INEBRIATED ELDERS: THE PROBLEM OF SUBSTANCE ABUSE AMONG THE ELDERLY

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With increasing frequency, members of the nation's elderly population are being diagnosed as substance abusers. In this note, Ms. Abrams explores why the rate of such diagnoses is increasing, as well as possible means of preventing this "epidemic" from becoming any worse. Ms. Abrams suggests that the causes of the current substance abuse problem among the elderly range from inadequate training in the medical community to a general shift in societal attitudes toward substance abuse. It is argued that, because the elderly do not engage in the same type of social interaction as the vast majority of the country's adult population, it is substantially more difficult to identify those in need of treatment for substance abuse problems. The proposed solution to the problem is to educate those that have regular contact with the elderly about this unique class's substance abuse so that afflicted individuals can be identified and treated. Moreover, Ms. Abrams argues that, with evolving professional customs, physicians and pharmacists may be subject to liability if they fail to adequately diagnose, monitor, and treat substance abuse in their elderly patients.

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I. Introduction

Mary was not fond of the taste, but she appreciated the effects of liquor.[1] She liked the way it made her feel relaxed and upbeat.[2] As long as she moderated her intake, she did not think she had a problem.[3] She considered herself a social drinker,[4] even though she often drank twice as much as the other women.[5] She eventually collapsed in the living room of her Florida condo, but managed to rouse herself from semi-consciousness long enough to crawl to the telephone and call for help.[6] The next day, her son and daughter sat by her hospital bedside, facing the reality that their seventy-two-year-old mother, whom they had never seen drunk, was an alcoholic.[7] Four years later, Mary stated, "The memory of my position in that living room keeps me sober."[8]

Tom would start his workday with a shot of whiskey and a cup of coffee.[9] He would have a few more drinks at lunch, and then go back to finish an afternoon of work before heading home.[10] Though he was rarely absent from the job, when he retired at age fifty-five, he had more time on his hands, and boredom led to increased drinking.[11] Even during yearly physical exams, he was never asked about alcohol.[12] Tom's doctor checked him for diabetes, but ignored another possible cause of Tom's leg problems—alcoholism.[13] Not until Tom was hospitalized did a doctor question him about his alcohol use.[14]

Mary and Tom are examples of what has been dubbed an "invisible epidemic"—substance abuse among the elderly.[15] Senior citizens are increasingly being diagnosed with substance abuse problems, including alcohol abuse as well as abuse of prescription and over-the-

1. Margo Harakas, *Alcoholic Seniors*, CHI. TRIB., Feb. 25, 2000, *available at* 2000 WL 3639998.
2. *Id.*
3. *Id.*
4. *Id.*
5. *Id.*
6. *Id.*
7. *Id.*
8. *Id.*
9. Kay Lazar, *The 'Invisible Epidemic'—Alcoholism Among Seniors a Hidden Health Hazard*, BOSTON HERALD, Feb. 27, 2000, at 003.
10. *Id.*
11. *Id.*
12. *Id.*
13. *Id.*
14. *Id.*
15. *Id.*

counter drugs.[16] Because drug use by the "baby boom" generation has been greater than in previous generations, this problem is likely to escalate as the number of citizens age sixty-five and older continues to rise.[17]

This note will discuss the problem of substance abuse among the elderly. Part II examines the factors that keep the problem hidden and the difficulty associated with treating a problem that many, through ignorance or denial, fail to recognize. Part III addresses the social, medical, and legal inadequacies, and the ramifications thereof, that keep the problem hidden and difficult to treat. Part IV presents recommendations for the prevention, detection, and treatment of the problem of senior substance abuse so that it does not reach epidemic proportions as the population ages.

II. Background

When people think of substance abuse, they tend to associate the problem with younger age groups. However, the recently recognized phenomenon of late-onset alcoholism, an aging population, and the shift in societal norms experienced by baby boomers during their younger years all factor into a potentially explosive substance abuse problem among the elderly within the next twenty years.

A. Rates of Substance Abuse

Seventeen percent[18] of Americans age sixty and older, or three million Americans, are addicted to alcohol.[19] According to the National Institute on Alcohol Abuse and Alcoholism, six to eleven percent of elderly hospital admittees show some symptoms of alcoholism.[20] Twenty percent of the elderly who are admitted to psychiatric

16. Thomas L. Patterson & Dilip V. Jeste, *The Potential Impact of the Baby-Boom Generation on Substance Abuse Among Elderly Persons*, 50 PSYCHIATRIC SERVICES 1184, 1184 (1999).

17. *Id.*; *see also* JEANNE REID, NAT'L CTR. ON ADDICTION & SUBSTANCE ABUSE AT COLUMBIA UNIV., UNDER THE RUG: SUBSTANCE ABUSE AND THE MATURE WOMAN 13 (1998) (stating that baby boomers are those persons born between 1946 and 1964).

18. Lazar, *supra* note 9.

19. Harakas, *supra* note 1.

20. NAT'L INST. ON ALCOHOL ABUSE & ALCOHOLISM, U.S. DEP'T OF HEALTH & HUMAN SERV., ALCOHOL ALERT: ALCOHOL & AGING 40 (1998), *available at* http://silk.nih.gov/silk/niaaa1/publication/aa40.htm (last visited Oct. 23, 2000) [hereinafter ALCOHOL ALERT].

wards and fourteen percent of elderly emergency room patients show signs of substance abuse.[21] The rate of seniors who are admitted to acute-care hospitals for alcohol-related problems is comparable to the rate of admissions of seniors for heart attacks.[22]

B. Societal Norms

Attitudes about substance abuse reflect societal norms, which are a product of attitudinal development in a person's younger years.[23] Many of today's seniors, born in the 1920s, developed attitudes toward alcohol that reflect the stigma attached to alcohol use during that time.[24] In general, people's drinking patterns are relatively constant over time.[25] Segments of today's elderly population show lower rates of alcoholism and drug abuse problems; such rates are a consequence of life-long stigmatization of such behavior.[26] Members of the current elderly population are also infrequent users of recreational drugs.[27] Use of hallucinogens, illicit drugs, and cannabis is rare, and is limited almost exclusively to "longstanding opioid users and aging criminals."[28]

As the baby boomers[29] age, the threat of an explosion in the number of elderly substance abusers increases. The first wave of baby boomers will reach the age of sixty-five in the year 2011.[30] Baby boomers' experience with drugs far outpaces that of their parents and grandparents.[31] While statistics of baby boomers' substance abuse

