any statistically significant relation to mortality. The mean age of the patients from Groups I and II who died was ten years higher than the mean age for Group I and eight years higher than the mean age for Group II. However, Killian relates some anecdotal evidence suggesting that patient attitudes—which were not systematically examined—may have been a factor. Many of the patients became distressed as they observed the buildings that had already been evacuated being demolished or burned; they feared that they were going to be burned along with the dormitories. One eighty-year-old man who had lived at the farm for thirty years became depressed when he realized that he would have to move. He was found dead clutching a bunch of carrots from his garden. Another elderly man who steadfastly denied that he was to be transferred died in the ambulance as he was being moved.

In 1971, Markus, Blenkner, Bloom, and Downs published a study of two sets of relocations from old downtown nursing homes in Cleveland and Washington, D.C. to new suburban facilities. They compared post-transfer mortality rates with anticipated rates calculated from data covering the previous fifteen years for each home. They observed some increased mortality—for example, the rate was 1.5 times higher than anticipated for male residents of the Cleveland home and 1.63 times higher for women in the Washington home—but this effect was not universal. Female residents of the Cleveland home experienced a decrease in mortality after the transfer. Deviations from anticipated mortality varied by age grouping. The authors speculate that inconsistencies in the data may have been due to differences in admission policies, both between the two homes, and between normal and pre-relocation policies (that is, for one or two months prior to the planned relocation, the homes may have cut back on convalescent admissions). No attempt was made in this study to gather data on the patients’ physi-

20. Id. at 25.
21. Id. at 26. Recall that in Aldrich and Mendkoff’s study, denial was highly correlated with increased mortality. See Aldrich & Mendkoff, supra note 10 and accompanying text.

In a subsequent unpublished study of the closing of Modesto State Hospital, researchers also found increased mortality. Patients who were physically frail or psychologically impaired were most likely to die. R.A. Marlow, When They Closed the Doors at Modesto, Presented at National Mental Health Conference on the Closure of State Hospitals (Feb. 14-15, 1974), cited in Richard Schulz & Gail Brenner, Relocation of the Aged: A Review and Theoretical Analysis, 32 J. GERONTOLOGY 323, 327 (1977).

22. Elliot Markus et al., The Impact of Relocation upon Mortality Rates of Institutionalized Aged Persons, 26 J. GERONTOLOGY 537 (1971).
23. Id. at 538.
cal condition, nor on their mental states and attitudes, which the researchers acknowledge may be better predictors of mortality than the variables they documented: age, sex, and length of residency.\textsuperscript{24}

In light of the above research (and other studies documenting adverse effects on newly institutionalized and voluntarily transferred patients) several studies were conducted which presumed that relocation might cause increased mortality.\textsuperscript{25} In at least two such studies, the researchers attempted to determine whether this phenomenon could be prevented by proper preparation of the patients prior to transfer. The transferred patients in these research projects actually experienced a decrease in mortality rate.\textsuperscript{26} Another study found no significant difference in mortality between the transferred and nontransferred patients, but the researchers were uncertain as to what factors had produced this result.\textsuperscript{27}

B. STUDIES DENYING THAT INVOLUNTARY TRANSFERS CAUSE INCREASED MORTALITY

While many researchers became convinced that involuntary transfer could have serious and even fatal adverse effects on geriatric patients, other scientists reported findings that did not support this view. For example, a 1974 article by Elizabeth Markson and John Cumming describes their observations regarding the transfers of 2,174 mental patients, of whom 494 were over age sixty-five, to different facilities within the New York State mental health system.\textsuperscript{28} According to the authors, the mortality rate of the transferred patients did not increase. However, the methodology of this study was not especially rigorous. There was no control group set up with which to compare the transferred patients,\textsuperscript{29} so their mor-

\textsuperscript{24} Id. at 540.
\textsuperscript{26} Amenta et al., supra note 25, at 358 (decline in death rate of transferees, measured by baseline method, from 17% in 1980 to 11% for first half of 1981); Zweig & Czank, \textit{supra} note 25, at 135 (6.82% drop in death rate of the discharged and transferred patients; margin of error less than 5%).
\textsuperscript{27} Ogren & Linn, \textit{supra} note 25.
\textsuperscript{29} The authors did subsequently compare the transferred patients with small groups of healthy geriatric patients, some in mental hospitals and some in outpatient programs. The mortality rate for the transferred patients was 9.1%; while that of the nontransferred chronic geriatric patients was 8.6%, a statistically insignificant difference. The outpatient group
Mortality rate was compared with that of new geriatric admissions to the system during the time period of the study, and with the death rate for all chronic geriatric patients. There are obvious flaws in these comparisons based on differences between the compared groups as described by the authors. The transferred patients had been hospitalized for an average of nineteen years, so comparison of their mortality rate with new residents is invalid. A number of studies have documented increased mortality among newly admitted patients to institutions; thus it is not surprising that the new admissions would have a higher mortality rate. Comparison with all chronic patients is suspect because, as the authors note, the transfer patients as a group were physically healthier.

The authors endeavor to explain the increased mortality found in other studies by speculating that this effect was the result not of the move itself but of other factors such as "poor physical health and mental confusion." They attribute the fact that the mortality rate was slightly higher in the first thirty days of their own study to a "weed[ing] out" of patients who "despite a lack of obvious physical stigmata barring their transfer, were poor relocation risks because of underlying physical illness, mental confusion, or dependence upon a familiar institutional environment." Markson and Cumming, however, overlook the obvious explanation that transfer may be detrimental precisely because so many elderly patients possess these characteristics.

One particular study denying the mortality effect of transfer has received a large measure of the attention focused on this issue. This research was performed by Borup, Gallego, and Heffernan in Utah between 1976 and 1978. The findings were published in a series of articles in The Gerontologist. The authors studied two groups (which does not seem to be an appropriate population for valid comparison with institutionalized patients) had a death rate of 5.7%. Id. at page 318.

30. See Morton A. Lieberman, Relationship of Mortality Rates to Entrance to a Home for the Aged, 16 GERIATRICS 515 (1961); Ben Z. Locke, Hospitalization History of Patients with Mental Diseases of the Senium, 17 J. GERONTOLOGY 381 (1962); Elizabeth W. Markson, The Geriatric House of Death: Hiding the Dying in a Mental Hospital, 1 AGING & HUM. DEV. 37 (1970); Ivan N. Mensch, Studies of Older Psychiatric Patients, 3 GERONTOLOGIST 100 (1963); J.R. Whittier & D. Williams, The Coincidence and Constancy of Mortality Figures for Aged Psychotic Patients Admitted to State Hospitals, 124 J. NERVOUS & MENTAL DISEASE 618 (1956).


32. Id.

33. Id. at 319.

nursing home patients, an experimental group of 529 who were transferred from homes that were closed because they could not meet new state standards, and a control group of 453 living in homes that met the standards and so were unaffected. In the first published article on their findings, the authors compared mortality rates for the two groups and reported that the transferred patients had a significantly lower mortality rate (sixty-two or 11.2% of the experimental patients died, compared with eighty or 17.7% from the control group). The authors attributed this finding to age differences between the relocated patients and the control group, which included more patients over eighty (122 controls were over eighty; ninety-seven experimental patients were over eighty), and far fewer patients under sixty-five (fifty controls were under sixty-five; 141 experimental subjects were under sixty-five). While these age differences were obviously important, the authors did not consider the possibility that transferring patients from substandard facilities to better ones might have a positive effect on their longevity.

In their second article, Borup, Gallego, and Heffernan examine two patient characteristics that might be affected by transfer—health (as reported by the patients themselves) and functioning (as reported by nursing home staff)—and their relation to mortality. For this aspect of the research, only those patients who were, in the judgment of the staff, capable of being interviewed were included as subjects. Clearly this criterion would eliminate from comparison those patients with the lowest levels of functioning.

