LDS Values and Advocacy for the Nursing Home Patient

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A basic premise of membership in AMCAP is that one will adhere to principles and standards (values) of the Church of Jesus Christ of Latter-day Saints. During the past several years a number of well written articles have appeared that explore areas wherein LDS values may be in conflict with or at least not overly compatible with clinical expectations. (See Bergin, 1980; Madsen and Millet, 1981). It is the writer's impression that, for the most part, these articles urge adherence to gospel values when incompatibility is present.

Possibly as succinctly stated as one could desire, the DeHoyos' argue, "...Mormon therapists are trying to integrate their professional training and the gospel." (DeHoyos, 1983) With this position, the writer has no argument. Yet, in the hard reality of advocating for or working with the nursing home client, incompatibilities are frequent and answers that give comfort and direction to the worker are rather elusive. This article is not an attempt to provide answers nor is it a plea for colleague sympathy nor for a special dispensation to ignore LDS values. Rather, it is hoped it may stimulate an exchange of ideas and thus start a process of resolution of the concerns.

Three concepts common in the health care arena may need brief operationalization: Medicare, Medicaid and Nursing Home. Medicare is a form of insurance, generally available to those 65 years of age and older. It is a federal program authorized under Title XVIII of the Social Security Act. It is especially designed to assist in meeting health care needs for those needing acute hospital care. Due to its "insurance" base, it is socially acceptable. Unfortunately, Medicare coverage for nursing home care is very limited.

Medicaid, Title XIX of the Social Security Act, is an assistance (welfare) program. It is a joint effort between federal and state governments to assure availability of medical services to all who may be in need. As with most welfare programs, those who seek help are expected to meet a means test. Basically, the means test demands verification that the person has very limited resources. Rather, it is hoped it may stimulate an exchange of ideas and thus start a process of resolution of the concerns.

Nursing homes of today are fully licensed facilities that provide long-term medical care and supervision. The nursing home of today is of recent invention, based upon a most common factor—necessity. The necessity is due to the fact that an ever growing portion of our society can be considered as elderly. Medical science has provided means whereby many previously fatal conditions are now treatable. The life span has been extended, and we simply have more old folks who need care.

The nursing home of today is not the "human junkyard" of yesterday. Stricter laws, licensing, developing knowledge, and public demand are but a few reasons the nursing home has as its goal the total well-being of the patient. The patient in the nursing home must be considered as a human being. That is, all the virtues, needs, and foibles we each enjoy are also enjoyed by the nursing home patient. Yes, even sexual activity is or might be part of the interest.

Among the many duties of the social worker in the nursing home, i.e. filling out forms and signing reports, the role of patient advocate is thought to be of extreme importance. One reason for the importance of the nursing home advocate role is found in the totalness, the newness and the bewilderment of the mass of decisions to be made amid the lack of explicated social norms for guidelines. This confusion the advocate addresses is found within the patient and, equally if not more important, within the family support system.

Certainly it is not thought necessary to operationalize basic LDS values implied by such words and phrases as family, marriage, life, tithes and offering, Word of Wisdom, taking care of oneself, family responsibility and use of public welfare. Yet, it is just such values that may well cause concern.

Possibly a few vignettes might serve as a base to explore how LDS values might be of concern while one serves as an advocate to the nursing home patient and their family. (All vignettes used are based upon composite situations and not any one case.)

As the family reported her history, "Grandma Hardy was born in 1910. She grew up in a close family setting—in fact her paternal Grandmother Cox lived with the family until she died of 'old age' at 71." One might best describe Grandma Hardy as having grown up totally accepting the LDS values of a close family, work for what you get, be honest, marry in the temple and raise a family.

Grandma Hardy did in fact follow suit. Married at 17, she had two sons and three daughters by the time she was 27. She was widowed when she was thirty. "She had it tough but the little home and ground allowed her to raise a garden, chickens and a cow—they didn't eat fancy but never went hungry. She was always active in the Church, held some important positions, worked hard to see that everyone of the children graduated from high school, sent the second boy Tom on a mission and never
took a dime from a soul that wasn’t earned.”

“The children all turned out fine—all married to good solid people, raising fine families. Of the 18 grandchildren, several have served missions, some are in college, others are married and starting families of their own and some are still living at home.”

The problem started several years ago. There were some health problems. A few pills and a couple of operations took care of it, but it seemed she just got worse in other areas. “Kept forgetting things—left the kitchen stove on one night and darn near burned the house down. She thought people were trying to take her stuff.” Many other little behavior patterns developed that were sometimes funny but sometimes of great concern.

To resolve the problems a plan of having one of the unmarried grandchildren live with her was tried but it just didn’t work. The family held a meeting and decided they each would take her for a month. The plan was put into action and the old home was rented out. The best way to describe the rotating living plan is to use the world “disaster.” “Grandma seemed to get even more confused. She always kept packing her suitcase to go home, accused the families of stealing her money, would not take her medicine, and finally—the last straw. Grandma was staying at the youngest daughter’s place. One Saturday, while everyone was out of the house, Grandma wandered off. She was found several blocks away, walking down the middle of the street wearing nothing but a wristwatch and one shoe.”