21. *Id.*
22. *Id.*
23. *Id.*
24. *Id.* Beginning in 1920, the Eighteenth Amendment to the U.S. Constitution prohibited "the manufacture, sale, or transportation of intoxicating liquors within, the importation thereof into, or the exportation thereof from the United States and all territory subject to the jurisdiction thereof for beverage purposes[.]" U.S. CONST. amend. XVIII, § 1. In 1933, the Eighteenth Amendment was repealed by the Twenty-first Amendment, in which the federal government delegated regulation of the transportation or importation of intoxicating liquors to the states, its territories and possessions. *Id.* amend. XXI, §§ 1, 2.
25. ALCOHOL ALERT, *supra* note 20.
26. *Id.*
27. DAN BLAZER, EMOTIONAL PROBLEMS IN LATER LIFE: INTERVENTION STRATEGIES FOR PROFESSIONAL CAREGIVERS 164 (1998).
28. Roland M. Atkinson, *Substance Use & Abuse in Late Life*, *in* ALCOHOL AND DRUG ABUSE IN OLD AGE 2, 7 (Roland M. Atkinson ed., 1984). Opioids include heroin and hydromorphone. *Id.* at 6.
29. *See* REID, *supra* note 17, at 13.
30. Patterson & Jeste, *supra* note 16, at 1184.
31. *Id.*

shows a steady decrease in use until the age of thirty, it then stabilizes at a higher rate than that of previous generations of older citizens.[32] The sheer size of the baby boom population, along with increased life expectancy rates[33] and higher rates of substance abuse, foretell the emergence of a major problem that existing social services and medical providers are now ill equipped to handle. As the rates of first-time drug use increase, and current drug users grow older, experts anticipate that drug abuse treatment programs will need to increase by fifty-seven percent by the year 2020 in order to adequately serve all those who need these services.[34]

C. Patterns of Substance Abuse in the Older Adult

Alcohol abuse among the elderly is generally classified into three patterns, depending on the age of onset and the severity of the substance abuse problem.[35] The first category includes the aging alcoholic, who carries a life-long substance abuse problem into his or her senior years.[36] The second category includes geriatric problem drinkers who may experience an intermittent alcohol problem, but do not fall into a regular pattern of abuse.[37] The third category recognized by researchers is the late-onset alcoholic.[38] A person may not regularly abuse alcohol until his or her fifties, or later, when he or she drinks in response to major physical and life changes, such as, health problems,[39] loss of a spouse,[40] retirement,[41] caregiving,[42] sleeplessness,[43] financial problems,[44] or chronic illness or pain.[45] Moving to a retire-

32. *Id.* at 1186.
33. REID, *supra* note 29, at 13.
34. *SAMHSA Use of Resources: Hearing Before the House Comm. on Gov't Reform, Subcomm. on Criminal Justice, Drug Policy & Human Resources*, 106th Cong. (2000) (testimony of Camille Barry, Deputy Director, Ctr. for Substance Abuse Treatment, Substance Abuse & Mental Health Serv. Admin., U.S. Dep't of Health & Human Serv.), *available at* 2000 WL 11068327.
35. IN-HOME ASSESSMENT OF OLDER ADULTS: AN INTERDISCIPLINARY APPROACH 169–70 (Charles A. Emlat et al. eds., 1995).
36. *Id.*
37. *Id.* at 170.
38. *Id.*
39. *Id.*
40. *Id.*
41. *Id.*
42. Karen McNally Bensing, *Alcoholism Often Slips By in Elderly,* PLAIN DEALER (Cleveland, Ohio), Jan. 24, 1999, at 7K.
43. *Id.*
44. Harakas, *supra* note 1.
45. *Id.*

ment community may also trigger overdrinking, when the social activities provide more opportunities to drink.[46]

Prescription and over-the-counter drug abuse also increases with advancing age.[47] "Elderly persons use prescription medications approximately three times as frequently as the general population."[48] Although some people turn to alcohol as a response to depression,[49] others turn to antidepressant medications, which are sometimes misused to the point of drug abuse. Fifty percent of all sedatives are used by people over the age of fifty-nine.[50] Further, one out of six Medicare recipients is prescribed medication inappropriately.[51]

D. Gender Differences

Out of the three million senior alcoholics, 1.8 million are women.[52] The older substance abuser does not have the same tolerance for drugs and alcohol as the individual had when younger, so decreased consumption does not necessarily correlate to a decrease in intoxication.[53] The older body does not metabolize alcohol as well as the younger body does, and at any age, women's tolerance of alcohol is lower than men's.[54] This propensity is exacerbated by the fact that older women take an average of five prescription drugs each day,[55] and some medications can intensify the physical effects of alcohol.[56]

46. *See* Bensing, *supra* note 42 at 7K.
47. *See* Patterson & Jeste, *supra* note 16, at 1185.
48. *Id.* "Older Americans take an average of 4.5 prescription and two nonprescription drugs daily." Robert N. Butler, *Listening for the Blues*, TIME, Jan. 29, 2001, at G4.
49. Approximately six million people age sixty-five and older experience chronic depression. *See* Butler, *supra* note 48, at G4. Older people who suffer from depression are more likely than younger people to commit suicide. *Id.* "Each year, 20% of the suicides in this country are committed by people 65 and older, although they make up only 13% of the population." *Id.* White men in their eighties have the highest suicide rate in the United States, and older men who are depressed are more likely than older women to hide the depression from a physician. *Id.* In fact, "[a]s many as 70% of older people who commit suicide have visited their primary-care physician within the previous four weeks." *Id.* Furthermore, alcohol and drug abuse actually "predispose the elderly to depression." *Id.* In such situations, it may be difficult to tell whether the depression is the cause or the effect of the substance abuse.
50. REID, *supra* note 29, at 21.
51. *Id.* at 59.
52. *See* Harakas, *supra* note 1; *see also* REID, *supra* note 29, at 19.
53. Patterson & Jeste, *supra* note 16, at 1184.
54. Bensing, *supra* note 42, at 7K.
55. *Id.*
56. *Id.*

Consequently, rates of depression for female alcoholics are twice as high as for nonalcoholic females, and almost four times as high as for male alcoholics.[57]

Women are also more prone than men to late-onset alcoholism.[58] While the first symptoms of alcoholism occurred in fifteen percent of males between ages sixty and sixty-nine, and in fourteen percent of males between the ages of seventy and seventy-nine, twenty-four percent of women experience the first symptoms of alcoholism between the ages of sixty and sixty-nine, and twenty-eight percent of women experience those symptoms between the ages of seventy and seventy-nine.[59]

Women become addicted to alcohol more easily than men.[60] They also develop alcohol-related health problems more quickly and are more prone to die from accidents relating to alcohol, as well as intended acts of violence and suicide.[61] Furthermore, women often suffer from shame and embarrassment, and their families often fail to help because of denial or desperation.[62]

Mature women are also more prone to use prescription drugs.[63] Older women are more likely to use several prescription drugs at a time and to use those drugs on a long-term basis.[64] They also use three types of psychoactive drugs—tranquilizers, sedatives, or hypnotics and antidepressants—more than any other age group and gender, and they frequently take narcotic painkillers.[65] One in four mature women, or about 6.4 million mature women, use one or more psychoactive prescription drugs.[66] About 2.8 million mature women may have a problem with psychoactive prescription drug abuse.[67] Chronic pain from failing health can lead to misuse of, and dependence on, painkillers, and can also lead to depression.[68]

57. REID, *supra* note 29, at 30.
58. *Older Adults at Serious Risk; Alcoholism*, USA TODAY, Feb. 1, 2000 (Magazine), at 11.
59. *Id.*
60. REID, *supra* note 29, at 15.
61. *Id.* at 5.
62. *Id.* at 17.
63. *Id.* at 21.
64. *Id.*
65. *Id.*
66. *Id.*
67. *Id.* at 5.
68. *Id.* at 31.