The authors observed no differences in self-reported health status between the experimental and control groups. They note, however, that ninety-nine percent of the transferred patients indicated that the care they were receiving in their new home was equal to or better than the care at the previous facility. Similarly, transferred patients were found to be less likely to have an unrealistically negative view of their health (hypochondria) after the move. The hypochondria level of patients who did not move (and consequently did not experience an improvement in care) tended to increase over time. The authors also note that relocated patients may have had less time to reflect on their health status as a result of preparatory and adjustment activities.

35. Margin of error less than 5%. Borup I, supra note 34, at 136.
36. Id. at 136-37.
37. Borup II, supra note 34, at 473.
The daily functioning level—the level of ability to walk, bathe, dress, eat, use the toilet, read, write, etc.—of the relocated patients remained stable before and after the move, while that of the control group deteriorated. The authors attribute this effect solely to the fact of relocation. However, it is likely that the improved facilities and the preparatory and adjustment procedures implemented also contributed to this phenomenon.

According to Borup, Gallego, and Heffernan, the health status of the patients prior to relocation did not have a significant correlation with mortality; however, the patients who died had significantly lower levels of daily functioning. Therefore, the authors recognize that “patients who have problems with daily functioning in the nursing home will become more vulnerable to death when relocation intervenes . . . .” Nevertheless, the authors still categorize their study as finding that relocation has no significant effect on mortality.

The conclusions drawn by Borup, Gallego, and Heffernan from the data they gathered are vulnerable to some serious criticisms. To begin with, the authors telegraph a discernible bias in the introductions to their two studies. The authors offer the following statements as “background”:

A full range of long term institutional health care (skilled, intermediate, and personal) has been historically available in Utah. In providing this service within the confines of its limited financial resources, the health care industry had converted many facilities designed for purposes other than health care into nursing homes. However, demanding regulations have regularly appeared on the scene bringing with them increasing burdens to the nursing home industry. These regulations required such modifications as sprinkler systems, proper exit widths, larger room sizes, elimination of stairways and many other similar modifications. With the full implementation of the 1974 nursing home regulations in 1977, the final death blow was dealt to many nursing homes.

This discussion conveys the message that the imposition of minimum standards of patient safety and comfort constituted an unreasonable burden on nursing home operators, and indicates a greater concern for the interests of the industry than for patient welfare. Thus, it seems probable that the authors were not impartial in un-

38. Id. at 475.
39. Id. at 469.
40. Borup I, supra note 34, at 135 (this version does not contain the words “long term institutional”); Borup II, supra note 34, at 468.
dertaking their determination of whether relocation might be harmful or fatal to patients.

In addition to the question of bias and the methodological problems discussed above, there are other deficiencies in the Utah nursing home studies. First, the authors convey a misimpression about the general trend in previous relocation research. They state that three quarters of the studies done on the subject have found no significant increase in mortality as a result of relocation. This categorization of the data is overly simplistic and inaccurate. The authors make no distinction between studies of voluntarily and involuntarily transferred patients, despite evidence that voluntary transfers are not as likely to cause increased mortality. Furthermore, they do not acknowledge the fact that at least one study assumed that transfer could cause death and specifically endeavored to counteract this effect. They include two studies that found increased mortality for particular subgroups of subjects in their list of studies denying the mortality effect (as well as in the increased mortality list). The authors of these studies, however, definitely did not deny that there is a mortality effect.

Second, Borup, Gallego, and Heffernan are much too quick to universalize their findings. They barely acknowledge that the positive effects of relocation they observed may have been influenced by the fact that all the transferees experienced an improvement in their environment. They make no attempt to describe what efforts were made to prepare the patients, although a later article indicates that such efforts were made; nor do they acknowledge, as other researchers have, that adequate preparation can reduce or eliminate the mortality effect. Instead, they conclude, on the basis of their findings, that “relocation does not increase the probability of mor-

41. Borup I, supra note 34, at 136, 139; Borup II, supra note 34, at 469, 475.
43. Zweig & Czank, supra note 25.
45. “Improper generalization is probably the major error in social science research.” Reid Hastie et al., Inside the Jury 44 (1983).
46. See infra note 55.
tality for patients in general and specific sub-groups in particular,\textsuperscript{47} that "personal health evaluations are not affected by relocation,"\textsuperscript{48} and that "relocation has a positive effect on the functioning level of patients."\textsuperscript{49} Whereas most researchers couch their conclusions carefully in terms of possible inferences to be drawn from what they observed, and often call for corroborating research, these authors purport to make—on the basis of their limited observations—definitive statements about how the world is. They make the common scientific assumption that because their experiment did not confirm the research hypothesis (that relocation increases mortality), they have proved the null hypothesis (that there is no causal relation whatsoever between relocation and mortality). This assumption is plainly erroneous.

If a study results in failure to reject a null hypothesis, the researcher has not really "proved" a null hypothesis, but has failed to find support for the research hypothesis. It is not unusual to find studies with negative outcomes where the researcher has placed a great deal of stock in "acceptance" of null hypotheses. Such interpretations, strictly speaking, are in error because the logic of a research design incorporates the testing of some alternative (research hypothesis) against the status quo (null hypothesis). Although failure to find support for the alternative does leave one with the status quo, it does not rule out other possible alternatives.\textsuperscript{50}

In this case, it is possible that although transfer of the Utah patients to better facilities did not result in increased mortality or other detrimental effects, nursing home patients who are relocated to inferior facilities, or who are inadequately prepared, or especially old or sick or poorly adjusted, may indeed suffer increased or hastened mortality because of relocation. For Borup, Gallego, and Heffernan to suggest that because they did not observe the mortality effect it cannot possibly exist is at best unscientific, and at worst irresponsible.

Borup, Gallego, and Heffernan were sharply criticized for their cavalier characterization of the mortality effect of transfer as a myth,\textsuperscript{51} and their suggestion that nursing home administrators and staff need not expend any effort in attempting to prevent this

\textsuperscript{47} Borup I, supra note 34, at 138.
\textsuperscript{48} Borup II, supra note 34, at 472.
\textsuperscript{49} Id. at 474.
\textsuperscript{50} FREDERICK WILLIAMS, REASONING WITH STATISTICS: HOW TO READ QUANTITATIVE RESEARCH 79 (4th ed. 1992).
\textsuperscript{51} Borup I, supra note 34, at 138-39.
“mythical” effect.\textsuperscript{52} According to the critics, “the question no longer is whether relocation has negative (or positive) effects, but under what conditions and with what kinds of populations are those negative or positive effects most likely to be observed.”\textsuperscript{53} Norman Bourestom and Leon Pastalan also criticize Borup, Gallego, and Heffernan for failing to discuss the mental and physical health status and attitudes of their experimental subjects.\textsuperscript{54}

Perhaps as a reaction to criticism, Borup individually published a third paper reporting findings from the Utah nursing home study in 1981.\textsuperscript{55} This article deals primarily with psychological aspects of transfer, such as patient concerns, problems, and responses to problems with the move.\textsuperscript{56} Borup reports that patients’ attitudes about the move generally improve after they have settled into their new homes.\textsuperscript{57} Understandably, those who are unwilling to move are most upset initially, but the majority of these patients (74.1\%) develop a positive attitude eventually.\textsuperscript{58} Patient attitudes about a transfer are also affected by the amount and source of information available to them.\textsuperscript{59} Approximately one third of the transferees reported problems with losses of personal belongings. Of these patients, about half remained distressed over their losses three to six months after the move.\textsuperscript{60} Overall, more women than men experienced stresses and problems associated with relocation, and patients over eighty experienced stress for longer periods.\textsuperscript{61} Borup concludes that nursing home administrators and staff should implement various procedures for reducing patient stress, increasing available information—especially about the location of the new home and the date of the move—and safeguarding patient possessions during the move.\textsuperscript{62}

Borup and Gallego repeat their assertion that the scientific evi-
idence, their own as well as that of previous studies, does not support any link between relocation and increased mortality in an article directly responding to Bourestom and Pastalan.\textsuperscript{63} They reject Bourestom and Pastalan's contention that differences among the previous studies make generalization (i.e., acceptance of the null hypothesis) impossible. They claim that while differences in patient characteristics constitute "intervening variables" that may cause higher mortality rates for some transferred groups, "relocation in and of itself does not 'cause' an increase in mortality."\textsuperscript{64} This analysis misses the point. Everyone knows that moving, by itself, is stressful but not fatal. It is equally obvious that old people are often weak and sick, and that they are going to die sooner or later—quite possibly sooner. The point is, precisely, that transfer, when accompanied by these "intervening variables," may hasten death if it is not accomplished with solicitous concern for patient welfare.

