Is There a Conflicted Surrogate Syndrome Affecting Quality of Care in Nursing Homes?

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Is there a point at which family complaints about care cease to be constructive and become excessive and counterproductive? Do excessive complaint behaviors represent a “conflicted surrogate syndrome” that is indicative of psychopathology in the family member or family system? Can this psychopathology result in avoidance behavior by the nursing staff sufficient to result in poor care? While many family/resident complaints are valid and should be viewed as constructive there are occasions when excessive complaints by the family of a nursing facility resident are a result of psychiatric illness or psychological problems in the family member(s) or are evidence of an abnormality in the family system. This series of brief case reports is offered to create discussion of what might be termed a “conflicted surrogate syndrome” that may result in avoidance behavior by staff and consequent poor care. (J Am Med Dir Assoc 2006; 7: 168–172)

This inquiry began when an ombudsman (Dr. Kidder) reported case histories to a long-term care physician (Dr. Smith) asking for his opinion regarding whether excessive family complaints could unintentionally result in poor care. A discussion followed that led to the question entitling this case series presentation.

Family complaints directed to the nursing facility or to outside authorities are often legitimate. However, at times complaints may be unwarranted. Enough of these unwarranted complaints may eventually lead to avoidance behavior by the staff causing them to miss important clues that are indicative of a change in resident status or to unwarranted transfers. We propose that potential cases of this hypothetical phenomenon should be reported and a dialogue begun to determine if it should be recognized as “conflicted surrogate syndrome.”

As background and to evaluate this hypothesis, we present data concerning nursing home complaints, resident acuity, a PubMed literature search, and case histories from our experience.

NURSING HOME COMPLAINTS

In July of 2003 the Office of the Inspector General analyzed National Ombudsman Reporting System (NORS) data from 1996 through 2000. These data came from 9 states encompassing 30% of US nursing home beds. The top 12 complaints represented 74,566 complaints or about 40% of the total. The number of complaints has grown from approximately 145,000 in 1996 to approximately 186,000 in 2000.1

During the same period resident acuity levels have increased as follows: Management Minute Index 2%; bedfast 7%; contractures 17%; taking psychoactive drugs 19%; pressure sores 22%; and total nursing hours per resident day 6%.2

It is worthwhile to compare these complaints about care issues to acuity and staffing levels over the same period of time since increasing acuity might lead to an increase in complaints. This could be a consequence of inadequate caregiver knowledge, staffing, systems, equipment, or funding to deliver state-of-the-art care. Alternatively, the more frequent bad outcomes associated with increasing acuity may be misconstrued by family as poor care. However, the complaint and acuity data presented above does not prove this one way or another. To a degree these data are congruent with family/resident complaint data; however, hypothesizing a cause-and-effect relationship would be premature.

LITERATURE SEARCH

We did a PubMed search to determine if there was literature relevant to a proposed “conflicted surrogate syndrome”; that is, complaints made other than in good faith, complaints as a result of psychological problems or mental illness in those who complain, or due to pathological family systems. We found no articles; however, our search did discover 6 publications of peripheral interest related to complaints about...
nursing home care. These studies are summarized for background.

In a study by Lindgren and Murphy, 36 family members of nursing home residents with cognitive impairment were asked to complete a questionnaire designed to learn about perceptions of care. Significant differences were found in 8 items of physiologic and psychosocial functioning: difficulties with chewing, swelling of feet, orthopnea, weakness, easy bruising, recognition of people, lack of privacy, and boredom. In all these areas, nurses rated the issues as being less problematic than did the family members.

Is it possible that family members are reacting to these functional losses and expecting nurses to react with the same intensity? And when they don’t, does the discordance induce the complaint behavior? Could this be one reason why the increase in complaints seems to correlate with the increase in acuity levels?

In another study by Attree of the University of Manchester, 34 acute medical patients and 7 relatives were asked questions using a qualitative approach. Good quality care was characterized as individualized, patient focused, and related to need. By definition, quality care was also provided with demonstrated involvement, commitment, and concern. Overburdened staff may find it difficult to exhibit these qualities consistently and thus make chronic complaint behaviors more likely.

In the authors’ experiences, required CNA training does not include, and in-service education rarely involves education on displaying professional deportment.

Three nursing home studies from Northern Ireland, Canada, and the Netherlands agree that family members should not be treated as outsiders but should be integral to the care process. The following quotations illustrate this point:

“Despite the generally accepted notion that involving family members in care is important, family members were regularly treated as outsiders. This demonstrated that there is room for improvement in the communication by nursing home staff with family members.”

