[COMMITTEE PRINT]

94th Congress
1st Session

SENATE

REPORT
No.

NURSING HOME CARE IN THE UNITED STATES: FAILURE IN PUBLIC POLICY

Supporting Paper No. 3

DOCTORS IN NURSING HOMES: THE SHUNNED RESPONSIBILITY

PREPARED BY THE

SUBCOMMITTEE ON LONG-TERM CARE

OF THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

FEBRUARY 1975

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PREFACE

Federal support of long-term care for the elderly has, within a decade, climbed from millions to billions of dollars.

What is the Nation receiving for this money?

This report explores that, and related questions.

It concludes that public policy has failed to produce satisfactory institutional care—or alternatives—for chronically ill older Americans.

Furthermore, this document—and other documents to follow—declare that today's entire population of the elderly, *and their offspring*, suffer severe emotional damage because of dread and despair associated with nursing home care in the United States today.

This policy, or lack thereof, may not be solely responsible for producing such anxiety. Deep-rooted attitudes toward aging and death also play major roles.

But the actions of the Congress and of States, as expressed through the Medicare and Medicaid programs, have in many ways intensified old problems and have created new ones.

Efforts have been made to deal with the most severe of those problems. Laws have been passed; national commitments have been made; declarations of high purpose have been uttered at national conferences and by representatives of the nursing home industry.

But for all of that, long-term care for older Americans stands today as the most troubled, and troublesome, component of our entire health care system.

It is costly and growing costlier.

It is increasing in numbers, already providing more beds than there are beds in general hospitals.

And there is every reason to believe that many more beds will be needed because the population of old persons in this Nation continues to grow faster than any other age group.

Nursing home care is associated with scandal and abuse, even though the best of its leaders have helped develop vitally needed new methods of care and concern for the elderly, and even though—day in and day out—underpaid, but compassionate, aides in many homes attempt to provide a touch of humanity and tender care to patients who, though mute or confused and helpless, nevertheless feel and appreciate kindness and skill.

This industry, which has grown very rapidly in just a few decades—and most markedly since 1965, when Medicare and Medicaid were enacted—could now take one of three courses:

It could continue to grow as it has in the past, spurred on by sheer need, but marred by scandal, negativism, and murkiness about its fundamental mission.

It could be mandated to transform itself from a predominantly proprietary industry into a nonprofit system, or into one which takes on the attributes of a quasi-public utility.

Or it could—with the informed help of Government and the general public—move to overcome present difficulties, to improve standards of performance, and to fit itself more successfully into a comprehensive health care system in which institutionalization is kept to essential minimums.

Whatever course is taken, it is certain that the demand for improvement will become more and more insistent.

Within the Congress, that demand has been clearly expressed in recent years. But often congressional enactments have been thwarted by reluctant administration, or simply have been ignored. Now, facing the prospect of early action upon a national health program for all age groups, the Congress must certainly consider long-term care a major part of the total package. Wisely used, the momentum for a total health care package could be used to insure better nursing home care.

Within the administration, there has been drift and unresponsiveness to congressional mandate since 1965. There are signs, however, that rising costs and rising public concern have aroused certain members of the executive branch to see the need for long-term care reform more clearly than before. Their actions and initiatives are welcome, but it is essential that the Department of Health, Education, and Welfare take far more effective, well-paced action than it has thus far.

Everywhere, the demand for reform is intensifying. People know that a nursing home could be in everyone's future.

They ask why placement in such a home should be the occasion for despair and desperation, when it should be simply a sensible accommodation to need.

The Subcommittee on Long-Term Care of the Senate Special Committee on Aging continually has asked the same question.

Care for older persons in need of long-term attention should be one of the most tender and effective services a society can offer to its people. It will be needed more and more as the number of elders increases and as the number of very old among them rises even faster.

What is needed now? As already indicated, the forthcoming debate over a national health program will offer opportunity for building good long-term care into a comprehensive program for all Americans.

But the issues related to the care of the chronically ill are far from simple. Tangled and sometimes obscure, technical questions related to such matters as reimbursement, establishment of standards, enforcement, and recordkeeping, often attract the attention of policymakers, to the exclusion of other questions, such as:

Could nursing homes be avoided for some, if other services were available?

What assurance is there that the right number of nursing homes are being built where they are most needed?

What measures can Government take to encourage providers themselves to take action to improve the quality of nursing home care?

What can be done to encourage citizen action and patient advocacy at the local level?

Such questions intrude even when the best of care is given. In other settings, however, scandal and calamity enter the picture; and dark new questions emerge.

The subcommittee, in this report and succeeding Supporting Papers, recognizes the importance of the nursing home industry; and it pledges every effort to continue communication with representatives of the industry and with members of the executive branch.

For these reasons, the subcommittee has devised an unusual format: After publication of the Introductory Report, a series of follow-up papers on individual issues will follow; then we will publish a compendium of statements invited from outside observers; after this will come our final report. In this way, the subcommittee can deal with the many parts needed to view long-term care as a whole.

Testimony from many, many days of hearings and other research have been tapped for this report, which is extensive and heartfelt. Concern about people has been at the heart of this effort. The subcommittee has, therefore, been especially dependent upon responsive staff effort. Mr. Val Halamandaris, associate counsel for the Senate Special Committee on Aging, deserves specific mention for his role in assuring that subcommittee inquiries remained directed at their real target: to wit, people in need of good care. Mr. Halamandaris has had the primary responsibility for directing the subcommittee's hearings: he is responsible for the excellent research on data and for writing this report. He is more than a skilled and attentive attorney; his investigatory skills are rooted in concern and, when necessary, outrage. He has made it possible for this subcommittee to compile and offer more information and insights into the nursing home industry than the Congress has ever had before.