What to do? Easy! The woman is in need of medical care; she must have very close supervision in a controlled environment. The answer, use the services of a nursing home. (Admittedly, our value system is operating here.)

So? Wherein lies a problem with LDS values? The family is reluctant to use the nursing home. Their reluctance is based upon solid LDS values with very clear scripture support.

“Honour thy father and thy mother: that thy days may be long upon the land which the Lord thy God giveth thee.”

Exodus 20:12

“But if any provide not for his own, and specially for those of his own house, he hath denied the faith, and is worse than an infidel.”

Timothy 5:8

You also recall that one of the last acts of Christ was to secure for his mother the watching care of one of his disciples—St. John (John 19:26-27).

How can the family fulfill these values and “put Grandma away”? The heartfelt pain—and I know of no better word—the family suffers is devastating. Inner-family relations suffer. Possibly to protect a sense of well being, it is not unusual to project blame. “Older sister Jane has a big house, her kids are all gone, she has nothing to do! Why doesn’t she take Grandma in?”

Admittedly, the writer knows of no official church statement that counterindicates use of a nursing home. Yet how does the advocate handle the family’s statement of: “The Church knows we need education and we have a great college system. The Church knows we need recreation and we have the greatest sports program in the world. The Church knows we need medical care and we had the finest chain of hospitals in America. But, I don’t see the Church providing any nursing homes. I don’t feel right about putting Grandma here.”

Even so, let us assume the family, due to hard reality, accepts nursing home care for Grandma. The very real factor of paying for the nursing home care may bring about another conflict with LDS values. We are specifically told to care for our own. In fact, the Welfare Plan Handbook of Instructions carries the statement, “Where Church relatives, financially competent to take care of their kin refuse to do so, the matter should be reported to the bishop of the ward in which such relatives reside.” (1969) (What the bishop’s action should be is not spelled out.)

Yet, at the present time in the Utah area, nursing home care is approaching $1,500 per month. A quick look at Grandma Hardy’s finances—and a quick look is all that is required to see the whole thing—gives reason for the conflict of values.

<table>
<thead>
<tr>
<th>Income:</th>
<th>Social Security</th>
<th>$250.00</th>
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<tr>
<td></td>
<td>Income from Home Rent</td>
<td>150.00</td>
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<tr>
<td>TOTAL</td>
<td></td>
<td>$410.00</td>
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Deduct house taxes, fire insurance, maintenance of $50.00 per month and the total monthly income is $360.00.

<table>
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<tr>
<th>Assets:</th>
<th>Savings Account</th>
<th>$1,300.00</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Home*</td>
<td>3,000.00</td>
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If Grandma Hardy pays her own way as she has been taught to do, in one month she will be broke. The family can, of course, all chip in an equal share and make up the $1,140 per month shortage.” (Cost of $1,500 less income of $360) Such a plan will allow them to “take care of their own.” This means each family only has to pay $228 per month. Admittedly, members of AMCAP with our fine educations and great incomes could easily assume such a small obligation in order to maintain the value system pointed out above. There are many who simply cannot. Yes, the family could “…go and sell that treasure in heaven …” (Matt. 19:21) However, I think a lot of people seem to prefer a few of their treasures in the “here and now.”

I know of a bishop and his family who made the above “all chip in arrangements.” When a sibling cannot pay the $228, the bishop simply makes up the shortage from his ward’s Fast Offering Fund. Frankly, I question the propriety of his action. Even if it is correct, I would suggest that with all the Church’s resources, paying nursing home bills would soon bankrupt the Church—witness what such action is doing to the nation.

As an advocate for the patient, can you recommend the use of a public assistance program—Medicaid?

If so, how does one handle the conflict with the basic

*The ownership of a home may or may not be an asset. Many policies have been issued concerning homes: i.e., if a relative is living in the home, it is not an asset. If it is rented to a non-relative, it must be listed for sale. If sold on a contract, the contract becomes an asset. In short, it is a difficult process for the family to handle, so let’s skip over the home as an asset for the moment.
LDS value as stated in 1 Timothy 5:8 and in the Welfare Plan Handbook of Instructions.

AID FROM RELATIVES

Obviously no person should become a charge upon the public when his relatives are able to care for him. Every consideration of kinship, of justice and fairness, of the common good, and even of humanity itself, requires this. Therefore, all Church welfare workers will urge to the utmost the caring for the needy by their kin, if they have sufficient funds or supplies to enable them to do so. (1969, p.4)

"But if any provide not for his own, and specially for those of his own house, he hath denied the faith, and is worse than an infidel." (1 Tim. 5:8)

Yes, the home could be sold and the proceeds used to keep Grandma. But—a $30,000 home must be sold for cash or payments large enough to pay the $1140 per month shortage to the nursing home. This will last about 30 months and then we are back to the Medicaid or “all chip in” question. Also, Grandma might get better—some patients have—then where will she live if the home is sold? Another factor is that Grandma won’t sign sale papers. She has always planned to use the house to leave each of the children a “little something.”