Women are also "heavy and long-term users" of over-the-counter medications.[69] Over-the-counter diet pills, sleep medications, and cold and cough medicines can be considered "psychoactive" or "mood-altering" because they act as stimulants or sleep-inducers.[70] While many mature women use prescription and over-the-counter medications appropriately, others start to dangerously overuse the drugs or mix them with alcohol.[71] This inappropriate use can lead to chronic abuse or addiction;[72] mixing sedating psychoactive drugs with alcohol actually accelerates the development of a dependence on the drug because the alcohol magnifies the drug's effect.[73]

III. Analysis

The difficulty of dealing with substance abuse among the elderly revolves around medical, legal, and social considerations. These considerations make the diagnosis and treatment of elderly substance abuse especially difficult. The diagnosis and intervention methods discussed below are equally applicable to both alcohol and prescription drug abuse.[74]

A. Difficulty with Diagnosis in the Older Adult

1. MEDICAL PROVIDERS ARE LESS LIKELY TO IDENTIFY ELDERLY SUBSTANCE ABUSERS

Although most individuals rely on medical care providers to screen them for potential health problems, this does not happen as routinely with senior substance abuse. The ability or desire of medical care providers to routinely screen for substance abuse problems is complicated by numerous factors, including inadequate training,[75] at-

69. *Id*. at 21.
70. *Id.*
71. *Id*. at 24.
72. *Id.* The Center for Addiction and Substance Abuse (CASA) defines inappropriate use of prescription drugs as "overuse or use of medications in combination with alcohol or other substances when this mix is dangerous." *Id.* at 25. Inappropriate use is categorized as "occasional ('misuse') or chronic ('abuse' or 'addiction')." *Id.*
73. *Id.*
74. BLAZER, *supra* note 27, at 165, 176.
75. REID, *supra* note 29, at 48–50. Training on substance abuse "is too often . . . as little as one or a few hours." *Id.* at 50. "[M]ost physicians (67 percent) reported that the training took no more than a day." *Id.* Failure to keep abreast of medical knowledge can have serious implications for physicians; the duty to keep medical knowledge current and "keep abreast of medical progress" can render a noncom-

tributing physical symptoms to other medical causes,[76] reluctance to confront a senior suspected of substance abuse,[77] and confusing the symptoms of substance abuse with the normal aging process.[78] Senior substance abusers may make the diagnosis more difficult by denying or minimizing the substance abuse when questioned about it.[79]

According to the Federal Substance Abuse and Mental Health Services Administration, alcohol problems among the elderly "remain[] underestimated, underidentified, underdiagnosed, and undertreated."[80] Only one percent of primary care physicians consider alcohol abuse when a patient shows symptoms typically associated with this problem.[81] Health care providers are not necessarily as alert to the danger of senior substance abuse as they might be for their younger patients, and substance abuse may not be as routinely discussed with older patients.[82] A report by the Center for Addiction and Substance Abuse (CASA) states, "[M]any of [the primary physicians] lack such keen eyes."[83] Physicians tend to focus on individual symptoms to develop a narrow diagnosis, but "the consequences of alcohol abuse and dependence usually appear as an array of seemingly unrelated symptoms."[84]

Although older Americans might see a medical care provider more often than younger people do,[85] doctors may fail to diagnose the

pliant physician liable for medical malpractice. *See* Gordon L. Ohlsson, *Theories of Recovery*, 1 MEDICAL MALPRACTICE (MB) ¶ 8.05 (Aug. 2001).

> [A] physician is under a duty to use that degree of care and skill which is expected of a reasonably competent practitioner in the same class to which he belongs, acting in the same or similar circumstances. Under this standard, advances in the profession, availability of facilities, specialization or general practice, proximity of specialists and special facilities, together with all other relevant considerations, are to be taken into account.

Shilkret v. Annapolis Emergency Hosp. Ass'n, 349 A.2d 245, 253 (Md. 1975).

76. REID, *supra* note 29, at 48.

77. Lazar, *supra* note 9, at 003.

78. ALCOHOL ALERT, *supra* note 20.

79. LINDA TERI & PETER M. LEWINSOHN, GEROPSYCHOLOGICAL ASSESSMENT & TREATMENT 99 (1986). It is for this reason that evaluation of an elderly patient for substance abuse should include participation by family members. *Id*.

80. Lazar, *supra* note 9, at 003.

81. REID, *supra* note 29, at 46.

82. *See* Al Allen, *Alcoholism*, COURIER-J. (Louisville, Ky.), Jan. 31, 1999, at 06h.

83. REID, *supra* note 29, at 16.

84. *Id.*

85. Up to ninety-three percent of mature women visit a physician regularly. *Id.* at 20.

problem as one of substance abuse.[86] The symptoms of substance abuse may include dizziness,[87] upset stomach,[88] appetite loss,[89] memory loss,[90] mental impairments,[91] fragility,[92] and falls and injuries.[93] These symptoms mimic those caused by other health problems related to aging,[94] including insomnia,[95] diabetes,[96] and depression.[97] Consequently, most elderly alcoholics who are hospitalized are not diagnosed as alcoholics before they return home.[98] Substance abuse thus may not be diagnosed, and symptoms may be treated inappropriately or not treated at all.[99] "Unless physicians—and others who know and serve mature adults—look at the constellation of complaints and ask themselves not only 'Is it age?,' but also 'Can it be substance abuse?,' they won't see the underlying alcohol or drug problem."[100]

Doctors who suspect a problem of substance abuse may be reluctant to act on the suspicion.[101] A doctor may feel awkward discussing the issue with someone who is old enough to be her grandmother;[102] people are bashful about questioning an elderly person regarding his or her lifestyle.[103] "'Its [sic] difficult to think of some 93-year-old-lady as being a drunk. . . . It doesn't mesh in our heads.'"[104] Doctors may also shrug off suspected substance abuse because they believe the elderly person does not have much else to look forward to in life.[105] They may take the attitude, "I'm not going to tell her she can't drink anymore."[106] Also, even if questioned about the abuse many elderly alcoholics will deny that they drink to excess.[107]

86. *Id.* at 16.
87. *See* Bensing, *supra* note 42, at 7K.
88. *Id.*
89. *Id.*
90. *Id.*
91. *Id.*
92. *See* REID, *supra* note 29, at 16.
93. *Id.*
94. ALCOHOL ALERT, *supra* note 20.
95. *Id.*
96. Lazar, *supra* note 9, at 003.
97. *Id.*
98. *Id.*
99. ALCOHOL ALERT, *supra* note 20.
100. REID, *supra* note 29, at 16.
101. *See* Lazar, *supra* note 9, at 003.
102. *Id.*
103. *Id.*
104. *Id.*
105. *Id.*
106. *Id.*
107. Bensing, *supra* note 42, at 7K.