He has been helped considerably by other committee personnel. Staff Director William Oriol has provided guidance and consultation leading to the design and special points of emphasis in this report. Committee Counsel David Affeldt has given generously of his legislative expertise, as well as painstaking attention to detail.

Particularly fortunate for the subcommittee was the fact that a professional staff member, John Edie, had special qualifications for making a substantial contribution to this effort. Mr. Edie, an attorney, formerly served as counsel to a program on aging in Minneapolis, Minn. When the subcommittee went to that city for intensive hearings on scandalous shortcomings in nursing home care there, Mr. Edie testified and then continued his efforts on behalf of reform. In the preparation of this report, he has worked closely and at length with Mr. Halamandaris and his associates.

The subcommittee also stands in debt to a select group in the nursing home industry and within the executive branch. Usually without much attention or encouragement, these public servants have stubbornly refused to compromise their goal, seeking high, but reasonable, standards of care.

With the publication of the Introductory Report, the subcommittee begins a final exploration of issues. We will publish responsible comments on findings expressed in this document and the Supporting

Papers which precede and will follow. And we will, in our final report, perhaps 8 to 10 months from now, make every effort to absorb new ideas or challenges to our findings. The care of chronically ill older Americans is too serious a topic for stubborn insistence upon fixed positions. Obviously, changes are needed. Obviously, those changes will occur only when public understanding and private conscience are stirred far more than is now the case.

FRANK E. MOSS,
Chairman, Subcommittee on Long-Term Care.

CONTENTS

NURSING HOME CARE IN THE UNITED STATES: FAILURE IN PUBLIC POLICY

SUPPORTING PAPER NO. 3

DOCTORS IN NURSING HOMES: THE SHUNNED RESPONSIBILITY

ABOUT THIS REPORT

To deal with the intricate circumstances and governmental actions associated with nursing home care in this Nation, the Subcommittee on Long-Term Care of the U.S. Senate Special Committee on Aging is issuing several documents under the general title of *Nursing Home Care in the United States: Failure in Public Policy.*

An Introductory Report, published in November, declared that a coherent, constructive, and progressive policy on long-term care has not yet been shaped by the Congress and by the executive branch of this Nation.

Examining the role of Medicare and Medicaid in meeting the need for such care, the report found that both programs are deficient.

Further, it raised questions about current administration initiatives originally launched personally by President Nixon in 1971.

These shortcomings of public policy, declared the report, are made even more unfortunate by the clear and growing need for good quality care for persons in need of sustained care for chronic illness. It called for good institutions and, where appropriate, equally good alternatives, such as home health services.

(A more detailed summary of major findings from the Introductory Report appears later in this section of this report.)

Supporting Paper No. 3 analyzes the reasons for the absence of the physician from the nursing home setting. It then analyzes the consequences of this absence as well as offering recommendations designed to insure greater physician involvement in the care of nursing home patients.

THE FACTUAL UNDERPINNING OF THIS STUDY

Fifteen years of fact-gathering preceded publication of this report. In 1959, the Senate Committee on Labor and Public Welfare established a Subcommittee on Problems of the Aged and Aging. Findings from subcommittee reports and hearings have been evaluated. That

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subcommittee acknowledged in 1960, as this report acknowledges in 1974, that nursing homes providing excellent care with a wide range of supportive services are in the minority.

With the establishment of the U.S. Senate Special Committee on Aging in 1961, additional hearings were conducted. The most recent phase began in 1969 with hearings on "Trends in Long-Term Care." Since 1969, 22 hearings were held and some 3,000 pages of testimony were taken, as of October 1973.

These hearing transcripts have provided valuable information and expert opinions, as have several supplementary studies by the subcommittee staff, the General Accounting Office and private groups such as Ralph Nader's Study Group on Nursing Homes in 1971. The Library of Congress and other congressional committees, as well as professional organizations such as the American Nursing Home Association, have also been helpful. Finally, a great portion of the data is from the Department of Health, Education, and Welfare and other administrative or independent agencies, such as the Securities and Exchange Commission. The assistance of State officials proved especially helpful.

ORGANIZATION OF THIS STUDY

The Introductory Report and this Supporting Paper will be followed by other Supporting Papers to be published at approximately monthly intervals over the next few months. Each will deal with a fairly specific issue, and each of these issues will be examined in the detail needed for understanding, not only by legislative and health specialists, but by laymen.

A study of this magnitude would be incomplete without reaction by the nursing home industry and by representatives of the executive branch. Accordingly, national organizations and appropriate governmental units will be invited to submit statements within 2 months after publication of the final Supporting Paper. Finally, the subcommittee will issue a concluding report intended to update earlier information and to analyze the situation at that time.

The format is unusual, perhaps unprecedented. But the nursing home industry is too vital a part of our health system and of the national scene for lesser treatment.

MAJOR POINTS OF THIS SUPPORTING PAPER

Physicians have shunned their responsibility for nursing home patients. With the exception of a small minority, doctors are infrequent visitors to nursing homes.

Doctors avoid nursing homes for many reasons:

- **There is a general shortage of physicians in the United States, estimates vary from 20,000 to 50,000.**
- **Increasing specialization has left smaller numbers of general practitioners, the physicians most likely to care for nursing home patients.**

• Most U.S. medical schools do not emphasize geriatrics to any significant degree in their curricula. This is contrasted with Europe and Scandinavia where geriatrics has developed as a specialty.

• Current regulations for the 16,000 facilities participating in Medicare or Medicaid require comparatively infrequent visits by physicians. The some 7,200 long-term care facilities not participating in these programs have virtually no requirements.