Although Borup and Gallego are unlikely to abandon their "no increased mortality" theory, in their 1981 article they stress that transfer can have other traumatic effects that may be prevented or ameliorated through proper procedures and programs.\textsuperscript{65} On this point, at least, there appears to be universal agreement.

C. ANALYSES ATTEMPTING TO RECONCILE THE CONFLICTING DATA

Borup, Gallego, and Heffernan were not the only scientists to notice that the evidence on transfer effects was conflicting. Most interested psychologists and gerontologists, however, took a different approach to the problem. Rather than seeking to disprove the existence of the mortality effect by dismissing the findings of the scientists who had observed it, as Borup and his colleagues did, other scientists attempted to formulate explanations that could accommodate all of the data. In fact, other than the writings of Borup, Gallego, and Heffernan, virtually all of the literature on transfer trauma accepts the validity of the studies that reported increased mortality, and goes on to ask why negative or positive effects of relocation occur when they do.

Schulz and Brenner begin with a theoretical framework bor-

\textsuperscript{63} Jerry H. Borup & Daniel T. Gallego, Mortality as Affected by Institutional Relocation: Update and Assessment, 21 The Gerontologist 8 (1981) (the two articles appearing side by side in the "Forum" section of this journal).

\textsuperscript{64} Id. at 12.

\textsuperscript{65} Id. at 14 (advocating preparation in order to reduce the stress of relocation).
rowed from social psychology. According to this model, relocation is a major life change that naturally produces stress; however, the degree of stress experienced is a function of the perceived predictability and controllability of the stressful event. Schulz and Brenner attempt to analyze the existing data on relocation of the elderly in light of the predictability-control model. They hypothesize that according to the model, voluntary moves should have fewer negative effects than involuntary moves (the control factor), and transfers involving a lesser degree of change and a greater degree of preparation should have fewer negative effects (the predictability factor).

The authors acknowledge that other variables, such as an improvement in environmental quality as a result of the move, will also affect patient outcomes. They also recognize that their work has certain limitations based on its nature as an informal post hoc analysis of data gathered by others, and that some of the data analyzed exhibit methodological shortcomings. Nevertheless, Schulz and Brenner confidently conclude, based on their examinations of previous studies, that the subjects' level of control over the move and the new environment, and the predictability of the move—as measured by the similarity of the new surroundings to the old and the amount and quality of preparation—were in fact predictors of patient outcomes. Schulz and Brenner also note that in at least one study, "patients who improved went to environments which encouraged residents to be independent, make their own decisions about the use of time and space, try out new skills, and develop new relationships and activities inside and outside of the facility. Patients denied these favorable conditions exhibited withdrawal and deterioration." The authors recommend controlled experiments to confirm their findings, and to discover ways in which the lives of the institutionalized elderly may be enhanced by increasing their sense of control.

A 1980 article by Anson Levitan (one of the few that takes a broad view of the transfer issue) reviews the transfer trauma literature and concludes that the weight of evidence confirms the exist-
ence of the transfer trauma phenomenon, including the mortality effect. According to Levitan, "the literature shows the following factors to be associated with a high risk of transfer trauma: (1) involuntary relocation involving a significant change in environment, (2) disorientation, (3) passivity, (4) withdrawal, (5) 'field dependence' or impaired cognitive functions, (6) neurosis or depression, and (7) psychosis." Studies denying the existence of transfer trauma or its effect on mortality have, in Levitan's view, failed to take these factors into account. For example, Markson and Cumming's study excluded residents with high risk traits, such as disoriented patients or those with poor medical prognoses; Borup, Gallego, and Heffernan did not analyze the nature or degree of environmental change its subjects experienced, nor any of the other risk factors enumerated above. Levitan also notes a distinction—largely ignored by researchers—between mass transfers in which staff and residents remain together and those in which the residents are dispersed (for example, when a home is decertified). Clearly the degree of disruption and stress is lower when patients are not separated from their familiar caretakers and friends.

Levitan suggests that those who argue against the existence of transfer trauma generally do so because they believe that institutionalization is detrimental to the elderly—resulting in "dependence, apathy and withdrawal"—and therefore is to be avoided or terminated whenever possible. By contrast, Levitan argues that "the importance of noninstitutional care is not undermined by recognition of transfer trauma." For some patients, including those with high risk characteristics, institutionalization is generally both appropriate and beneficial, and it is deinstitutionalization (or other inappropriate transfer) that threatens these patients with harm. Thus, Levitan concludes that the most vulnerable individuals should not be moved unless absolutely necessary, while other patients should be relocated to whatever setting is most conducive to their welfare, with proper planning and counseling in all cases.

74. Id. at 655 (defining "field dependent" individuals as "being highly influenced by their environment and as having limited cognitive abilities").
75. Id.
76. Supra notes 28-33 and accompanying text.
77. Levitan, supra note 73, at 656.
78. Id. at 657.
79. Id.
80. Id. at 658.
Levitan also recommends that alternatives to entering a nursing home be available for those elderly individuals who are capable of living independently.\textsuperscript{81}

In 1981, \textit{The Gerontologist} devoted a substantial portion of one issue to a symposium on transfer trauma. In her introduction to this group of articles, Nancy Eustis cautions that in social policy contexts such as this one, "it is potentially harmful to ignore the evidence of negative effects, although not demonstrated in all or even most studies."\textsuperscript{82} In the lengthiest symposium piece, Thomas Coffman catalogues the wide diversity of methodology and statistical analysis techniques used in transfer trauma research.

Some studies have used control groups while others have used baseline (pre-move) data for comparisons, with many variations on each design. Some investigators have performed no statistical tests on their data. Others have used conventional tests of significance, but not always the same or equivalent tests, nor always in the accepted manner. Still others have invented unique significance tests of their own. Chi-square tests have sometimes been performed on multi-cell tables so constructed that estimates of significance do not clearly address a single issue such as survival versus non-survival. The time periods examined sometimes span pre-move and post-move periods and the post-move time spans range from a few weeks to 12 months (even though many authorities believe that effects will be most evident in the first 3 to 6 months afterwards). Deaths have been counted and mortality rates computed on various assortments of actual or intended movers and non-movers, baseline estimates, "at-risk" populations, etc.\textsuperscript{83}

Because this confusion makes cross-study comparisons exceedingly difficult, Coffman undertakes a "z-score"\textsuperscript{84} analysis of the multitude of statistical data. Using a rather lenient two-tailed (appropriate because both increases and decreases in mortality have been observed) probability of .10 as the confidence level, Coffman states that twelve of the twenty-six studies analyzed did not report statistically significant differences in mortality correlated with relocation. Eight of the remaining studies showed significant decreases and six showed increases. Coffman maintains that neither the increased mortality observations nor the decreased mortality (survival) find-

\begin{enumerate}
\item \textit{Id.} at 659.
\item Defined as "standard normal deviates ... for differences between proportional mortality rates." \textit{Id.} at 495 (Appendix A).
\end{enumerate}
ings can be dismissed on the basis of experimental deficiencies, since methodological problems were, in his opinion, about evenly distributed among the studies.85

Coffman concludes, in light of further, meta-analysis of the data, that the most lethal moves are those that involve closure of an institution or dispersal of its residents; such moves result in what Coffman terms "disintegrative processes"—that is, "serious deterioration in the support system" on which vulnerable elderly residents depend.86 If sufficient replacement support is not immediately provided, the negative effects can be catastrophic. Coffman also notes a related high correlation between staff morale and patient outcomes.87 Coffman's conclusions seem consistent with those of Schulz and Brenner, in that both approaches view the quality of the patient's interaction with the overall environment as crucial.