"The general duty to possess and exercise the requisite skill and care has been frequently been [sic] applied by courts, with varying degrees of clarity, to more or less specific duties."[108] Though the practice of medicine depends on the physician's "exercise of independent judgment," courts have attempted to make the requisite standard of care more objective by specifying certain duties with which a competent physician must comply in order to avoid malpractice liability.[109] Thus, courts have found that a physician has a duty to take a medical history,[110] examine the patient,[111] discover the cause of the symptoms,[112] attend the patient for as long as the patient requires attention,[113] and reveal serious risks inherent in diagnostic or therapeutic procedures.[114] Courts have also found a duty of physicians to give instructions to the patient to carry out treatment and follow-up,[115] maintain patient confidentiality,[116] keep current with medical progress and knowledge,[117] refer the patient to a specialist when the case is outside the physician's skill or knowledge,[118] and prescribe a drug in accordance with the manufacturer's directions.[119]

Elderly patients report that physicians often fail to screen them for alcohol or prescription drug abuse. As mentioned earlier, the symptoms of such abuse often mimic the symptoms of physical ailments frequently experienced by the elderly.[120] The case of *Fleming v. Prince George's County*[121] is illustrative of the disastrous results that can

108. Ohlsson, *supra* note 75, ¶ 8.05.
109. *Id.*
110. *Id.* ¶ 8.05(1); *see* Looney v. Davis, 721 So. 2d 152, 157–58 (Ala. 1998) (holding that evidence was sufficient to show a breach of the standard of care when the obtained medical history was not appropriate nor sufficiently thorough, leading to the patient's death).
111. Ohlsson, *supra* note 75, ¶ 8.05(2); *see also* Fleming v. Prince Georges County, 358 A.2d 892, 895, 908–09 (Md. 1976) (holding that two physicians might not have met the required standard of care necessary when they failed to examine an elderly patient whose obstinate, stubborn, and cantankerous behavior was symptomatic of her cerebral arteriosclerosis; instead the patient was prescribed Librium, Seconal, and Valium, resulting in the patient's suicide).
112. Ohlsson, *supra* note 75, ¶ 8.05(3).
113. *Id.* ¶ 8.05(4) (citing Bateman v. Rosenberg, 525 S.W.2d 753 (Mo. Ct. App. 1975)).
114. *Id.* ¶ 8.05(5).
115. *Id.* ¶ 8.05(6) (citing Krusilla v. United States, 287 F.2d 34 (2d Cir. 1961)).
116. *Id.* ¶ 8.05(7).
117. *Id.* ¶ 8.05(8).
118. *Id.* ¶ 8.05(9).
119. *Id.* ¶ 8.05(10).
120. *See supra* notes 86–97 and accompanying text.
121. 358 A.2d 892 (Md. 1976).

occur when a physician fails to examine a patient and carefully consider all the possible origins of the patient's symptoms.[122] Orpha Fleming, age sixty-seven, was admitted to the hospital with congestive heart failure, lung disease, and hypertension.[123] The family physician prescribed Librium for the patient, who complained of nervousness and anxiety.[124] Later that evening, another physician prescribed Seconal for Fleming's restlessness, to be followed by Valium if the Seconal was ineffective.[125] The patient tried to escape from the window of her hospital room, falling several floors to the ground and sustaining injuries that led to her death one month later.[126]

Expert testimony in the *Fleming* case revealed that

> it is a well-known fact that elderly people who become obstinate and stubborn and cantankerous frequently are manifesting one of two things: One of them is that they are developing some cerebral arteriosclerosis, some senility is a common term, or maybe a manifestation of depression. There are well-known medical facts. . . . [The physician] fell below the standard of care when he merely assumed her behavior was due to obstinacy or stubbornness and did not, at that point, investigate . . . whether, in fact, this represented some medical emotional change rather than a personality problem.[127]

The court held that a directed verdict for the defendants was improper; sufficient evidence was presented to prove a breach of the duty of care against both doctors, each of whom failed to examine the patient upon her admittance to the hospital or thereafter.[128]

The *Fleming* case, although illustrative of a finding of medical malpractice for failure to examine the patient, also illustrates how easy it is to misdiagnose the symptoms of an elderly patient and, consequently, fail to treat the true cause of the symptoms.[129] The situation also could lead to a breach of the duty to discover the cause of the symptoms. A physician "must make sufficient inquiries and perform such recognized tests as to discover the cause of the patient's symptoms."[130] Similarly, a physician who is quick to attribute an elderly patient's symptoms to a physical cause related to the aging process

122. *Id.* at 895.
123. *Id.* at 894.
124. *Id.* at 895.
125. *Id.*
126. *Id.* at 894–95.
127. *Id.* at 895–96.
128. *Id.* at 892–99
129. *See id.*
130. Ohlsson, *supra* note 75, ¶ 8.05(3).

without adequately considering the possibility that the symptoms may be attributable to substance abuse could find himself or herself liable for negligence by breaching a duty to examine and/or discover the cause of the symptoms.[131]

> A patient is entitled to an ordinarily careful and thorough examination, such as the circumstances, the condition of the plaintiff, and the physician's opportunities for examination will permit, and, while he does not insure the correctness of his diagnosis, a physician or surgeon is required to use reasonable skill and care in determining through diagnosis the condition of the patient and the nature of his ailment, and is liable for a failure, due to a want of the requisite skill or care, to diagnose correctly the nature of the ailment, with resulting injury or detriment to the patient.[132]

A physician may breach the standard of care and thus incur liability by failing to reveal serious risks of treatment to the patient[133] or by failing to prescribe drugs in accordance with manufacturers' instructions.[134] The case of *White v. Lawrence*[135] is illustrative of these duties. Earl White, a fifty-five-year-old alcoholic, received treatment from his family care physician "for a variety of ailments, including bronchitis, high blood pressure, and back and elbow problems."[136] The physician testified that "the decedent was 'pretty much' intoxicated whenever he saw him, and that the decedent's 'perception, conception, understanding and everything was altered' by alcohol."[137] The patient was also severely depressed.[138] White's wife was worried about the effect that the decedent's drinking had on his health, as the decedent's liver and pancreas were impaired by his heavy alcohol consumption.[139] In order to deter Mr. White's drinking, the physician gave Mrs. White a prescription for Antabuse (Disulfiram) and directed her to grind the drug and place it in the decedent's meals without his knowledge.[140] Mr. White continued to consume alcohol, and a day after the Antabuse was surreptitiously placed in his food, he went to the emergency room, complaining of hot flashes and pain.[141] The