• Medicare and Medicaid regulations constitute a disincentive to physician visits; rules constantly change, pay for nursing home visits is comparatively low, and both programs are bogged down in redtape and endless forms which must be completed.

• Doctors claim that they get too depressed in nursing homes, that nursing homes are unpleasant places to visit, that they are reminded of their own mortality.

• Physicians complain that there are few trained personnel in nursing homes that they can count on to carry out their orders.

• Physicians claim they prefer to spend their limited time tending to the younger members of society; they assert there is little they can do for the infirm elderly. Geriatricians ridicule this premise. Others have described this attitude as the "Marcus Welby syndrome."

The absence of the physician from the nursing home setting means placing a heavy burden on the nurses who are asked to perform many diagnostic and therapeutic activities for which they have little training. But there are few registered nurses (56,000) in the Nation's 23,000 nursng homes. These nurses are increasingly tied up with administrative duties such as ordering supplies and filling out Medicare and Medicaid forms. The end result is that unlicensed aides and orderlies with little or no training provide 80 to 90 percent of the care in nursing homes.

It is obvious that the physician's absence results in poor medical, and to some degree, poor nursing care. Poor care has many dimensions, it means:

• No visits, infrequent, or perfunctory visits.

• The telephone has become a more important medical instrument in nursing homes than the stethoscope.

• No physical examinations, proforma or infrequent examinations.

• Some patients receive insulin with no diagnosis of diabetes.

• Significant numbers of patients receive digitalis who have no diagnosis of heart disease.

• Large numbers of patients taking heart medication or drugs which might dangerously lower the blood pressure, do not receive blood pressure readings even once a year.

• Some 20 to 50 percent of the medications in U.S. nursing homes are given in error.

• Less than 1 percent of all infectious diseases in the United States are reported—a special problem in nursing homes where patients have advanced age and lessened resistance. This fact was graphically proven in 1970 when 36 patients died in a Salmonella epidemic in a Baltimore, Md. nursing home.

• Physicians do not view the bodies of patients who have died in nursing homes before signing death certificates.

The need for physicians to exercise greater responsibility for the 1 million patients in U.S. nursing homes is abundantly clear from these and other facts. Until doctors take a greater interest the litany of nursing home abuses will continue, the majority of America's nursing homes will be substandard, and the quality of patient care will be unacceptable.

MAJOR POINTS OF INTRODUCTORY REPORT

(Issued November 19, 1974)

Medicaid now pays about 50 percent of the Nation's more than $7.5 billion nursing home bill, and Medicare pays another 3 percent. Thus, more than $1 of every $2 in nursing home revenues is publicly financed.*

There are now more nursing home beds (1.2 million) in the United States today than general and surgical hospital beds (1 million).

In 1972, for the first time, Medicaid expenditures for nursing home care exceeded payments for surgical and general hospitals: 34 percent as compared to 31 percent for hospitals.

Medicaid is essential for growing numbers of elderly, particularly since Medicare nursing home benefits have dropped sharply since 1969. Average Social Security benefits for a retired couple now amount to $310 a month compared to the average nursing home cost of $600. Medicaid (a welfare program) must be called upon to make up the difference.

The growth of the industry has been impressive. Between 1960 and 1970, nursing home facilities increased by 140 percent, beds by 232 percent, patients by 210 percent, employees by 405 percent, and

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* The Committee's Introductory Report, as released on November 19, 1974, incorporating the latest statistics from HEW reported that total revenues for the nursing home industry in 1972 were $3.2 billion and $3.7 billion for 1973. Subsequent to publication of this report the Social Security Administration released new estimates for 1974. Total expenditures are estimated at $7.5 billion. This change reflects spending for the Intermediate Care program, which until recently was a cash-grant program to old age assistance recipients. With its change to a vendor payments program such expenses are properly countable as nursing home expenditures. Consequently, changes were made in this report.

expenditures for care by 465 percent. Measured from 1960 through 1974, expenditures increased almost 1,400 percent.

Despite the heavy Federal commitment to long-term care, a coherent policy on goals and methods has yet to be shaped. Thousands of seniors go without the care they need. Others are in facilities inappropriate to their needs. Perhaps most unfortunate, institutionalization could have been postponed or prevented for thousands of current nursing home residents if viable home health care and supportive services existed. Although such alternative forms of care may be more desirable from the standpoint of elderly patients—as well as substantially less expensive—the Department of HEW has given only token support for such programs.

Despite the sizable commitment in Federal funds, HEW has been reluctant to issue forthright standards to provide patients with minimum protection. Congress in 1972 mandated the merger of Medicare and Medicaid standards, with the retention of the highest standard in every case. However, HEW then watered down the prior standards. Most leading authorities concluded at subcommittee hearings that the new standards are so vague as to defy enforcement.

There is no direct Federal enforcement of these and previous Federal standards. Enforcement is left almost entirely to the States. A few do a good job, but most do not. In fact, the enforcement system has been characterized as scandalous, ineffective, and, in some cases, almost nonexistent.

The President's program for "nursing home reform" has had only minimal effect since it was first announced in 1971 and actions in 1974 fall far short of a serious effort to regulate the industry.

The victims of Federal policy failures have been Americans who are desperately in need of help. The average age of nursing home patients is 82; 95 percent are over 65 and 70 percent are over 70; only 10 percent are married; almost 50 percent have no direct relationship with a close relative. Most can expect to be in a nursing home over 2 years. And most will die in the nursing home. These patients generally have four or more chronic or crippling disabilities.