Coffman closes with two notes of caution. First, even if the occurrence of the mortality effect is rare, policymakers should not minimize the other negative effects that relocation may cause. Second, extrapolation from experimental data may be inaccurate because most research is conducted at "better" institutions; problems of all kinds may be more prevalent and more serious in lesser facilities.88 In making decisions about transfers, the general welfare and survival of elderly residents must be of paramount importance.

Claire Kowalski's symposium article reviews successful efforts to make relocation a positive experience.89 She echoes Levitan's recommendation that patients should be evaluated to determine the least restrictive placement alternative that will meet their needs.90 For patients who require an institutional home, the crucial sense of control that Schulz and Brenner assert can be fostered. According to Kowalski, "frail elderly [patients] may still perceive the locus of control as being in themselves if they have voluntarily entrusted their care to others whom they trust, and if these others behave so as to merit that trust."91

85. Id. at 491.
86. Id. at 492.
87. Id. at 493.
88. Id. at 494.
90. Id. at 517 (stating that a patient's health and social functioning should be assessed with a view toward the most appropriate type of residence).
91. Id.
III. LEGAL USES OF TRANSFER TRAUMA DATA

As may be gathered from the scientific literature, both concern for the elderly and the interests of nursing home operators have generated attention to the transfer trauma phenomenon. In litigation, nursing home owners have raised the specter of transfer trauma in efforts to prevent decertification of their facilities or cessation of Medicare or Medicaid payments. Alternatively, patients have attempted to stop or forestall unwanted transfers by arguing that they will be harmed by relocation. Judicial sympathy for transfer trauma arguments has varied. In addition, as the transfer trauma phenomenon became widely documented and discussed in scientific literature and in case law, it attracted the interest of legislators, who have used it as the rationale for assorted nursing home regulations.

A. Cases

1. Cases Preceding O'Bannon v. Town Court Nursing Center

Two cases from the mid-1970s, while not employing the specific term “transfer trauma,” do reflect concern for possible harm to relocated patients. In the 1974 case Burchette v. Dumpson, patients sued the commissioner of the New York City Department of Social Services, seeking injunctive relief to prevent their impending transfer to nursing homes providing a lower level of care. In denying the defendant's motion for summary judgment, the court stated that “[t]he damage which may result from such transfers is irreparable in the true sense of the word. Changes in surroundings and movement of long distances of senior citizens who are suffering from physical and psychological infirmities are likely to aggravate their condition and increase the likelihood of death.”

The Seventh Circuit articulated a similar principle in Hathaway v. Mathews, a 1976 case brought by a nursing home owner to challenge the Department of Health Education and Welfare (HEW) termination of Medicaid benefits to patients residing in the home. According to the court, “to compel the residents of the Home to move to a new facility (or a number of new facilities) would create a

92. See infra.
93. See infra.
94. See infra.
96. Id. at 814.
97. Id. at 819.
98. 546 F.2d 227 (7th Cir. 1976).
major disruption in their lives. Where the deprivation to the individuals affected by the removal of a governmental benefit is this severe, the Government's asserted interest must be pressing to justify postponing the hearing until after termination."99

The first case to use the phrase "transfer trauma" was *Klein v. Mathews*100 in 1977. Citing *Burchette and Hathaway*,101 the court held that nursing home residents had a property interest in continued occupancy of, and continued payments to, the nursing home where they were living, and a corresponding due process right to a hearing prior to termination by HEW of the home as a Medicaid provider. The court noted that HEW itself had acknowledged the harm caused to transferred nursing home residents in an internal memorandum that stated, "‘There is a genuine hazard in the relocation of infirm aging persons from one facility to another. Dramatic increases in mortality far in excess of what would normally be expected have been documented.’"102 However, the court stressed that the possibility of increased mortality was not an indispensable element in its decision. "It is sufficient to say that transfer works grievous loss. Aside from the physical danger, transfer trauma presents serious psychological danger."103 The court held that patients forced to suffer such harm were in effect experiencing an impermissible reduction in their benefits.104

*Klein v. Mathews* was affirmed by the Third Circuit under the name *Klein v. Califano*.105 However, the appeals court based its decision on the fact that residents had a property interest in continuing occupancy derived from federal statutes and regulations prohibiting transfers except under specified circumstances. Transfer trauma was relegated to a footnote.

"We deem it unnecessary to address an alternative argument for invoking the due process clause in this case, that transfer trauma suffered by dislocated nursing home patients reduces the financial benefits to which the patients are entitled under the Medicaid program. We believe that the Medicaid program guarantees an already institutionalized patient a property interest in continued occupancy, an interest distinct from the interest in continued eligibility for benefits. Dislocation may cause transfer trauma, but

99. *Id.* at 231.
101. *Id.* at 1009.
102. *Id.* (quoting DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, TECHNICAL ASSISTANCE MEMORANDUM 2 (February 19, 1975)).
104. *Id.*
105. 586 F.2d 250 (3rd Cir. 1978).
the denial of the patient's property interest in continued occupancy is unaffected by the extent of the loss or harm associated with this denial. . . . We do not decide whether transfer trauma constitutes a deprivation of recipient's property interest in a given level of cash benefits.\textsuperscript{106} Although the court did not foreclose future use of this argument, it clearly did not accord transfer trauma as much weight as the district court.

Two other 1978 district court decisions gave little credence to the transfer trauma argument. The court in \textit{Cornell v. Creasy} stated that "[t]he scientific experts are in disagreement, and the statistical facts show no consistent trend toward higher mortality in transferred Medicaid patients solely on account of uncounselled transfers."\textsuperscript{107} In \textit{Schwartzberg v. Califano},\textsuperscript{108} the court deferred to the judgment of HEW. "Since HEW is aware of the phenomenon of 'transfer trauma,' it undoubtedly believes that the danger to health and safety imposed upon patients remaining at Kings Care outweighs the possible trauma attendant upon leaving it."\textsuperscript{109} A few months prior to the Court of Appeals decision in \textit{Klein v. Califano}, the U.S. District Court for the Northern District of California decided \textit{Bracco v. Lackner}.\textsuperscript{110} The plaintiffs were forty-four elderly residents of a nursing home in San Francisco that was threatened with a termination of government benefits. The city suffered from a shortage of nursing home beds for patients who required government financial assistance, and the residents feared they would have nowhere to go.

The court found that the residents were not being given sufficient notice and preparation for the relocation. It based this conclusion on its analysis of transfer trauma literature and testimony, including (among others) Aldrich and Mendkoff's study finding increased mortality, and testimony by Dr. Leon Pastalan regarding the type of preparation necessary to prevent or ameliorate negative consequences of transfer.\textsuperscript{111} The court also noted that few of the deficiencies enumerated by the city as grounds for closing the facility had anything to do with the safety of the structure itself; on the other hand, there was substantial evidence that problems with patient care, while previously

\textsuperscript{106} \textit{Id.} at 259, n.16.
\textsuperscript{107} 491 F. Supp. 124, 126 (N.D. Ohio 1978).
\textsuperscript{109} \textit{Id.} at 1047.
\textsuperscript{110} 462 F. Supp. 436 (N.D. Cal. 1978).
\textsuperscript{111} \textit{Id.} at 444-46.
quite serious, had for the most part been corrected. Thus, the court believed the situation presented no emergency.\textsuperscript{112} The potential danger to the patients from a hasty move was far greater in the opinion of the court.\textsuperscript{113}

Furthermore, according to the court "so long as the state has acted to give the Center residents a legitimate expectation of continued residency [by certifying the facility], it cannot deprive them of that expectation except in accordance with applicable federal standards."\textsuperscript{114} The applicable federal regulations provided that recipients' benefits could not be reduced without opportunity for a hearing,\textsuperscript{115} and the court considered involuntary transfer—with its attendant danger of transfer trauma as well as loss of associations—to constitute a reduction in benefits.\textsuperscript{116}