131. *See, e.g.*, *supra* notes 9–14 and accompanying text.
132. Golonka v. Gatewood, 257 N.W.2d 403, 408–09 (Neb. 1977).
133. *See* Ohlsson, *supra* note 75, ¶ 8.05(5).
134. *See id.* ¶ 8.05(10).
135. 975 S.W.2d 525 (Tenn. 1998).
136. *Id.* at 527.
137. *Id.*
138. *Id.*
139. *Id.*
140. *Id.*
141. *Id.*

emergency room staff noted the smell of alcohol on White's breath.[142] Because White was unaware that he had consumed Antabuse, the emergency room personnel were not made aware of that fact.[143] As a result, he was only treated for heat exhaustion and discharged. Several hours later he committed suicide by shooting himself in the head with a pistol.[144]

Perhaps the duty that is most pertinent to the topic of alcohol and drug abuse among the elderly is the duty to keep knowledge current. For the last century, courts have struggled to articulate and apply a legal standard of care that meshes with well-established tort principles and is fair to the physician and the patient.[145] The standard presumes that a physician possesses the medical knowledge necessary to competently practice his profession.[146] The *Restatement (Second) of Torts* states, "[O]ne who undertakes to render services in the practice of a profession or trade is required to exercise the skill and knowledge normally possessed by members of that profession or trade in good standing in similar communities."[147] The standard of care to which a physician is held, and to which he or she must adhere in order to avoid liability for medical malpractice, is a dynamic standard that depends on a number of factors, including "advances in the profession."[148] Medical research is ongoing and constant, and new treatments, drugs, and health problems are identified through advancements in medical knowledge and technology. Courts have

142. *Id.*
143. *Id.*
144. *Id.* at 527–28. In *White*, an expert testified that the physician
> owed a duty of care to the decedent not to administer Antabuse without the patient's full knowledge, to warn the decedent of the Antabuse-alcohol reaction, caution him against drinking while taking the drug, and make him fully aware of the possible consequences, including the fact that reactions may occur with alcohol up to 14 days after ingesting Antabuse.

Id. at 528. Another expert concluded that the physician's "covert administration of [Antabuse] to an actively drinking person, alcoholic or otherwise, is entirely inappropriate, violates the standard of care, and is dangerous to the point of recklessness." *Id.* Given the long list of possible side effects from Antabuse, *see id.* at 527 n.1, the physician's failure to reveal the risks of the medication to the patient, and the dangers of prescribing a drug with potentially severe side effects to an unknowing patient who suffered from depression, made the suicide "a major risk factor." *Id.* at 528.
145. Shilkret v. Annapolis Emergency Hosp. Ass'n, 349 A.2d 245, 247 (Md. 1975).
146. DAVID M. HARNEY, MEDICAL MALPRACTICE 89 (1973).
147. RESTATEMENT (SECOND) OF TORTS § 299(A) (1965).
148. *Shilkret*, 349 A.2d at 253.

long recognized the dynamic nature of the standard of care and imposed upon the physician a duty to keep abreast of medical progress.[149] This requires the physician to obtain current medical knowledge with respect to the types of medical problems she treats.[150] Otherwise, the physician may not possess the medical knowledge needed for the competent practice of her profession.

Screening and treatment can begin only when the physician understands that a patient might be at risk for a particular medical condition.[151] Thus, the duty to possess current knowledge of potential medical conditions and the knowledge of the methods used to diagnose those conditions is joined implicitly with the duty to know which patients, either because of age-related risks or unexplained symptoms, are at risk for a medical condition.[152] This is precisely why the elderly are at risk of failing to receive appropriate diagnoses and treatment for substance abuse—if the physician does not understand that the elderly are at special risk for substance abuse and fails to screen eld-

149. Ohlsson, *supra* note 75, ¶ 8.05(8).

150. *Id.* It also imposes an obligation not simply to possess knowledge about the services provided by the physician at the time they are rendered, but to stay current and inform the patient when a treatment is found to carry a previously unknown hazard. *Id.* The duty to possess knowledge of medical progress extends not simply to new treatments and procedures, but impliedly extends to diagnosis of health risks and conditions. *Id.* Inherent in this duty is the expectation that doctors who possess current medical knowledge are able to identify patients who are at risk of certain medical conditions. *Id.* Adult medical patients have come to expect certain diagnostic procedures as part of a complete routine physical exam—the monitoring of blood pressure, a recording of body temperature and pulse, perhaps a routine blood test to check cholesterol levels—and depending on the individual risks posed to a particular patient, a mammogram, prostate exam, or tests to determine liver function or blood sugar might be required. *Id.* Certainly none of those tests would be incorporated into the standard of care without the medical research supporting the need and importance of those procedures to the health of some patients. The knowledge gained by the results of those tests depends on the advancement of medical technology used to obtain accurate results that can be used for diagnosis and treatment of medical conditions.

151. *See generally* REID, *supra* note 29, at 46–49.

152. Interestingly, failing to screen patients who are not considered at risk for a medical condition may, in some situations, not insulate the physician against a claim of malpractice. *See* Helling v. Carey, 519 P.2d 981 (Wash. 1974) (holding that a physician was negligent in failing to test a thirty-four-year-old patient for glaucoma, despite expert testimony that medical standards did not require the test for individuals under age forty). A subsequent Washington statute arguably reimposed the common-law requirement of a departure from the standard of the profession for a finding of negligence. *See* Gates v. Jensen, 595 P.2d 919, 923 (Wash. 1979) (holding that even when the statutory "standard of the profession" is met, a physician has an obligation to go beyond the standard and require additional testing if the patient's condition so warrants). *See generally* WASH. REV. CODE ANN § 4.24.290 (West 1998)

erly patients for substance abuse problems, the elderly substance abusers will not be treated for substance abuse. Of course, the patient may self-identify as a substance abuser, or a caring family member might mention it to the doctor, but embarrassment or failure to recognize the magnitude of the problem may lead patients or their loved ones to be more inclined to hide the problem rather than broach the topic with the physician.[153]

2. SENIOR SUBSTANCE ABUSERS ARE LESS LIKELY TO SELF-IDENTIFY

Embarrassment or reluctance to admit to the underlying problem may cause some seniors to mask the symptoms of substance abuse or deny that symptoms exist. Some seniors prefer to self-medicate symptoms of depression. Believing depression to be a "Hollywood" ailment, these seniors resist medication, regarding it as something "for the weak," and psychotherapy as something "only Hollywood stars use[]."[154] These people might consider self-medication with alcohol a more acceptable alternative.[155] This makes them more prone to hospitalization after a fall or an auto accident, and may make life difficult for loved ones who are exasperated with the senior's reluctance to seek appropriate treatment.[156]

3. IDENTIFICATION OF ELDERLY SUBSTANCE ABUSE DOES NOT OCCUR THROUGH THE SAME SORTS OF SOCIAL INTERACTION AS THAT OF THE YOUNGER POPULATION

The usual methods of observing and identifying the telltale signs of substance abuse among the younger population are ineffective when diagnosing the problem in the elderly population.[157] Older substance abusers are more difficult to reach, because they tend to lead more isolated lives.[158] The standard criteria used to diagnose drinking and substance abuse are not as helpful in identifying problems in the elderly population, because most of these criteria rely heavily on assessing whether there are problems at work, problems at school, or problems with parenting and child neglect that are generally not rele-

153. *See generally supra* note 79 and accompanying text.
154. Bettye Anding, *Putting Your Brain in a Safe Place: Alcohol Is Bad Medicine for Depression*, TIMES-PICAYUNE, Feb. 27, 2000, at E1.
155. *Id*.
156. *Id*.
157. Lazar, *supra* note 9, at 003.
158. *Id*.

vant to the older population.[159] Retired individuals are not identified through the workplace, as are younger substance abusers.[160] They may drive rarely or not at all, so they are less likely to be identified while driving under the influence.[161] They may be widowed and live alone, and their children might have moved away,[162] or they may have moved away from their children to a retirement home.