Many more such problems could be explored, but let’s say they have been solved and Grandma Hardy is in the nursing home and is happy. Medicaid is in force and all is well. Yet, Grandma has never let a Fast Sunday go by without giving an offering. Also, she has paid tithing on her SSA check and the house rent on a very faithful basis. Medicaid allows her $125 per month to spend on personal desires. All other money goes to the nursing home—a conflict of values? How do we help her accept non-payment of tithes and offerings?

Well, Grandma Hardy is a hard case—but a very common one. Let me offer some other cases.

Grandpa Thomas, born 1890, is admitted to a nursing home as a private pay patient. Grandpa Tom, as he is called, was orphaned as a young child. Nevertheless, by hard work as a ranch hand, he finally was able to get his own place and become a highly respected and successful cattle rancher. He has always been a very proud, honest, hard working man. As we might say today, he was “Macho.”

He has lived with his grandson Mike and his family for the past 15 years. They have provided the ideal love and respectful environment.

In the last few years Grandpa Tom has become quite weak physically, yet seems fully capable of making all of his own decisions. He has needed help in dressing and bathing—this has not been a problem. However, in the last two weeks Grandpa Tom has become totally incontinent. Though the granddaughter-in-law is a R.N. and has been cheerful and willing, the act of having to be cleaned and redressed after an uncontrolled bowel movement is more than Grandpa Tom can handle emotionally. He demanded to come into a nursing home.

On the second day of the nursing home stay he was discussed in Patient Care Meeting. Plans to provide full care were made. Two weeks later he was again discussed. For the past several days he had refused to eat and would only sip water. His physical condition was fast becoming precarious.

We can, of course, admit Grandpa Tom to an acute hospital for access to various life support systems. We can also respect his apparent plan to stop living.

The LDS values concerning life are clear. Yet, should we demand that every effort be put forth to maintain Grandpa Tom’s life? Should a proud, independent man be forced to live through daily care that is emotionally devastating?

Another issue—Jack Hanson, age 71, needs your skills as an advocate. His plight is given to you as follows. He and his wife celebrated their 50th wedding anniversary last year. They were married in the temple in 1931. They raised seven children and saw them through missions and some college. They were able to make wise investments to the end that they now enjoy a monthly income of $1850, although they have very little in savings. All money has been invested in joint accounts. They own a nice home. In short, good, solid LDS values have allowed them to realize their dream of a comfortable retirement.

Unfortunately, Mrs. Hanson recently suffered a major stroke and will require nursing home care until she dies. She is totally incapable of any social interaction. Remember, nursing home care is costing about $1500 per month. Their little savings account is being very rapidly exhausted and the investments that they have, if cashed in, will stop most of their income.

The bottom line is simple. Mr. Hanson cannot live in the home and meet his social and theological responsibilities on the money left after he pays the nursing home. He would soon exhaust his resources if he cashes in the investments, and he has far too much to qualify for Medicaid assistance.

A simple solution—divorce Mrs. Hanson, claim all right to their joint accounts and pay a small sum, say $200 per month as alimony. Mrs. Hanson would then be eligible for Medicaid and Mr. Hanson can continue to live in dignity.

At this point tears roll down Mr. Hanson’s cheeks. He sobs, “I couldn’t do that. She is my wife. I love her.” And, of course, there are the well-stated values concerning the sacredness of marriage. The Hanson children are not able to pay the nursing home bill. Do we press for divorce or destroy a life dream of a comfortable old age?

Or, visualize the common nursing home social life for a moment—bleak at best. A common attempt to—at the risk of a bad pun—add a little spirit to the situation, wine and cheese tasting parties are held. Do you encourage such blatant violation of the Word of Wisdom?

How do we advocate for Harry—a long time temple worker, whose wife can no longer care for him due to his loss of ability to test reality? (We can’t use the term senile any longer.) He is in a nursing home and devotes the major portion of his time to courting the women patients. He very frequently becomes very overt in his sexual advances. Or what do we advocate for Myrtle, another patient who is more than delighted to receive Harry’s attention?

How do we best serve the incontinent patient who demands the near life long pattern of wearing garments
be continued?

How do we best serve the married patient when he is in a nursing home, has the ability and desire to continue an active sex life with his willing, non-patient wife?

Many more such situations might be explored. Some, as above, bring about head-to-head confrontations with gospel values. Others tend to fall into the more gray areas. Still, they are all reality; they must be faced; action must be taken.

Without a doubt, we as professionals who intervene in the lives of others know full well that within the values of the Gospel and the teachings and life of our Savior lie the only true road to happiness. Yet, there are still some questions.

NOTES