Several other cases prior to the Supreme Court's decision in \textit{O'Bannon v. Town Court Nursing Center} also acknowledged the existence and relevance of transfer trauma. In \textit{Brede v. Department of Health}, the Ninth Circuit Court of Appeals stated that "[t]here has been considerable judicial and scientific recognition of the phenomenon known as 'transfer trauma'," citing \textit{Bracco v. Lackner}, \textit{Klein v. Mathews}, and \textit{Burchette v. Dumpson}.\textsuperscript{117} The court in \textit{Brede} had been asked to decide whether elderly patients remaining at a leprosarium that the state of Hawaii wanted to close had a right to a hearing. The circuit court remanded for a factual determination as to "[t]he degree to which this phenomenon is applicable to the leprosy patients presently resisting transfer" from the home to a hospital in Honolulu, since in the court's view, this would be relevant to the issue of what process was due. "To the extent . . . that transfer trauma is a possible result of the state's decision to relocate the Hale Mohalu patients, relocation may constitute a deprivation cognizable under the due process clause."\textsuperscript{118}

Two state cases also expressed concern about transfer trauma. In the Colorado Court of Appeals case \textit{MacLeod v. Miller},\textsuperscript{119} the court reversed a lower court denial of injunctive relief requested by

\begin{itemize}
  \item \textsuperscript{112} \textit{Id.} at 455 ("The Department's cries of emergency ring hollow in light of the desire of those actually facing the alleged emergency to remain in the Center.").
  \item \textsuperscript{113} \textit{Id.} at 445-47, 453 (citing \textit{Hathaway v. Mathews}, \textit{Klein v. Mathews}, and \textit{Burchette v. Dumpson} as examples of prior judicial recognition of transfer trauma).
  \item \textsuperscript{114} \textit{Id.} at 449.
  \item \textsuperscript{115} 45 C.F.R. § 205.10(a)(5) (1992).
  \item \textsuperscript{116} 462 F.Supp. 436 (N.D. Cal. 1978).
  \item \textsuperscript{117} 616 F.2d 407, 412 (9th Cir. 1980).
  \item \textsuperscript{118} \textit{Id.}
  \item \textsuperscript{119} 612 P.2d 1158 (Colo. Ct. App. 1980).
\end{itemize}
the plaintiff, a nursing home patient suffering from multiple sclerosis. The nursing home planned to transfer the plaintiff, a Medicaid recipient, to a home in another town for nonmedical reasons. The court found that "expert testimony at the hearing established that plaintiff would suffer 'transfer trauma' if moved away from his support group . . . . This trauma could present both psychological and physical side effects and worsen his condition."\textsuperscript{120} Because this injury would not be compensable by adequate damages, the court regarded an injunction as an appropriate remedy.

Finally, in \textit{Health Care Administration Board v. Finley},\textsuperscript{121} the New Jersey Supreme Court upheld the right of the state Health Care Administration to issue a regulation requiring nursing homes to provide beds to indigent patients. According to the court, in the absence of this regulation, indigent patients could be summarily transferred to their detriment if their benefits expired. Because the regulation was a reasonable means of preventing transfer trauma, it represented a legitimate exercise of the state’s police power.\textsuperscript{122}

2. \textit{O’Bannon v. Town Court Nursing Center}

The trend toward judicial sympathy for patients who might suffer transfer trauma was interrupted by the U.S. Supreme Court’s decision in \textit{O’Bannon v. Town Court Nursing Center}.\textsuperscript{123} When HEW notified the nursing home that it was being decertified, both the home and a group of patients filed suit to block HEW’s action. A district court issued a preliminary injunction, but when HEW denied Town Court’s petition for reconsideration, the court dissolved the injunction. The home and the patients both appealed. The Third Circuit Court of Appeals decided the case on the same day as \textit{Klein v. Califano}.\textsuperscript{124} The appeals court denied further relief to the home, but held that the patients were entitled to a hearing prior to termination of their benefits.\textsuperscript{125} Helen O’Bannon, Secretary of the Pennsylvania Department of Public Welfare (the agency responsible for administering the state Medicaid program), petitioned for certiorari.

The respondents, as well as several \textit{amici curiae}\textsuperscript{126}, filed briefs in

\textsuperscript{120} \textit{Id.} at 316.
\textsuperscript{121} 415 A.2d 1147 (N.J. 1980).
\textsuperscript{122} \textit{Id.} at 1153.
\textsuperscript{123} 447 U.S. 773 (1980).
\textsuperscript{124} \textit{Klein v. Califano}, 586 F.2d 250 (3rd Cir. 1978), was decided first, and it was followed in \textit{Town Court Nursing Center v. Beal}, 586 F.2d 280 (3rd Cir. 1978).
\textsuperscript{125} See, \textit{Klein v. Califano}, 586 F.2d 250, 258 (3rd Cir. 1978).
\textsuperscript{126} \textit{Amici} included (1) Jill Harris and the Residents of Edgefield Manor; (2) The Na-
which they provided the court with copious information about the potentially devastating effects of transfer trauma. However, the majority responded to this information with a lack of interest bordering on disdain. Ignoring the impassioned arguments of the respondents and the amici, the opinion simply acknowledges the evidence and blandly states, in a footnote, that the justices will “assume for the purposes of this decision that there is a risk that some residents may encounter severe emotional and physical hardship as a result of a transfer.” 127 The Court goes on to characterize the impact of relocation on residents as “an indirect and incidental result of the Government’s enforcement action, [that] does not amount to a deprivation of any interest in life, liberty, or property.” 128 According to the Court, the due process right is not triggered by “indirect adverse effects of governmental action.” 129 Furthermore, the government’s actions are intended to benefit the patients. Finally, in the Court’s view, the home has a strong economic incentive to challenge the decertification, and so will adequately represent the interests of the patients. 130

There are several flaws in the Court’s reasoning. First, it is not at all clear that transfer and its attendant risks are an indirect result of the government’s decision in any coherent sense. As noted by The Legal Aid Society of New York, et al. in their amicus brief, and acknowledged by Justice Blackmun in his concurrence, transfer is “a necessary, not an incidental, consequence of decertification;” 131 “a basic purpose of decertification is to force patients to relocate.” 132 Thus, the relocation and its effects are truly direct products of the government’s action.

Second, in declaring the government’s decertification decision to be for the patients’ benefit, the Court makes two unsupported—and unstated—assumptions: (1) that the home is (as the government asserts) providing substandard care and therefore is an unqualified facility; and (2) that the harm from residing in such a facility exceeds

127. 447 U.S. at 784 n.16.
128. Id. at 787.
129. Id. at 789.
130. Id. at 789 n. 22.
131. Brief for Amicus Curiae, The Legal Aid Society of New York City, Legal Services for the Elderly Poor, Coalition of Institutionalized Aged and Disabled, Inc. at 39, O’Bannon (No. 78-1318).
132. 447 U.S. at 793 (Blackmun, J., concurring).
the harm that would result from transfer. Justice Brennan observes in his dissent that "[i]t is no answer to say that respondents' only right is to stay in a qualified home, . . . because whether the home is qualified is precisely the issue to be determined." The patients were seeking a right to be heard on this very question. The Court denied them that right by taking the government's word on the subject as gospel. Because the Court refuses to recognize that the home's status is a legitimate subject of controversy, the Court is blind to the valuable contribution that patients could make to a resolution. Furthermore, because the majority gives such short shrift to the transfer trauma argument, the Court fails to see that the "cure" of transfer may be much worse that the "disease" of substandard care—depending, of course, on how serious the facility's deficiencies are, which is exactly the question that needs to be answered.