“This article addresses issues regarding facility policies and staff attitudes toward family involvement, particularly whether the family member is seen as an integral part of the care system or peripheral to the care system.”

Another study by Ryan and Scullion suggests differing perceptions as a possible source of conflict. Family members thought they should have a greater role in care than did nursing personnel. Families trusted the clinical judgment of the staff. But staff may be reluctant to trust family members, especially in situations where care involved an element of risk. “The results indicate that families in this study were more willing to help in nursing home care and were perhaps undervalued as a resource within the nursing home setting.”

We note that efforts to involve the family in caregiving in the United States may be limited by federal regulations at 483.75(e)(4), which requires nurse aides to complete 75 hours of training. We mention this regulation because there have been reports that family members have been prohibited from providing care (eg, assistance with eating) as a result of this regulation.

Hertzberg and Ekman describe the experiences of relatives and staff who are caring for aged people with dementia living in nursing homes. Their goal was to study relationships and interactions and try to identify obstacles and promoters to good relationships and interactions. Observation of staff/family group discussion was conducted for 27 hours. Influence, trust, participation, and conflict resolution were thought to be important issues. “Suggestions for enhancing relationships between relatives and staff include:

- preplanned, informal, individual conversations between relatives and staff;
- development of ways to give regular 2-way feedback about matters concerning the resident and the relationship between staff and relatives;
- giving staff credit for measures taken to facilitate relatives' involvement in the nursing home care;
- measures to improve documentation about family involvement; and
- working together with minor practical tasks.”

With this background we offer several cases as an initial description of what we propose to be recognized as “conflicted surrogate syndrome.” We suggest that, while many complaints are justified and should be viewed as constructive criticism, not all complaints are bonefide or justified by the realities of the situation. Some are simply due to lack of knowledge, incorrect beliefs, or misperceptions. Others are due to unreal expectations driven by psychopathology of the family member or family system. The latter are the focus of this case series description.

**CASE HISTORY ONE**

R.F. was an 85-year-old female residing in long-term care. Nursing home administration requested the ombudsman visit and mediate discord between the facility and the resident’s son.

The resident’s son visited every day. The ombudsman observed that virtually each day he would walk directly to his mother’s room and return to the nursing desk in a very short period of time with a complaint. Examples included the fact that his mother had not been changed, she was not dressed in daytime clothing, had not been fed, and had not received planned medication. The ombudsman observed that due to the frequency of complaints and angry approach by R.F.’s son that nursing staff would become silent and avoid him. The ombudsman was of the belief that most of these complaints were unfounded, but not. The ombudsman also observed that nursing staff attempted to avoid caring for R.F. and to avoid her room for fear of criticism by her son.

The son’s motivation for excessive complaint behavior seemed to come from a combination of a lifetime of complaint behavior stemming from a belief that everyone was cheating and overcharging him. On one occasion a financial dispute arose with the pharmacy provider. When this was resolved in
his favor, his response was not thankful or positive. Instead, he immediately launched a complaint about the nurses not administering the drugs. When the Ombudsman showed him the medication administration record to prove that the drugs were administered, he complained that the records were falsified. Subsequently his mother began refusing food. The son insisted on a nasogastric feeding tube against the recommendation of her physicians. She later died from aspiration pneumonia. Mr. F wanted to bring a lawsuit against the facility. The ombudsman saw Mr. F months later on 2 occasions. He was still insisting that the facility killed his mother and implied that the ombudsman was culpable.

CASE HISTORY TWO

B.G. was an elderly female admitted to long-term care with congestive heart failure secondary to coronary artery disease with hypertension. Mr. G made lengthy visits to his wife daily. The ombudsman was requested to visit with the nursing facility administration as a result of multiple complaints by Mr. G that the nursing facility felt were unwarranted. After interviewing, the ombudsman agreed that the complaints were excessive and generally unfounded. On one occasion Mr. G complained to the ombudsman that a poinsettia had been placed in the bathroom. He argued that it was “in the way.” The ombudsman suggested that the flower was cheerful and perhaps he should be less critical. Mr. G finally agreed that this was probably true.

The ombudsman discovered that Mrs. G frequently called her husband when he was not at the facility to complain to him about various aspects of care. On one occasion she had called to tell him that the call light had not been placed within her reach. Within minutes Mr. G had traveled to the facility since he lived nearby. He discovered that the call light was indeed within her reach and in clear view.