Most national health insurance proposals largely ignore the long-term care needs of older Americans. Immediate action is required by the Congress and executive branch to improve past policies and programs which have been piecemeal, inappropriate, illusory, and short-lived.

MAJOR POINTS OF SUPPORTING PAPER NO. 1
(Issued December 17, 1974)

"THE LITANY OF NURSING HOME ABUSES AND AN EXAMINATION OF THE ROOTS OF CONTROVERSY"

The subcommittee's Supporting Paper No. 1 reveals the following were the most important nursing home abuses:

- Negligence leading to death and injury;
- Unsanitary conditions;
- Poor food or poor preparation;
- Hazards to life or limb;
- Lack of dental care, eye care or podiatry;
- Misappropriation and theft;
- Inadequate control of drugs;
- Reprisals against those who complain;
- Assault on human dignity; and
- Profiteering and "cheating the system."

The inevitable conclusion is that such abuses are far from "isolated instances." They are widespread. Estimates of the number of substandard homes (that is, those in violation of one or more standards causing a life-threatening situation) vary from 30 to 80 percent. The subcommittee estimates at least 50 percent are substandard with one or more life-threatening conditions.

These problems have their roots in contemporary attitudes toward the aging and aged. As Senator Frank E. Moss, chairman of the Subcommittee on Long-Term Care, has said:

> It is hell to be old in this country. The pressures of living in the age of materialism have produced a youth cult in America. Most of us are afraid of getting old. This is because we have made old age in this country a wasteland. It is T. S. Eliot's rats walking on broken glass. It's the nowhere in between this life and the great beyond. It is being robbed of your eyesight, your mobility, and even your human dignity.

Such problems also have their roots in the attitudes of the elderly toward institutionalization. Nursing home placement often is a bitter confirmation of the fears of a lifetime. Seniors fear change and uncertainty; they fear poor care and abuses; loss of health and mobility; and loss of liberty and human dignity. They also fear exhausting their savings and "going on welfare." To the average older American, nursing homes have become almost synonymous with death and protracted suffering before death.

However, these arguments cannot be used to excuse nursing home owners or operators or to condone poor care. Those closest to the action rightly must bear the greatest portion of responsibility.

To deal with the litany of abuses, action must be taken immediately by the Congress and the executive to: (1) Develop a national policy with respect to long-term care; (2) provide financial incentives in favor of good care; (3) involve physicians in the care of nursing home patients; (4) provide for the training of nursing home personnel; (5) promulgate effective standards; and (6) enforce such standards.

MAJOR POINTS OF SUPPORTING PAPER NO. 2
(Issued January 17, 1974)

"DRUGS IN NURSING HOMES: MISUSE, HIGH COSTS, AND KICKBACKS"

The average nursing home patient takes from four to seven different drugs a day (many taken twice or three times daily). Each patient's drug bill comes to $300 a year as compared with $87 a year for senior citizens who are not institutionalized. In all, $300 million a year is spent for drugs, 10 percent of the Nation's total nursing home bill.

Almost 40 percent of the drugs in nursing homes are central nervous system drugs, painkillers, sedatives, or tranquilizers.

Tranquilizers themselves constitute almost 20 percent of total drugs—far and away the largest category of nursing home drugs.

Drug distribution systems used by most nursing homes are inefficient and ineffective. An average home of 100 beds might have 850 different prescription bottles and 17,000 doses of medication on hand. Doctors are infrequent visitors to nursing homes. Nurses are few and overworked. All too often, the responsibility for administering medications falls to aides and orderlies with little experience or training.

Not surprisingly, 20 to 40 percent of nursing home drugs are administered in error.

Other serious consequences include: the theft and misuse of nursing home drugs; high incidence of adverse reactions; some disturbing evidence of drug addiction; and lack of adequate controls in the regulation of drug experimentation.

Perhaps most disturbing is the ample evidence that nursing home patients are tranquilized to keep them quiet and to make them easier to take care of. Tragically, recent research suggests that those most likely to be tranquilized may have the best chance for effective rehabilitation.

Kickbacks are widespread. A kickback is the practice whereby pharmacists are forced to pay a certain percentage of the price of nursing home prescription drugs back to the nursing home operator for the privilege of providing those services.

The atmosphere for abuse is particularly inviting when reimbursement systems under Federal and State programs allow the nursing home to act as the "middle man" between the pharmacy (which supplies the drugs) and the source of payment (private patient, Medicare, or Medicaid).

Kickbacks can be in the form of cash, long-term credit arrangements, and gifts of trading stamps, color televisions, cars, boats, or prepaid vacations. Additionally, the pharmacist may be required to "rent" space in the nursing home, to furnish other supplies free of charge, or to place nursing home employees on his payroll.

The average kickback is 25 percent of total prescription charges; over 60 percent of 4,400 pharmacists surveyed in California reported that they had either been approached for a kickback or had a positive belief that kickbacks were widespread; these same pharmacists projected $10 million in lost accounts for failure to agree to kickback proposals.

In order to lower costs to meet kickback demands, pharmacists admitted numerous questionable, if not illegal, practices such as: billing welfare for nonexistent prescriptions, supplying outdated drugs or drugs of questionable value, billing for refills not dispensed, supplying generic drugs while billing for brand names, and supplying stolen drugs which they have purchased.

Congressional action in 1972 to make kickbacks illegal has had little effect. HEW has yet to announce regulations to implement this law.