Finally, the Court assumes that the nursing home can adequately represent the rights of the patients. Both Justice Brennan and the amici disagree with this view. Justice Brennan states that "the patients have some interests which are separate from the interests of the provider, and they could contribute some information relevant to the decertification decision if they were given an opportunity." Amici Jill Harris et al. argue that while the facility can try to defend itself regarding the sufficiency of cleanliness, staffing, maintenance, recordkeeping, etc., only the patients can provide vital information about their social ties, and the effect that transfer will have on their lives. "It cannot be assumed that doctors or other medical personnel involved in a survey team are familiar with transfer trauma or with the patient conditions which correlate with high risk in a move." If the patients are not given a voice, important information will be omitted from consideration.

In his concurrence, Justice Blackmun chastises the majority for failing to give the transfer trauma issue sufficient weight. Although the Court assumes that "transfer trauma" exists, . . . it goes on to reject this argument. By focusing solely on the "indirectness" of resulting physical and psychological trauma, the Court implies that regardless of the degree of the demonstrated risk that widespread illness or even death attends decertification-

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133. Id. at 806. (Brennan, J., dissenting).
135. 447 U.S. at 806 (Brennan, J., dissenting).
136. Brief for Amicus Curiae Jill Harris and the Residents of Edgefield Manor at 76-77, O'Bannon (No. 78-1318).
induced transfers, it is of no moment. I cannot join such a heartless holding.\textsuperscript{137}

Surprisingly, Justice Blackmun then proceeds to undertake his own incredibly perfunctory analysis of the transfer trauma literature. Apparently relying entirely on Borup, Gallego, and Heffernan's declaration that transfer trauma is a myth, Blackmun states that "many informed researchers have concluded at least that this danger is unproved," and opines that "[r]ecognition of a constitutional right plainly cannot rest on such an inconclusive body of research and opinion."\textsuperscript{138} Although Blackmun also cites two other studies that did assert the existence of transfer trauma, he only gives credence to Borup, et al. This is hardly the balanced evaluation of the data one would have anticipated based on Blackmun's compassionate preamble. As George Annas has observed,

\begin{quote}
[I]t seems somewhat extreme to base a judicial decision primarily on one article that is not even cited or discussed by the other justices. The article may well be authoritative, but its mere appearance in \textit{The Gerontologist} does not make it so. Indeed, Blackmun also cites two other articles from this journal that came to a different conclusion.\textsuperscript{139}
\end{quote}

Thus, the transfer trauma phenomenon was never given adequate attention by the Supreme Court.

3. Subsequent Cases

Justice Blackmun's concurrence in \textit{O'Bannon} appeared to leave the door ajar for the introduction of better evidence establishing the existence of transfer trauma.\textsuperscript{140} The majority had also indicated that there might be a distinction between groups of residents who were relocated in mass transfers as a result of decertification or closure decisions by the government (an "indirect" effect), and individual patients who were forced to move as a result of government determinations (presumably a "direct" effect).\textsuperscript{141}

\textsuperscript{137} 447 U.S. at 802-03 (Blackmun, J., concurring).
\textsuperscript{138} \textit{Id.} at 804.
\textsuperscript{139} George J. Annas, \textit{Transfer Trauma and the Right to a Hearing}, 10 HASTINGS CTR. RPT. 23, 24(1980); see also James A. Thorson, \textit{Relocation of the Elderly: Some Implications from the Research}, 1 GERONTOLOGY REV. 28 (1988) (Blackmun relied on Borup's study, which excluded the most vulnerable patients, and Blackmun apparently misinterpreted the cited study by Boursom and Tars).
\textsuperscript{140} See e.g., Maryanne Newman-Hafner, Note, \textit{O'Bannon v. Town Court Nursing Center, Inc.: Limiting the Due Process Rights of Nursing Home Residents}, 24 ST. LOUIS L.J. 828, 851 (1981). ("While there is presently much debate about the existence of transfer trauma, perhaps the Supreme Court will reevaluate its position on this claim if the medical community can conclusively establish the existence of this phenomenon.")
\textsuperscript{141} \textit{O'Bannon}, 447 U.S. at 785-87.
In *Yaretsky v. Blum*, the plaintiffs persuaded the Second Circuit Court of Appeals that *O'Bannon* was distinguishable from their situation, and that the *O'Bannon* decision had not "foreclose[d] the question [of] whether there is a liberty interest in the avoidance of transfer trauma ...." Moreover, *O'Bannon* was not decided on the basis of a record that included much detailed information about the existence of transfer trauma .... We note that the record in this case contains ample evidence that transfer of elderly patients, even when it does not pose an increased risk of mortality, carries with it the undeniable possibility of emotional and psychological harm—at least in the case of many individuals. To us this does not seem any less a "liberty interest" than a prison inmate's interest in not being transferred from a penitentiary to a psychiatric hospital; which interest was accorded constitutional protection in *Vitek v. Jones* ....

However, in reaching its decision in favor of the plaintiffs, the court of appeals had to find that the transfer decisions were state action. This aspect of the decision proved fatal to the plaintiffs' case when it was appealed to the Supreme Court as *Blum v. Yaretsky*. In *Blum* the Supreme Court held that, although the transfer decisions were necessitated by the Medicaid payment scheme, the actual determination that a patient required a different level care than he or she was receiving was made by a private doctor, and so there was no state action. The additional evidence on transfer trauma in the record was to no avail, because the Court never reached that element of the case.

Since *Yaretsky v. Blum*, most courts presented with transfer trauma arguments have adopted the rationale of *O'Bannon* either expressly or implicitly. However, there is evidence of a gradual

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143. *Id.* at 821.
144. *Id.*.
change in the last few years, reflecting recognition of transfer trauma by numerous state legislatures. In 1986 the Court of Appeals of Michigan found that a Medicaid patient with muscular dystrophy could be transferred from a hospital to a nursing home, despite his claim that he would suffer transfer trauma as a result. Nevertheless, the court did not discount the existence of the phenomenon; it merely decided that "the evidence did not show a sufficient likelihood that petitioner would suffer 'transfer trauma.'"\(^{147}\)

Subsequently, several cases have specifically acknowledged the existence of transfer trauma and the efforts by legislators to deal with the problem. For example, the U.S. District Court for the Western District of Missouri based its decision in *Lexington Management Company, Inc. v. Department of Social Services*\(^{148}\) in part on the legislative history of the Omnibus Budget Reconciliation Act of 1980. In explaining its decision to enjoin the federal and state defendants from withholding Skilled Nursing Facility ("SNF")-level Medicaid funding for the plaintiff's facility pending exhaustion of the plaintiff's administrative remedies, the court stated, "Congress... recognized that alternatives to immediate decertification were desirable to minimize 'the need for traumatic transfers of large numbers of patients during the time needed improvements are being made in the facility.'"\(^{149}\) The court was persuaded that, in the case before it, the residents would suffer transfer trauma if the home were closed as a result of the threatened reduction in funding.\(^{150}\) Therefore, the government's decision to terminate SNF-level Medicaid funding rather than seek some less drastic alternative "fl[ew] in the face of congressional intent, and therefore, constitute[d] a gross and impermissible abuse of discretion."\(^{151}\)

The very same legislative history was invoked by an Ohio district court in *Wayside Farms v. U.S. Department of Health and Human Services*.\(^{152}\) According to the *Wayside I* court, Congress recognized that "there is a nationwide shortage of skilled nursing home beds and that there is a validity in forestalling the need for traumatic transfers of large numbers of patients pending correction of deficiencies which do not pose an immediate threat of harm to


\(^{148}\) 656 F. Supp. 36 (W.D. Mo. 1986).

\(^{149}\) Id. at 44 (quoting H.R. REP. No. 96-1167, 96th Cong., 2nd Sess., reprinted in 1980 U.S. CONG. & AD. NEWS 5526, 5570).

\(^{150}\) 656 F. Supp. at 41.

\(^{151}\) Id. at 45.