On another occasion Mrs. G had complained to the ombudsman about pain in her right ear. The ombudsman suspected an external ear infection and brought this to the attention of a staff nurse. It was the ombudsman’s perception that this nurse made no effort to review the chart, assess the patient for this complaint and the ombudsman speculated that chronic complaining by the resident and her husband had created a callousness of the nursing staff and the dynamic much like that of the old fable “The Little Boy Who Cried Wolf.” Subsequently, on another shift this complaint was addressed and the attending physician diagnosed otitis externa and prescribed an antibiotic.

CASE HISTORY THREE

E.S. was an 82-year-old female resident residing in long-term care in a comatose state. The daughter visited each evening.

E.S.’s daughter approached the ombudsman in the nursing facility hallway one evening as the ombudsman visited another resident. This daughter expressed excessive thanks for “listening to her when no one at the nursing home would.” She brought the ombudsman into her mother’s room to show him some of the feeding tube formula that had been spilled on the floor. She was very upset. She told the ombudsman of a particular nurse that had pulled the tube out purposefully and had caused this spill. The ombudsman indicated that he knew this nurse quite well and he felt that it was doubtful that this nurse would perform such an act on purpose. He also remarked that this did not appear to be a catastrophe and he would notify someone to come and clean up the spill and also someone to reinsert the tube. After bringing this to the attention of the nursing staff, the spill was promptly cleaned up and the tube was reinserted. However, the daughter remained angry and appeared to “want revenge” in the perception of the ombudsman.

The ombudsman counseled that the tube appeared to have been pulled out accidentally or that E.S. had dislodged it herself by moving about in bed. The daughter was unsatisfied with this counseling.

Upon investigation, the ombudsman learned that E.S.’s daughter “kept up a constant stream of complaints” to the facility. Frequently these complaints centered on the availability of comfort items, such as washcloths, diapers, or towels. According to the nursing facility staff this daughter frequently would not attend to her own mother’s personal care but would even deliver personal care, make transfers, etc., to other residents. She had been told by the nursing facility staff that this was not allowed, but to no avail.

In the ombudsman’s perception, the litany of complaints eventually led to the nursing facility staff ignoring the complaints of the resident’s daughter. She then began to slip written complaints under the administrator’s door. The ombudsman found that the nursing facility had offered to help E.S.’s daughter arrange a transfer to another facility where she might be happier but E.S.’s daughter had not availed herself of this offer. Later, after the ombudsman concluded this investigation, the daughter did move E.S. to another facility.

CASE HISTORY FOUR

C.E. was an elderly man who visited his wife in the nursing home daily, staying for hours even though she had severe dementia and was unable to converse. It appeared that she recognized E.G. at some level but she did not speak his name. E.G. had transferred Mrs. G through a series of no less than 5 nursing facilities and had made numerous calls to the state’s toll-free abuse hotline at each of these facilities. The state’s department of human services investigated each complaint. A few were substantiated without citation, but most were unsubstantiated. E.G. would sometimes complain directly to the staff or to the administration, but would not negotiate or collaborate in problem solving. Many of his complaints involved preferences for care rather than standard of care delivery.

A long-time acquaintance volunteered information that seemed to be relevant. Mr. G and Mrs. G had each been married before to other partners. In mid-life they had an extramarital affair that was discovered and each divorced. They then married each other. Mrs. G’s children by the previous marriage, who were now adults, blamed E.G. for the breakup and rarely spoke to him. It was thought that Mr. G’s pattern of excessive complaints and visiting for periods of time well beyond the “call of duty” might be an attempt to please
or placate Mrs. G’s children. Counseling sessions were given and eventually this dynamic was explored and E.G. was allowed to ventilate. Mr. G was told by the physician that after he had stood by his wife this long, his love and devotion should be proven to most people. If his stepchildren could not see that, it was unlikely that they ever would. This was repeated during several sessions and characterized as “black-and-white thinking.” He was also urged to be more forgiving of minor errors by the nursing facility staff and was reminded of the old adage “you catch more flies with honey than with vinegar.” Thereafter, patterns of chronic complaining were diminished (but not absent) and were directed to the facility rather than calling the abuse hotline.

DISCUSSION

What causes the “conflicted surrogate syndrome”?

It is commonly felt that some unjustified complaints by families are driven by guilt. The family member(s) shows overprotective behavior to compensate for guilt in having to place their loved one in a nursing facility. Another theory postulates that family members who have been bombarded by newspaper, television, and congressional exposé concerning poor care in nursing facilities. Consequently, their expectation is for poor performance despite facility practices representing the standard of care.

It might be that the high cost of long-term care when a resident is “self-pay” tends to make a family demand their “money’s worth.” It is possible that some family members whose loved one’s care is funded by Medicaid assume that their love one receives substandard care for this reason, and makes excessive complaints since “the squeaky wheel gets the oil.”