MAJOR POINTS OF FORTHCOMING SUPPORTING PAPERS

Supporting Paper No. 4

"NURSES IN NURSING HOMES: THE HEAVY BURDEN (THE RELIANCE ON UNTRAINED AND UNLICENSED PERSONNEL)"

Of the 815,000 registered nurses in this Nation, only 56,235 are found in nursing homes, and much of their time is devoted to administrative duties. From 80 to 90 percent of the care is provided by more than 280,000 aides and orderlies, a few of them well trained, but most literally hired off the streets. Most are grossly overworked and paid at, or near, the minimum wage. With such working conditions, it is understandable that their turnover rate is 75 percent a year.

One reason for the small number of registered nurses in nursing homes is that present staffing standards are unrealistic. The present Federal standard calls for one registered nurse coverage only on the day shift, 7 days a week, regardless of the size of the nursing home. By comparison, Connecticut requires one registered nurse for each 30 patients on the day shift, one for every 45 in the afternoon; and one for each 60 in the evening.

Supporting Paper No. 5

"THE CONTINUING CHRONICLE OF NURSING HOME FIRES"

In 1971, there were 4,800 nursing home fires; 38 persons were killed in multiple death fires and some 500 more in single death fires. An estimated $3.5 million loss was directly attributable to nursing home fires.

Nursing home patients are especially vulnerable to fires. Many are under sedation or bound with restraints. Physical infirmities and confusion often cause resistance to rescue.

There is reason to believe the number of nursing homes failing to meet fire safety standards is actually increasing.

In 1971, the General Accounting Office reported that 50 percent of U.S. nursing homes were deficient in regard to fire safety. A January 1974 study by the U.S. Office on Nursing Home Affairs said that 59 percent of skilled nursing facilities are certified with deficiencies. HEW spokesmen indicated that in excess of 60 percent of intermediate facilities do not comply with existing standards. The requirements are on the books, but they are not heeded. Even more dramatically, the GAO 1974 study indicates 72 percent of U.S. nursing homes have one or more major fire deficiencies.

Supporting Paper No. 6

"WHAT CAN BE DONE IN NURSING HOMES: POSITIVE ASPECTS IN LONG-TERM CARE"

It is unjust to condemn the entire nursing home industry. There are many fine homes in America. A growing number of administrators are insisting upon positive approaches to therapy and rehabilitation, innovations in physical structure of the physical plant; employee sensitivity training and cooperative agreements with local schools of nursing; and even self-government and other activities for the patients.

"Ombudsmen" programs have been established by Presidential direction and are making some headway. In some States, the nursing home industry has launched an effort to upgrade its facilities by establishing directories, rating systems, and a "peer review" mechanism. These efforts offer the prospect of improving nursing home

conditions if conducted in a vigorous and effective manner. In Chicago, nursing homes have a "cool line" telephone number for relatives, visitors, or patients who have complaints.

Supporting Paper No. 7

"THE ROLE OF NURSING HOMES IN CARING FOR DISCHARGED MENTAL PATIENTS"

Thousands of elderly patients have been transferred from State mental institutions to nursing homes. The number of aged in State mental hospitals decreased 40 percent between 1969 and 1973, according to subcommittee data, dropping from 133,264 to 81,912. This trend is caused partially by progressive thinking intended to reduce patient populations in large impersonal institutions. Another powerful reason, however, may be cost and the desire to substitute Federal for State dollars. It costs the States an average of $800 per patient per month to care for mental patients in State hospitals while these same individuals can be placed in boarding homes at a substantially reduced cost. Charges of "wholesale dumping" of patients have been made in several States. Acute problems have been reported, most notably in California, Illinois, and New York.

Supporting Paper No. 8

"ACCESS TO NURSING HOMES BY U.S. MINORITIES"

Only 4 percent of the 1 million nursing home patients in the United States are members of minority groups, even though their health needs are proportionately greater. Part of the problem is caused by cost obstacles or lack of information about Medicaid. Discrimination is the greatest obstacle to greater utilization by blacks. But discrimination need not be overt; often relatives are made to feel that their parent or grandparent would not be made comfortable. In the case of Asian-Americans and Spanish-speaking Americans, language barriers often cause insurmountable difficulties. Cultural and other problems, including rural isolation, cause problems to American Indians.

Members of minority groups at subcommittee hearings have been sharply critical of the Nixon administration's nursing home "reforms." They protested the "arbitrary and punitive" closing of a few minority owned nursing homes that do exist and the absence of assistance to help upgrade standards.

Supporting Paper No. 9

"PROFITS AND THE NURSING HOME: INCENTIVES IN FAVOR OF POOR CARE"

Profits by nursing homes have occasioned serious and persistent controversy. Nursing home administrators say that Medicaid reimbursement rates are low and that they can hardly become the basis for profiteering. Critics say that the economics of nursing home operation, supported in such large measure by public funds, should be examined more closely and publicly than they now are.

On the basis of available evidence, including a subcommittee survey made in 1973–74, the subcommittee has found that the 106 publicly held corporations controlled 18 percent of the industry's beds and accounted for one-third of the industry's $3.2 billion in revenue (as of 1972). Between 1969 and 1972, these corporations experienced the following growth:

122.6 percent in total assets;

149.5 percent in gross revenues; and

116 percent in average net income.

One recent HEW study, however, shows marginal rates of return in a sample of 228 nursing homes. Thus, the issue is far from settled. But a joint study—conducted by the General Accounting Office and the subcommittee—suggests significant increases in total assets, revenues, and profits for individual operators as well.

Two final documents will be issued as part of this study: A compendium of statements by the industry and administration spokesmen, and a final report by the Subcommittee on Long-Term Care.