\(^{152}\) 663 F. Supp. 945 (N.D. Ohio 1987) [hereinafter *Wayside I*].
them.\textsuperscript{153} The plaintiff had offered evidence that transfer would be
difficult or impossible for many of its residents,\textsuperscript{154} and the court
therefore enjoined the government from terminating Wayside's pro-
vider agreement or its Medicaid funding until its administrative
remedies were exhausted.\textsuperscript{155}

However, when the case returned to the Ohio district court a
year later, a different judge gave minimal weight to the plaintiff's
transfer trauma argument. In \textit{Wayside Farm, Inc. v. Bowen},\textsuperscript{156} the
decision to terminate Wayside's provider agreement had been up-
held by the Appeals Council. The facility was appealing that rul-
ing, and was again seeking an injunction to maintain its Medicaid
funding pending its latest appeal. The district court held that in-
junctive relief was inappropriate because the plaintiff had shown lit-
tle likelihood of success on the merits.\textsuperscript{157} (The facility's challenges
to the Appeals Council's decision were primarily procedural, and
the court found them unpersuasive.)\textsuperscript{158} The court purported to give
equal consideration to the question whether granting or denying the
injunction would cause substantial harm to others, and acknowl-
edged that "some of the residents may suffer severely from a move
should the funds be terminated."\textsuperscript{159} Nevertheless, the court in ef-
fect declared the harm to be irrelevant because of the likelihood that
the facility would lose eventually.

Notwithstanding the evidence that many of the residents of Way-
side may suffer from what has been referred to as "transfer
trauma," the Court is of the view that it would be just as harmful
for the residents to prolong an inevitable move given the low
showing of likelihood of success on the merits of the plaintiff's
case.\textsuperscript{160}

This holding essentially nullifies the "substantial harm" prong of
the injunctive relief analysis, but beyond that, it reveals a deficient
understanding of transfer trauma. A delay in transferring the resi-
dents—even if such a move were demonstrably inevitable—would
certainly \textit{not} be equally harmful; on the contrary, it would allow
more time for adequate preparation and provision of support serv-
ices. The \textit{Wayside II} court's failure to grasp the nature and signifi-

\begin{thebibliography}{99}
\bibitem{153} Id. at 952.
\bibitem{154} Id. at 954.
\bibitem{155} Id. at 955.
\bibitem{156} 698 F. Supp. 1356 (N.D. Ohio 1988) [hereinafter \textit{Wayside II}].
\bibitem{157} Id. at 1364.
\bibitem{158} Id. at 1362-64.
\bibitem{159} Id. at 1365.
\bibitem{160} Id.
\end{thebibliography}
cance of transfer trauma is further illustrated by the court's quotation from *Gruter Foundation, Inc. v. Bowen.* According to the *Gruter* court, "if the present surroundings are found injurious to the residents' health and safety, the trauma caused by remaining there is of greater concern to this court . . . ." Apparently both the *Gruter* and *Wayside II* courts fell into the same error as the Supreme Court in *O'Bannon,* by assuming that the government's disputed determination about the state of a facility must be correct, and that the harm from the facility's deficiencies must be greater than the potential harm from transfer. In at least some cases, either or both of these assumptions will be wrong. Residents may suffer harm or even death as a result of jurists' lack of understanding.

Neither the *Gruter* nor the *Wayside II* court mentioned the Congressional concern over transfers that was articulated in the legislative history of the Medicaid statutes, and upon which the *Wayside I* court relied. It is also interesting to note that Ohio (where these three cases were decided) is not a state that currently acknowledges transfer trauma in its state laws.

The Missouri Supreme Court in *Villines v. Division of Aging* stated that "[t]he severity of the complications from 'transfer trauma' ranges from mild depression to severe illness and death," and in deciding to overturn the state's decision to revoke the plaintiff's nursing home license, the court considered the intent of the state legislature in adopting nursing home regulations.

The legislature no doubt saw the availability of remedies less drastic than the shutdown of a deficient home as being in the best interest of nursing home residents for many of whom forced transfers occasioned by revocation would be dispiriting and even life-threatening. The court concluded that revocation should be a last resort, to be implemented only when all efforts to secure compliance had failed.

A California Court of Appeal similarly invoked the intentions of

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162. *Gruter, 652 F. Supp. at 254, quoted in Wayside II, 698 F. Supp. at 1366.* Even more disturbing, the court in *Gruter* went on to state that "although any trauma incumbent in transferring Gruter residents is of great concern to this court, their health and safety is of far greater concern," as if transfer trauma were totally unrelated to the residents' health. 652 F. Supp. at 254.

163. *See supra* notes 129-30 and accompanying text.

164. 722 S.W.2d 939 (Mo. 1987) (en banc).

165. *Id. at 946.*

166. *Id. at 945* (quoting Stiffelman v. Abrams, 655 S.W.2d 522, 530 (Mo. 1983) (en banc)).
the legislature in *Newland v. Kizer*. Plaintiffs who were facing transfer had filed suit to require the state Department of Health Services to promulgate regulations governing operation of nursing homes by receivers. The court found that the department was required to do so, because "the Legislature intended to provide an alternative to avoid the transfer trauma accompanying the abrupt involuntary transfer of frail elderly patients from one nursing home to another."  

Finally, in *Good Shepherd Health Facilities of Colorado v. Dept. of Health*, another receivership case, the Colorado Court of Appeals declared that "[the statute] expressly provides that the statutory purpose is to safeguard against 'potential transfer trauma' resulting from relocation of patients, when, as here, a long-term health care facility is closed because of violation of applicable laws and regulations." On this basis the court decided that the state could not withhold funds from the receiver. Thus, legislative recognition of transfer trauma has clearly influenced the courts in the years since *O'Bannon*.

## B. Legislation

1. Federal

Evidence of congressional interest in and concern over transfer trauma dates from as early as 1974. In that year, testimony by researchers Lieberman and Pastalan was read into the Congressional record along with a statement by Illinois senator Charles Percy, in which he cautioned that aspects of federal Medicaid legislation could force relocation of as many as ten thousand elderly patients, and thereby result in severe harm, even death, for many of them. At the end of 1974, a Senate subcommittee issued a report documenting problems with nursing home care—including relocation difficulties—entitled *Nursing Home Care in the United States: Failure in Public Policy*.

The federal Medicaid statutes contain various safeguards of patients' welfare, including portions referred to as the Medicaid resi-
students’ Bill of Rights. The Medicaid program must be administered in a manner that promotes the “best interests” of patients. 173 In addition, residents may not be transferred except for medical reasons, or for the welfare of the patient or other patients, or for non-payment. 174 Furthermore, patients must be given notice and the opportunity for a hearing before their benefits can be reduced or terminated. 175 Additionally, the Omnibus Budget Reconciliation Act of 1987 (OBRA) refined existing regulations regarding the transfer of nursing home patients. 176

2. State

Many states have enacted legislation to address the problems of nursing home patients, including relocation. Ten states plus the District of Columbia actually mention transfer trauma in their statutes. 177 Most state laws are narrowly tailored to remedy specific problems, but a few states attempt to ensure the best possible treatment of elderly patients in all phases of long-term care.