Probably, a plethora of psychopathologies in an individual family member may express with excessive complaining, negativism, hyperirritability, anger, and/or paranoia. Similarly, pathologic family systems could lead to this behavior. “Recruitment” and “triangulation” of a family member by a psychotic, anxious, or depressed resident to be their surrogate and increase the credibility of their pathologic complaints may occur. In this way, the nursing facility resident may manipulate their family member(s) against their caregivers.

In Case One we are unsure of the son’s motivation in excessive complaining about trivial or unjustified matters. While frequent visitation and expression of care are laudable, excessive visitation suggests enmeshment and the possibility of pathological relationship between mother and son. Some information about the son’s lifelong patterns of thinking may suggest paranoid personality type. In the absence of an accurate recognition of the dynamics of this problem and therapeutic approach, this nursing facility staff behaved unprofessionally and tended to withdraw from care to avoid conflict.

Case Two strongly suggests that psychopathologies in the nursing facility resident (eg, depression, passive aggressive personality, etc.) and perhaps a history of greater power in the relationship allowed the resident to triangulate her husband against the nursing facility staff. By doing this she satisfied her motivations to give the nursing facility a problem as well as attain attention from her husband. Eventually, however, like most pathological behaviors, her maladaptive behaviors were detrimental to the resident. Having become “numbed” to chronic complaints, the nursing staff failed to act in a timely fashion on a real medical complaint.

In Case Three it appears that the resident’s daughter may have had a psychiatric or psychological problem expressed as a frequent complaint about care that was trivial or unjustified. She provided hands-on care not only to her mother but also to other residents. This is suspicious for pathologically poor judgment, problem with boundaries, narcissism, or grandiosity (but not proof of same). However, her inability to discontinue this behavior when told that it was inappropriate and perhaps illegal provides much stronger evidence of true pathology. Her failure to accept the nursing facility’s offer to make a transfer given that she was so unsatisfied with their performance also suggests pathology. Why would anyone want to stay at a facility where they believed care was inadequate unless the goal was not quality of care but rather some psychological reward for complaining? In this case the ombudsman suggested that the daughter was on a “mission” to reform the facility.

Finally, this daughter did move her mother to another facility when appeals to an authority were unsatisfying.

Again, in the absence of any recognition of a “conflicted surrogate syndrome,” and a therapeutic approach directed at further identification of the specifics of the problem and resolution of the problem, the pathology went unaddressed to the detriment of the resident.

In Case Four it appears that E.G.’s main motivation for chronic complaining and excessive visitation of his severely demented wife was to prove to the step-children that he really loved her and to defuse their anger and ill will toward him for destroying the marriage of their biological parents. The nursing facility was simply “caught in the crossfire.”

This case identifies that when complaints are brought to the attention of the state survey agency, each is evaluated at face value. No attempt is made to understand multiple complaints or excessive and trivial complaining as evidence of unjustified complaining. This leads to unnecessary work and expense to the state survey agency. This approach to investigate all complaints, even when the latest of a litany of complaints is found unjust, is validating to the pathologic complainer and is countertherapeutic.

CONCLUSION

Other than our own observations, we were not able to find published evidence that confirm the notion that incorrect, unjustified, or pathologic complaints about nursing facility care diminish the quality of nursing home care. In addition, no literature exists that this may be an identifiable clinical syndrome analogous to the pediatric syndrome “Munchausen’s by proxy” or the psychiatric syndrome of “folie à deux” where the pathology of a person suffering mental illness is shared by another person or expresses in that other person due to their social/emotional relationship.

There is significant literature on nurse staffing levels and quality of care. Is it possible that low staffing levels first affect families with high complaint behaviors? This might be espe-
cially true in long-term care facilities where staff must deal, sometimes for years, with the same complaining family members.

We suspect that preplanned, informal, individual conversations with residents and staff (both management and direct care staff) would be a promising option for identifying and creating an individualized therapeutic approach to “conflicted surrogate syndrome.” The interventions proposed by Hertzberg and Ekman may be valuable for valid complainers as well as those with “conflicted surrogate syndrome.” Case Four illustrates the effectiveness of this approach.

We propose that further case reports be made and an ongoing discussion occur to determine by a consensus of experts if a “conflicted surrogate syndrome” should be recognized. From these cases it appears that failure to recognize this syndrome, which we believe is multi-etiologic, leads to wasted efforts by state authorities, failure of physician and long-term care staff to identify, and failures to treat that in turn lead to poor resident outcomes.

REFERENCES