B. Difficulty with Treatment in the Older Adult

Even when properly diagnosed, the standard methods of treatment for substance abuse may be ineffective when the substance abuser is elderly. Once a senior alcoholic or drug abuser is evaluated, the withdrawal process can begin.[163] Withdrawal is a psychological process as well as a physical process.[164] To treat withdrawal the elderly substance abuser should be given Valium or Librium to ease the physical withdrawal symptoms.[165] A cooperative senior with supportive and involved family members, who can monitor the dosage of the withdrawal drug over a period of four to five days, can undergo withdrawal at home.[166] However, those who experience anxiety during the withdrawal process or have a history of significant long-term alcohol abuse should be hospitalized.[167]

Medicare, the federal government's medical assistance program covering eligible individuals aged sixty-five and over,[168] covers some of the costs associated with inpatient hospital services.[169] Most medical complications in alcohol treatment occur "during the more acute

159. Patterson & Jeste, *supra* note 16, at 1184. CASA identifies "three effective early intervention methods" as "drunk-driver rehabilitation, public-intoxicant intervention and employee assistance programs." REID, *supra* note 29, at 16. Mature women are least likely to be identified with a substance abuse problem because they are less likely to drive, work, or be arrested for an alcohol-related crime. *See id.*

160. Lazar, *supra* note 9, at 003.

161. *Id.*

162. *Id.*

163. BLAZER, *supra* note 27, at 176.

164. *Id.*

165. *Id.* at 177.

166. *Id.*

167. *Id.* at 167, 177. In fact, sometimes an elderly substance abuser will not admit to, or undergo treatment for, the abuse until he or she is hospitalized for related or unrelated problems, and begins the withdrawal process during the hospital stay. *See id.* at 165–66.

168. 1 HARVEY L. MCCORMICK, MEDICARE AND MEDICAID CLAIMS & PROCEDURES § 3 (2d ed. 1986).

169. *Id.* § 323.

stages of alcoholism or alcohol withdrawal."[170] Detoxification is such a stage, and Medicare covers the cost of inpatient detoxification.[171] Generally, an individual who undergoes detoxification will be hospitalized for two or three days, though the hospital stay may be extended if the patient's condition warrants a longer stay.[172] Once detoxification is complete, the patient can be moved to a facility that provides inpatient rehabilitation services, a residential treatment program, or an outpatient treatment program.[173]

A chronic alcoholic may undergo alcohol rehabilitation in an inpatient hospital setting.[174] In such situations, the hospital stay will be covered only if it is "medically necessary for the care to be provided in an inpatient hospital setting."[175] Because rehabilitation is available through less expensive facilities and programs, Medicare will not cover a hospital stay for inpatient alcohol rehabilitation if another setting will suffice.[176] Even when the patient's condition warrants rehabilitation in an inpatient hospital setting, the stay is unlikely to last more than sixteen to nineteen days, after which the patient's care is usually continued outside an inpatient hospital setting.[177]

Outpatient hospital coverage is available for diagnostic services and therapy, subject to the same rules for outpatient services in general.[178] Treatment for drug abuse is similarly covered by Medicare when medically necessary.[179]

Once detoxified, the older substance abuser often feels quite healthy.[180] Continued treatment may include the use of Antabuse, which encourages abstinence by causing the patient to experience nausea and vomiting if he or she ingests alcohol.[181] When senior patients and family members understand the effects of mixing Antabuse with alcohol,[182] it is less likely that the patient will return to chronic

170. *Id.*
171. *Id.*
172. *Id.*
173. *Id.*
174. *Id.*
175. *Id.*
176. *Id.*
177. *Id.*
178. *Id.*
179. *Id.*
180. BLAZER, *supra* note 27, at 177.
181. *Id.*
182. The consequences of mixing Antabuse with alcohol are severe and potentially deadly.

alcohol abuse.[183] Elderly patients who have chronic health problems may be unable to utilize this means of encouraging abstinence.[184] So, Antabuse should not be prescribed for use by an elderly person who is not otherwise healthy.[185]

Self-help groups provide effective support for the senior substance abuser's long-term abstinence.[186] But when elderly substance abusers attend group meetings such as Alcoholics Anonymous, which are typically comprised of younger people, they may feel out of place.[187] They may not "identify with the people" in the group and believe them to be "too young, too strange."[188] Unless there are other attendees from the same age group or from the same social or cultural background, the elderly substance abuser may abandon the group meetings.[189] However, the values inherent in the philosophy of Alcoholics Anonymous are usually similar to those of older individuals, and its program is well-tailored to the needs of substance abusers, irrespective of age.[190]

When the elderly patient has become dependent on prescription drugs, he or she generally can withdraw from those drugs more easily than the younger person can.[191] "Many elderly patients are genuinely surprised when told they are dependent upon the drugs," and are further surprised to learn that the drugs, when used for more than a

> Antabuse is a prescription medication which produces a sensitivity to alcohol, such that a person consuming even small quantities of alcohol receives a highly unpleasant reaction. Antabuse plus alcohol, even in small amounts, produces the following reactions: flushing, throbbing in the head and neck, throbbing headache, respiratory difficulty, nausea, copious vomiting, sweating, thirst, chest pain, palpitation dyspnea, hyperventilation, tachycardia, hypertension, syncope, marked uneasiness, weakness, vertigo, blurred vision, and confusion. In severe reactions there may be respiratory depression, cardiovascular collapse, arrhythmias, myocardial infarction, acute congestive heart failure, unconsciousness, convulsions, and death.

White v. Lawrence, 975 S.W.2d 525, 527 n.1 (Tenn. 1998) (citing PHYSICIAN'S DESK REFERENCE 3008 (52d ed. 1998)).