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NURSING HOME CARE IN THE UNITED STATES: FAILURE IN PUBLIC POLICY

SUPPORTING PAPER NO. 3

DOCTORS IN NURSING HOMES: THE SHUNNED RESPONSIBILITY

———.—Ordered to be printed

Mr. Moss, from the Special Committee on Aging, submitted the following

REPORT

INTRODUCTION

Physicians have by and large shunned their responsibility for nursing home patients. With the exception of a small minority, doctors are infrequent visitors to nursing homes, avoiding them for many reasons. They become depressed, they are reminded of their own mortality, and there are few trained personnel in nursing homes to assist them. The pay is low, and it is often inconvenient for a physician to travel many miles to see one or two patients in isolated nursing homes.

Changing rules and redtape associated with the Medicare and Medicaid programs present additional disincentives to increased physician visits. And then, too, there has been little emphasis on geriatrics in U.S. schools of medicine.

Little wonder, then, that physicians elect to give their time and talents to the younger members of society—to individuals in whom they can see a cure or dramatic progress.

The physician's absence places a tremendous burden upon nurses who are asked to perform many diagnostic and therapeutic responsibilities for which they have little training. At the same time it must be stated that there are comparatively few nurses in today's nursing homes—only 56,000 registered nurses employed in 23,000 homes. Unfortunately, these nurses are increasingly burdened with administrative duties such as filling out Medicare forms and ordering supplies, leaving very little time to care for patients.

In the end, 80 to 90 percent of the care is given by untrained aides and orderlies, paid the minimum wage and showing a turnover rate of 75 percent a year. The results are predictable: poor patient care.

The quality of patient care will continue to be the central focus in the controversy over nursing homes. But the term "patient care" is illusive. It is an aggregate of medical care given by a physician, and nursing care given by a nurse.

In nursing homes, as elsewhere, physicians—and physicians alone—are permitted by law to diagnose ailments and prescribe therapeutic regimens to bring about the improvement of the patient. Nurses have traditionally worked under the direction of the physician carrying out his directives.

This Supporting Paper will focus on the central and critical role of physicians in nursing homes, why they are infrequent visitors, and the consequences of their absence. It suggests proposals for insuring greater attention to nursing homes from the medical community. Without such intervention nursing homes will remain as they are today: sharply criticized, riddled with abuse, and beyond the fringe of serious medical concern.

I. ABSENCE OF PHYSICIANS: THE EVIDENCE

From the very beginning of their entry into the American health scene, nursing homes have had trouble attracting physicians. This problem has been adequately documented by the Committee on Aging and its predecessor, the Subcommittee on Problems of the Aged and Aging of the Senate Committee on Labor and Public Welfare, which said in a 1960 report:

> Management of patients in nursing homes by physicians is either lacking or inadequate.[1]

Eleven years later, Senator Frank E. Moss, chairman of this committee's Subcommittee on Long-Term Care, announced that this same problem was one of the five root causes responsible for the poor care characterized by some of America's nursing homes.[2]

The Senator's conclusion was based upon committee investigations from 1963 through 1971 and testimony such as the following:

In the 1965 Denver hearings, Dr. I. E. Hendryson said that a closer working relationship between medical groups and the nursing home is a necessity. He testified that organized medical supervision of nursing homes is a "hit or miss operation" across the Nation and in Colorado.[3]

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[1] *The Aged and Aging in the United States: A National Problem,* a report by the Subcommittee on Problems of the Aged and Aging of the Senate Committee on Labor and Public Welfare, Washington, D.C., Feb. 23, 1960, p. 139.

[2] Press release by Senator Frank E. Moss, issued on Nov. 29, 1971.

[3] *Conditions and Problems in the Nation's Nursing Homes,* pt. 4, hearings by the Subcommittee on Long-Term Care, Denver, Colo., Feb. 23, 1965, p. 341.

Dr. Walter E. Vest of the Colorado Medical Society agreed in this evaluation.[4] Mr. Peter Samac, coordinator of Colorado's medical services, State Department of Public Welfare, stated that proper medical discipline such as found in hospitals "is conspicuous by its absence in nursing homes." [5]

In the 1965 New York hearings, Dr. Karl Pickard, medical administrator, Central Medical Group, Brooklyn, N.Y., and Dr. David N. Roginsky, medical director, Metropolitan Hudson Medical Group, New York City, testified of the lack of medical supervision in nursing homes. The following passage from the New York hearings reflects the tenor of most of the testimony received by the subcommittee:

> Dr. PICKARD. What is important here is that although there were many doctors who had 1, 3, and 10 patients each in one of our particular nursing homes—one of ours having 300 patients—there was no consistency or pattern of medical care. Each doctor treated his patient as he saw fit, and there was no supervision even of that. I must give you an example of a time when we took a few of our doctors to the nursing home. This was even before we started learning what the floors looked like and what facilities were available. We watched a doctor who came in, took his coat off, put it on his arm, and about 20 minutes later was leaving the nursing home.
>
> I asked the head nurse how many patients this man had seen. He had seen 20 patients in those 20 minutes. This gives a reason for our present program. We are not any better doctors, I daresay, than that particular doctor. He might have been an awfully good doctor, but in this nursing home he was not. He did not take the time necessary for good medical care. He could do this because no one was there to supervise his work.
>
> This may be one of the reasons why a particular case which I mention in the report that you have shows a patient who had been in the nursing home almost a year who had a hemoglobin of 4 grams (15 grams is normal); investigation proved this to be a malignancy.
>
> Fortunately, it was the type of malignancy that responded to surgery. This man has had some help. Maybe we relieved him of some future trouble.
>
> If that was the only case we had found, we would have done some good. There are innumerable instances of this sort of thing. Drugs used without taking any blood tests to find out if there was any toxic effect is another example of improper medical care.
>
> Dr. ROGINSKY. I would like to speak on one other subject as far as care is concerned. As you know, under the HIP program, our doctors are available 24 hours a day, 7 days a week.
>
> Prior to our coming into the program, the nurses informed me, and I knew this was true from my past experience over the previous 25 or 28 years that on Saturdays and Sundays and holidays, especially in the summer months, when the

[4] P. 333, pt. 4, hearings cited in footnote 3.
[5] P. 311, pt. 4, hearings cited in footnote 3.