Rhode Island addresses the problem of discrimination against Medicaid patients—who may be impermissibly transferred when their personal finances are exhausted to make room for private-pay patients—with the following rule:

Every patient who has been a resident of a nursing home which participates in Rhode Island’s medical assistance program and has made payments from private funds for at least 6 months shall, upon depletion of personal funds, be permitted to remain as a resident of said nursing home at the rate of payment to be paid by the department of social and rehabilitation services. 178

Similarly, the Illinois Department of Public Aid is authorized to continue paying for care of Medicaid recipients who live in a home that voluntarily withdraws from participation in the program. 179

Connecticut requires adequate planning prior to discharge.\textsuperscript{180} A number of states have "anti-dumping" laws designed to prevent nursing homes from sending patients to acute-care hospitals and then refusing to readmit them when the health crisis has passed.\textsuperscript{181}

An example of a comprehensive legislative scheme is provided by the California Health and Safety Code. Section 1325 states: "The legislature finds and declares that the transfer trauma which accompanies the abrupt and involuntary transfer of patients from one nursing home to another should be avoided when reasonable alternatives exist." The statute goes on to provide for the appointment of a receiver by the state Department of Health Services if continued operation by the licensee would present a danger to the patients. Other sections of the California Health and Safety Code promulgate stringent requirements and procedures for patient transfers, including pre-move evaluations of the patients' health status, notice, arrangements for future care, counseling when needed (as determined by the department), and the formulation of a relocation plan for any ten or more residents likely to be transferred because of decertification or any other change in provider status. All of the statutes specify that efforts must be made to minimize transfer trauma.\textsuperscript{182}

Illinois has adopted comprehensive transfer laws that provide for written notice, opportunity for a hearing, a right of appeal, and many other aspects of involuntary transfers and discharges.\textsuperscript{183} Michigan also now has a broad legislative scheme covering this area.\textsuperscript{184}

IV. CONCLUSION

Despite the Supreme Court's reluctance to acknowledge the seriousness of transfer trauma in \textit{O'Bannon v. Town Court Nursing Center}, the phenomenon now appears to be increasingly accepted as genuine and significant. In its 1989 publication on nursing home law, the Practicing Law Institute stated that "[t]ransfer trauma is now a generally recognized phenomenon that must be considered in

\textsuperscript{180} CONN. GEN. STAT. ANN. § 19d-535 (West 1992).

\textsuperscript{181} CONN. GEN. STAT. ANN. § 19a-537(a)(1), 19a-537(d) (1992); MICH. COMP. LAWS ANN. § 333.21777 (1992).

\textsuperscript{182} See CAL. HEALTH & SAFETY CODE §§ 1336.2, 1556, 1568.073, 1569.54 (West 1990).

\textsuperscript{183} ILL. REV. STAT. Ch. 111 1/2, §§ 4151-101 to 4153-803 (Smith-Hurd 1981).

transfer decisions.” Nevertheless, legal responses to the problem vary widely, so patients and their advocates as well as facility operators may still have difficulty in securing judicial assistance. For example, Wisconsin attempted to adopt a “variance” plan under which, in certain circumstances, patients could remain in a facility even though a transfer to a different level of care had been recommended. In one such instance, a terminal patient was permitted to stay in the facility where he and his wife lived so that they could be together until he died. The federal Health Care Financing Administration (HCFA), however, did not approve of this arrangement, and reduced Wisconsin’s Medicaid funding in response. The Court of Appeals for the Seventh Circuit held that the HCFA decision was not arbitrary or capricious, and refused to consider transfer trauma arguments because Wisconsin had not made them at the administrative level (the district court had remanded for additional factfinding on the issue).

The varied treatment that transfer trauma has received in the courts is indicative of an underlying problem: judges often have no idea how to deal with evidence from the social sciences (or other forms of “soft” science such as psychology and psychiatry). They may distrust such probabilistic evidence, and deny that data about how people have behaved in the past has relevance to proving the facts in the case at bar. As a result of these attitudes, judges may try to ignore social science data, as the Supreme Court majority did in O’Bannon. Alternatively, they may be tempted to use social science data selectively to bolster the rationale for the outcome they prefer, as Justice Blackmun did in his O’Bannon concur-

186. Wisconsin Dept. of Health & Social Serv. v. Bowen, 797 F.2d 391 (7th Cir. 1986).
188. See supra notes 122-23 and accompanying text.
In addition, courts may fail to recognize that scientific knowledge is cumulative; if a particular theory was rejected by another court years before, that fact may be dispositive, even though much corroborating evidence may have been added in the interim. All of these tendencies are exacerbated when the body of knowledge in the area being considered is inconclusive or conflicting.

A number of proposals have been offered to address this problem. In the 1970s, the formation of a "science court" was suggested as a solution for the difficulties presented by all kinds of scientific evidence—both "hard" and "soft"—for jurors as well as judges. More recently, commentators have advocated the creation of panels of experts or the use of specially qualified juries in certain cases. Other proposals include the use of court-appointed experts, heightened screening of experts and their testimony through assiduous judicial application of the federal rules of evidence, bifurcating issues at trial, and removing some types of cases from the judicial system entirely.

Professors John Monahan and Laurens Walker are willing to leave the evaluation of social science evidence in the hands of judges, but they have suggested a tripartite system for determining how such evidence should be treated in a particular case. First, when courts are using social science to formulate rules of law, they should treat it as they would legal precedent—as a source of "social authority," rather than a source of facts. The data should be presented by the parties in legal briefs, rather than by testimony. Additionally, the court should be free to conduct its own research. Judges could weigh the merits of scientific research according to principles similar to those they use in evaluating legal precedents: acceptance in the relevant community, valid methods, applicability to the instant case, and support in other research. Appellate courts would not be bound by the trial court's opinion of the scientific evidence, as they are when the data are regarded as facts, and new research would enable the courts to reach new conclusions.

The second part of Monahan and Walker's system concerns the use of social science to resolve particular factual disputes. In such

189. See supra notes 134-35 and accompanying text.
192. Id.
cases, the data provide a "social framework" for making factual determinations.194 Examples might include information about the general reliability of eyewitnesses, or expert testimony about psychological syndromes such as battered woman syndrome, rape trauma syndrome, or child sexual abuse syndrome. Social frameworks are a combination of social authority and fact.195 According to the model, generalized social framework evidence should be treated as social authority. Walker and Monahan express confidence that judges are fully capable of evaluating social science data.196

Finally, the third use of social science involves studies done for specific cases, such as studies of consumer perceptions conducted pursuant to trademark infringement litigation, or other applications of social science methodology to prove specific facts at issue in a case. Monahan and Walker call such data "social facts." Research of this type is also used to decide factual questions rather than to promulgate rules of law.197 According to Monahan and Walker, judicial acceptance of a particular social science methodology as valid should have precedential effect, but specific factual conclusions based on social science should not.198

Monahan and Walker's concept of social science as authority is attractive because it might have the salutary effect of prompting judges to treat social science with greater respect and resist the temptation to disregard it. Judges would be compelled to consider social science evidence with care if it were reversible error to ignore it or to adopt one party's version of the data without a legitimate rationale for such preference.

While some extremely complex "hard" scientific data may be beyond the ken even of judges, this does not appear to be the case with most social science. Thus, it should not be necessary to have separate social science courts or panels (except, perhaps, in rare instances involving unusually sophisticated statistical analyses). If, under Monahan and Walker's system, parties were to brief the issues comprehensively, and judges were to carefully evaluate the information they were given, it should be possible to arrive at just

195. Id. at 587.
196. Id. at 589.
198. Id. at 887.
decisions. However, for the present we must work within the legal system as it is.

Some commentators have argued that the legislature—not the courtroom—is the proper forum in which to address the problem of transfer trauma. Nevertheless, it would seem that in at least some cases, legislative remedies will come too slowly for threatened patients. Of course it should not be necessary to go to court and plead a parade of horribles in order to obtain the protection and consideration that elderly nursing home residents deserve, but at times it is necessary. Government agencies may become so obsessed with their "enforcement credibility" that they lose sight of the welfare of the patients.

On the other hand, winning the right to stay in a facility that is truly substandard is probably a Pyrrhic victory. Advocates for the elderly should be fighting, in the long term, for diligent cooperative efforts on the part of operators and regulators to maintain high quality facilities and care, and for laws that require adequate preparation and counselling of residents who do need to be transferred. The evidence showing that patients may indeed be better off after transfer to a superior facility with proper support services has been largely ignored. Like the blind men in the fable, legislators, government administrators, and elder advocates must see the "big picture." They must recognize both that poorly planned and executed involuntary moves can be extremely harmful to elderly patients, and also that well-planned and smoothly implemented relocations—moves that let patients feel they are in control—can promote health and enhance life.


200. See Amicus Curiae Brief for Harris, et al., supra note 136, at 63-64; Respondent's Brief at 13-16, O'Bannon (No. 78-1318), quoting district court bench opinion and order. ("[P]eople are much more interested in sustaining previously stated positions ... than they are in actually carrying out the very beneficial program having to do with nursing homes." Id. at 14.)