183. BLAZER, *supra* note 27, at 177.
184. *See id.*
185. *Id.*
186. *Id.*
187. *Id.*
188. Harakas, *supra* note 1.
189. *See, e.g.*, Harakas, *supra* note 1; text accompanying *supra* notes 1–8. Mary, the elderly woman described in the introduction, stopped going to Alcoholics Anonymous meetings because she could not relate to the younger group members. *Id.*; *see also* BLAZER, *supra* note 27, at 177.
190. BLAZER, *supra* note 27, at 178.
191. TERI & LEWINSOHN, *supra* note 79, at 105.

short time, can increase pain rather than lessen it.[192] Withdrawal is accomplished through gradual reduction in the amounts of prescription drugs and replacement with plain aspirin or plain acetaminophen.[193] Treatment often incorporates increased activity levels and exercise.[194] Encouraging activities that take place outside the house can help to lessen the patient's isolation.[195]

The homebound senior poses a special problem for treatment after withdrawal. Older substance abusers may not be as physically mobile as younger substance abusers and may not be able to attend support group meetings.[196] A senior substance abuser who is not able-bodied may successfully complete a residential treatment program only to be discharged without a continuing treatment plan.[197] There are few, if any, treatment programs for the homebound.[198] The mere fact of isolation in the homebound senior may be a factor in the substance abuse itself.[199] Sadly, only one percent of senior alcoholics receive treatment for their substance abuse problem.[200] Much depends on the support of family members who must be united in their desire to encourage the elderly person to seek treatment. Older alcoholics tend to resist treatment, thus any attempt to treat the patient without support of family members is usually unsuccessful.[201]

IV. Recommendation

Due to the isolation of many seniors from environments of common social interaction, for example, employment and education,[202] individuals who frequently interact with the elderly must be aware of and seek to identify the potential problem of senior substance abuse.[203] Family, friends, caregivers, pharmacists, and people who work in senior centers or deliver meals to homebound seniors are

192. *Id.* at 106.
193. *Id.*
194. *Id.*
195. *Id.* at 108.
196. Lazar, *supra* note 9, at 003.
197. *See id.*
198. *Id.*
199. *See id.* "If they were able to come in to meetings, they might not be drinking." *Id.*
200. Harakas, *supra* note 1.
201. BLAZER, *supra* note 27, at 176.
202. *See supra* note 159 and accompanying text.
203. REID, *supra* note 29, at 57.

in a position to assist in the prevention and detection of substance abuse among the elderly.[204]

Education about, and awareness of, the senior substance abuse problem must be considered a key component of any policy designed to increase prevention and detection of substance abuse among the elderly. Similar to educational programs about drug, alcohol, and tobacco use directed at a school-age population, a concerted effort must be made to educate senior citizens, their families, and those who provide services to seniors about the prevalence of elderly substance abuse. Only through prevention, detection, and (hopefully) treatment for abuse can the substance abuser avoid irreversible physical damage. Thus, those who work with or care for the senior population must receive the information necessary to identify those at risk and be trained to gently probe into habits that indicate the likelihood of substance abuse.

Senior centers, retirement communities, and community organizations serving the elderly should provide information directly to the elderly population. These organizations should raise awareness of the problem, assist in erasing the stigma associated with substance abuse and alcoholism, and serve as a contact point for individuals who may be concerned about their personal consumption of alcohol or substance abuse. If senior citizens are properly instructed about telltale signs of abuse and how to help friends and loved ones who may have a problem, they are more likely to seek help if they display those same signs themselves.

Once trained and educated about elderly substance abuse problems, certain groups of people will be better equipped to perform specific and unique roles that are well suited to their positions in the community. Indeed, CASA suggests that physicians, pharmacists, informal gatekeepers, visiting nurses and home health aides, and family and friends are all vital to a successful effort to prevent, detect and treat substance abuse among the elderly.[205]

204. *Id.*
205. *Id.*

A. Physicians

"[P]hysicians have a unique opportunity to intervene successfully" in substance abuse problems.[206] In fact, "as little as five minutes" of physician counseling will help prevent the development of substance abuse.[207] CASA recommends that all doctors learn, "whether through medical school, continuing medical education or their own initiative," about the effects of alcohol and prescription drugs on the mature body.[208] They should also take a "full inventory" of alcohol and prescription drug use by the mature patient before writing a prescription.[209] Health maintenance organizations and other managed care organizations generally coordinate patient care through a primary care physician who can watch for inappropriate, or multiple, prescriptions by physicians who do not know what other physicians are prescribing for the patient.[210]

Physicians' relative lack of awareness about substance abuse among today's elderly can result in a failure to diagnose an elderly patient's symptoms, which may have life-threatening consequences. Despite the fact that most physicians receive little or no training on substance abuse,[211] they nonetheless may be subjected to liability for medical malpractice for failure to diagnose a substance abuse problem.[212]

As medical practitioners increasingly incorporate substance abuse counseling and monitoring into their elderly patient care, this will become the professional custom of doctors who treat elderly patients. Those doctors who then fail to perform counseling and monitoring for substance abuse problems among the elderly may be subjected to medical malpractice claims for breach of a duty to the patient, falling below the standard of care common to the profession.[213]

206. *Id.*
207. *Id.* at 59.
208. *Id.*
209. *Id.*
210. *Id.*
211. REID, *supra* note 29, at 50; *see also supra* note 75.
212. RESTATEMENT (SECOND) OF TORTS § 282 (1965). A physician may be negligent for "conduct which falls below the standard established by law for the protection of others against unreasonable risk of harm." *Id.* Negligent conduct may arise through an action or "failure to do an act which is necessary for the protection or assistance of another and which the actor is under a duty to do." *Id.* § 284.
213. The professional standard of care pertains to those occupations in which specialized skill, training, and/or postgraduate education is necessary. JOHN L.

Physicians gradually and subconsciously may begin to incorporate substance abuse counseling and monitoring into the care of elderly patients simply because, as their patients age, they will continue to screen them for substance abuse problems as they now do. Also, some doctors are baby boomers themselves and are well acquainted with that demographic group's greater tendency to use illicit drugs and alcohol.[214] This will likely result in higher rates of screening for such tendencies. But physicians must educate themselves about the problem not only in tomorrow's elderly, but also in today's elderly, and they should aggressively screen their current patients to provide appropriate and effective medical treatment. If doctors fail to be more proactive about diagnosis in this regard, the courts may need to force it upon them.

B. Pharmacists

Pharmacists are also in a unique position to counsel and monitor substance abuse in the elderly. Because they maintain records of all drugs prescribed to a patient, pharmacists can monitor an elderly patient's prescriptions and notify the patient's physician(s) of duplication or dangerous combinations of prescription drugs.[215] Additionally, pharmacists can counsel the patient on how to use the drug safely[216] and are often more accessible and perhaps more approachable than a physician.

"Over the years, the view of pharmacy has evolved into greater recognition of pharmacists as proactive professionals in the health care field."[217] In recent years, some courts have increasingly been willing to find that pharmacists "owe a duty to exercise due care and diligence in the performance of their professional duties."[218] For example, one court found that a pharmacy failed to exercise due care and diligence when it failed to warn a patient about the safe dosage of a drug

DIAMOND ET AL., UNDERSTANDING TORTS 98 n.2 (1996). "[T]he standard of skill and knowledge required . . . is that which is commonly possessed by members of that profession or trade in good standing." RESTATEMENT (SECOND) OF TORTS § 299A cmt. e (1965).