> patient became acutely ill, they would have to call the city hospital ambulance. Not only was the doctor not available but he was so inadequately covered that there was nobody to see them at the nursing home.[6]

The subcommittee's most recent series of hearings, "Trends in Long-Term Care" began in 1969 and provided even more graphic illustrations. For example, Dr. Charles H. Kramer, president of the Kramer Foundation and clinical director of the Plum Grove Nursing Home, and assistant professor of psychiatry, University of Illinois College of Medicine, testified:

> Unfortunately, doctors are pretty scarce around long-term care institutions. They pop in and they pop out, and if you can get a note on a chart from them every month, you are doing very well. Perhaps 5 percent of doctors are interested in this field. The rest are afraid of it, they are depressed by it, and they would just as soon avoid it.[7]

Dr. Dora Nicholson of Washington, D.C., testified of her experience in getting medical treatment for her mother in a Maryland nursing home:

> Physicians, in my experience, never visited their patients. If you'll bear with me a little more of my experience with my mother. I am a physician myself, I had money enough to hire the best practitioner. I hired a very famous doctor, in fact, he has been promoted to chief of staff of an important and very large hospital. But I can tell you that I had to scream like hell to get him to come down to see my mother after 15 days.[8]

Dr. J. Raymond Gladue, president of the American Association of Physicians in Chronic Disease Facilities, testified that medical care in nursing homes was of two types, "very poor or scandalous." Dr. Gladue also stated that he has perceived no improvement in the quality of care over the past 5 years.[9]

Dr. Frank Furstenberg, associate director for program development at Mount Sinai Hospital in Baltimore, Md., agreed:

> The medical professions' role in nursing home care has left very much to be desired. Organized medicine has not followed the slogan of the President of the AMA, who recently said "it should be the shaper of the future." It has done very little to shape the future of care in the nursing home field.
>
> Individual physicians who have given patients excellent care for years too often literally forget the patient when he reaches the nursing home.[10]

A British expert, Dr. Lionel Z. Cosin, told the subcommittee that the health care system in America seems to be ill-designed for the aged, placing little emphasis on rehabilitation and a continuity of

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[6] P. 548, pt. 5, hearings cited in footnote 3.
[7] *Trends in Long-Term Care,* pt. 15, hearings by the Subcommittee on Long-Term Care, Chicago, Ill., Sept. 14, 1971, p. 1445.
[8] P. 827, pt. 10, hearings cited in footnote 7.
[9] P. 2781, pt. 22, hearings cited in footnote 7.
[10] P. 822, pt. 10, hearings cited in footnote 7.

care. He quoted Sister Thelma Wells, an R.N. who received her training at Massachussetts General Hospital, Boston, Mass., and who also completed graduate work in nursing at Case Western Reserve University in Cleveland, Ohio, prior to her British training and experience. Sister Wells flatly states that the average aged patient is better off in England than in America because of the lack of interest in the American medical community for problems of the infirm and elderly. She added:

> Unfortunately I have had little American experience with physicians who were either concerned about the causes of confusion and incontinence, or planned rehabilitative treatment for such problems. "He's old. It's to be expected," seems to be the frequent American health system attitude.[11]

The shortage of physicians for nursing homes is not limited to those who specialize in physical disease. Nursing homes have particular problems in attracting psychiatrists and psychologists who specialize in mental disease. Dr. Kramer testified:

> Most of my psychiatrist friends shy away from this field. That means that a girl with only a high school education may be dealing every day with serious psychological problems, with serious interpersonal relationship problems, and she is expected to manage, not only these, but severe physical disability in patients as well.[12]

This problem is of growing importance because of the large number of nursing home patients who are mentally impaired and because of recent trends to "dump" the elderly into nursing homes from State mental hospitals. The estimates of the number of nursing home patients who are mentally impaired varies from 86 percent by Dr. Alvin I. Goldfarb to 55 percent, which is the official Public Health Service estimate.[13] The numbers clearly are increasing. (More detail on the "wholesale transfers" of the mentally ill and disabled elderly from mental hospitals to nursing homes is contained in Supporting Paper No. 7.)

FINDINGS FROM STUDIES AND REPORTS

Independent studies such as the Nader Task Force Report on Nursing Homes have also expressed concern about physicians in nursing homes:

> . . . There is evidence pointing to the fact that doctors have not and are not making themselves available to nursing

[11] P. 1402, pt. 14, hearings cited in footnote 7.
[12] P. 1446, pt. 15, hearings cited in footnote 7.
[13] *Mental Health Care and the Elderly: Shortcomings in Public Policy,* report of the Special Committee on Aging, November 1971, p. 8; Fisch, M., Shaninian, S., and Goldfarb, A., "Early brain damage in the aged: a community and clinical study," Office of Consultant on Services for the Aged, State of New York Department of Mental Hygiene, duplicated (1962); Goldfarb, A., "Prevalence of psychiatric disorder in metropolitan old age and nursing homes." Journal of American Geriatric Society (1962), pp. 77–84; Goldfarb, Alvin I., "The Senile Older Person in Selected Papers," 5th Annual Conf. of State Executives on Aging, U.S. Department of Health, Education, and Welfare, Washington, D.C. 1965; Lowenthal, M., "Social isolation and mental illness in old age," Amer. Soc. Rev., 29, 1964, pp. 54–70; National Center for Health Statistics, 1965, "Characteristics of residents in institutions for the aged and chronically ill—United States," April–June 1963. Public Health Service Publication No. 1000—serial 12—No. 2. Washington: Government Printing Office.