214. *See supra* notes 31–32 and accompanying text.

215. REID, *supra* note 29, at 60.

216. *Id*.

217. Roseann B. Termini, *The Pharmacist Duty to Warn Revisited: The Changing Role of Pharmacy in Health Care and the Resultant Impact on the Obligation of a Pharmacist to Warn*, 24 OHIO N.U. L. REV. 551, 552 (1998).

218. *Id*. at 557.

prescribed by a physician.[219] Another court held a pharmacy liable for failure to monitor for adverse drug interaction after advertising that its computer system monitored its customer medications.[220] The court found that the pharmacy voluntarily undertook a duty to monitor medications for its customers through promotion of its computer system.[221] The foregoing demonstrates that some courts are moving toward imposing a standard of care on pharmacists beyond the accurate filling of prescriptions.[222]

Regulatory agencies have used their rule-making authority to make it easier for courts to hold as those discussed above have. Recent regulations by the Food and Drug Administration require pharmaceutical manufacturers to provide information about precautions for some drugs and dosages for "geriatric use."[223] The label must contain "what is known about a drug's effects on adults over 64 and any limitations or monitoring required when they take the medication."[224] Further regulation at the federal or state level might enhance the benefit of this labeling by requiring the pharmacist to disclose and discuss the information with the patient.

C. Informal Gatekeepers

Informal gatekeepers are in a unique position to recognize substance abuse problems among the elderly through interaction with the elderly in their homes or in informal situations in which substance abuse problems are more likely to manifest.[225] According to CASA, informal gatekeepers can include, among others, "mail carriers, law enforcement personnel, meter readers, bank personnel, power company billing personnel, . . . telephone company employees, fuel oil dealers, city/county employees, [and] managers of apartments of senior citizens."[226] Communities can establish informal gatekeeper networks and train them to identify the problem of substance abuse among the elderly and know how to contact the appropriate authority

219. *Id.*; *see also* Riff v. Morgan Pharmacy, 508 A.2d 1247, 1251–52 (Pa. 1986).
220. Termini, *supra* note 217, at 559; *see also* Baker v. Arbor Drugs, Inc., 544 N.W.2d 727, 731 (Mich. 1996).
221. Termini, *supra* note 217, at 559; *see Baker*, 544 N.W.2d at 731, 733.
222. *See generally* Termini, *supra* note 217.
223. REID, *supra* note 29, at 60.
224. *Id.*
225. *See generally id.* at 61.
226. *Id.* at 61. One such program, Elderly Services of Spokane, "has assembled a diverse cadre of gatekeepers." *Id.*

if needed. With such gatekeepers in place, a person who purposely abstains from alcohol or overuse of prescription drugs before a doctor's appointment is less able to conceal a substance abuse problem because the individual cannot easily manipulate his or her spontaneous and frequent contact with these informal gatekeepers.

D. Visiting Nurses and Home Health Aides

Visiting nurses and home health aides are also in an excellent position to evaluate an elderly person in an informal and more relaxed environment.[227] Although visiting nurses and home health aides serve the medical needs of their patients, they often receive little or no training on the issue of substance abuse among the elderly, and they are not trained on how to communicate with a patient who is suspected of substance abuse.[228] Yet, because they provide services in the patient's home, they are able to observe the suspected abuser in his or her own environment and to look for telltale signs of substance abuse, such as empty liquor bottles or numerous drug prescriptions.

Visiting nurses and home health aides often develop closer relationships with senior citizens than do doctors, due to the frequency of contact and increased time spent with the patient. The patient may be more responsive to questions by visiting nurses or home health aides and may be more likely to broach the subject of an alcohol or drug problem with them. With some training on the issue of elder substance abuse and how to discuss the issue with their patients, visiting nurses and home health aides need not remain an underutilized resource in substance abuse detection.

E. Family and Friends

Family and friends are also an underutilized resource in the prevention and detection of substance abuse among the elderly. Yet, authorities say that the support of families and friends is vital if an elderly substance abuser is to receive effective treatment for the problem.[229] When loved ones are not involved in an elderly person's treatment, the treatment is likely to fail, especially when the patient has been reluctant to admit to the problem or vehemently denies the

227. *See id.* at 63.
228. *Id.*
229. BLAZER, *supra* note 27, at 176.

problem exists.[230] In spite of their conflicting roles, loved ones are an invaluable source of information for a physician who is treating an elderly substance abuser. A family member or close friend may provide insight into the severity and duration of the patient's habit and can often provide details that the patient might be reluctant to reveal to the physician.[231] The simple fact that a loved one knows about the problem may lead a patient to be more forthcoming with the details because he knows the family member will tell the doctor if he does not do so himself.

A family member may also prove valuable through the ability to shed light on the patient's family medical history, which may include a history of substance abuse.[232] Genetic or hereditary factors may predispose an individual to substance abuse.[233] "Alcoholics who survive into late life after years of abuse and dependence clearly exhibit this genetic predisposition to the development of alcohol problems."[234] Of course, the simple involvement and love of family and friends may give an elderly substance abuser a reason to accept treatment rather than simply give in to the dependence.

However, family members may hesitate to confront an older family member about a substance abuse problem. Confronting an elderly relative about such a problem may be awkward, and some may feel they just do not know how to address the topic. A family member may feel she does not have ample reason or suspicion to confront the substance abuser and might worry she would anger the elderly relative. On the other hand, the confrontation may finally and painfully bring out into the open what the family has hidden over the years. Neither prospect is a pleasant one.

Family physicians can facilitate the dialogue by counseling patients who may have elderly parents or loved ones. As baby boomers age, many of them have elderly parents who may be experiencing a substance abuse problem. Physicians can convey the extent of the problem of elder substance abuse and discuss the subject with their middle-aged patients. Urging their patients to keep a close eye out for signs that an elderly relative may have a substance abuse problem would serve a number of purposes. These conversations would allow

230. *Id.*
231. *See id.* at 174.
232. *Id.*
233. *Id.* at 170–71.
234. *Id.* at 171.

younger people to understand the magnitude of the problem and learn about the resources available for older substance abusers to free themselves of their dependence, as well as providing an opportunity to freely discuss substance abuse problems that may afflict the younger patient, either at present or in the future. Most of all, it would give people the chance to develop the vocabulary necessary to bring the issue out into the open.

V. Conclusion

Substance abuse among the elderly is a growing problem that threatens to pose serious consequences for our aging population. Substance abusers may carry a life-long problem into their later years or develop late-onset substance abuse when they become older. Aging baby boomers, who have a more relaxed attitude about substance abuse, are likely to cause an explosive increase in the problem of elder substance abuse. Now is the time to talk about the problem, establish networks for prevention and detection of substance abuse problems, and develop effective treatments tailored to meet the needs of elderly abusers. Most of all, a vocabulary needs to be developed to facilitate discussion about this problem, so that grandma will not be thought of as a "drunk," but rather as a person with a disease that can be treated at any stage of life.