> homes as often or as consistently as the medical needs of the patients demand. This is indicated in the difficulty we have observed in nursing homes in getting in touch with doctors in emergencies, the complaints of patients at the infrequent and hurried visits from their doctors, and statistics on "gang visits" by physicians to nursing homes.[14]

A 1971 study by the Utah Nursing Home Association emphasized the difficulty providers have in finding physicians willing to come into nursing homes. The study quotes one administrator, who noted a particular problem with welfare patients:

> It's almost impossible for a welfare patient to get medical care. . . . Dumping welfare patients is a game. The Hippocratic Oath is pretty well by the board when it comes to welfare patients. Motivation for physicians is strictly financial.[15]

Another administrator complained:

> Our most difficult problem is trying to get a doctor when he is needed. Our only chance is to rush persons to the emergency room of the hospital.[16]

Even when physicians do visit nursing homes to see their individual patients, they accept no responsibility for the institution as a whole.

This point was brought into sharp focus by the Maryland Governor's Commission to investigate the Baltimore Salmonella (food poisoning) epidemic in which 36 patients out of 146 in a Baltimore nursing home died. Hearings by the subcommittee and the commission's report disclosed that 44 physicians were responsible for one or more of the 146 patients. The lack of overall responsibility delayed the reporting of the epidemic for almost a week. (These facts are discussed in more detail later in this paper.) However, both the committee and the State's blue ribbon panel were sharply critical of the medical profession for their "superficial concern" with the needs of nursing home patients.[17]

The 1971 Report of the Michigan Governor's Commission on Nursing Home Problems reinforced this same point, saying:

> It appears safe to assume that most patients' physician [of nursing home patients] are engaged in being just that, a physician, and not intimately involved in nursing home operations.[18]

The foregoing evidence of physicians not attending to the needs of nursing home patients is, for many, restating the obvious. In fact, there are few statements in the field of long-term care which are so universally accepted. But while it is obvious that physicians are absent from the nursing home setting, the reasons for their absence are complicated and less apparent.

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[14] "Nursing Homes for the Aged: The Agony of One Million Americans," a report by the Nader Task Force on Nursing Homes, December 1970, p. 183.

[15] "Status of Utah Nursing Home Industry—1971," a report by the Utah Nursing Home Association, Oct. 19, 1971, reprinted at pp. 1737–48, at p. 1740, pt. 16, hearings cited in footnote 7.

[16] P. 1740, pt. 16, hearings cited in footnote 7.

[17] For more detail on the Salmonella epidemic, see pts. 9 and 10, hearings cited in footnote 7.

[18] "Governor's Nursing Home Report," a report by Stanley H. Smith, project director, Management Sciences Group, Michigan, 1971.

II. WHY PHYSICIANS SHUN NURSING HOMES

"I have even heard of doctors who refuse to visit some nursing homes because they get too depressed." . . . Richard M. Nixon, June 25, 1971.

A. THE SHORTAGE OF PHYSICIANS

The U.S. Department of Labor currently estimates that the United States is short some 50,000 physicians.[19] This shortage is compounded by maldistribution since doctors tend to locate in larger cities on the East and West Coast. Rural areas are hard pressed to find adequate coverage.

With doctors in such demand, it is easy to understand why nursing homes receive low priority. Dr. Kassel points out that the physician feels he must divide his time among all the people and this generally means the elderly lose out. They tend to feel their time is better spent with the younger members of society who still have their lives ahead of them and can again be productive contributors to the production of goods and services.[20]

Yet another factor in the shortage is the increased specialization that has taken place over the past 20 years. Physicians who treat nursing home patients are largely general practitioners. Senator Yarborough told the subcommittee that in 1931 four out of five doctors were general practitioners but that at the present time only one out of five is a "G.P." [21] Other witnesses such as reporter Michael Richardson of the *St. Petersburg Times* have testified that with fewer "G.P.'s," the potential supply of nursing home doctors is decreasing rapidly.[22]

B. MEDICAL SCHOOLS: LOW PRIORITY FOR AGING

For all the specialization that has taken place in American medicine it is paradoxical that the care of the aged receives so little attention in U.S. schools of medicine. Geriatrics is a specialty in Europe and in Scandinavia, but not in America. It is difficult to understand why.

Throughout hearings by the Subcommittee on Long-Term Care, there are repeated references to the fact that medical schools provide little instruction in the care of the aged. Experts are united in this view. In the 1965 Denver hearings, Dr. Vest testified that only three U.S. medical schools were interested in geriatrics and that this was from the research point of view.[23]

Dr. John Knowles of Massachusetts General Hospital, testifying in the 1965 Boston hearings, asked the subcommittee "to help us exhort the medical profession, our medical schools, and our teaching hospitals to weave chronic care and nursing homes into the fabric of their interest and intellectual commitment." [24]

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[19] "Program To Increase Graduates From Health Professions Schools and Improve the Quality of Their Education," report by the General Accounting Office, Oct. 3, 1972, p. 1.
[20] *Patient Care* magazine, Mar. 30, 1972, p. 59.
[21] P. 909, pt. 11, hearings cited in footnote 7.
[22] P. 183, pt. 2, hearings cited in footnote 7.
[23] P. 334, pt. 4, hearings cited in footnote 3.
[24] P. 603, pt. 6, hearings cited in footnote 3.

The 1969–73 hearings produced numerous other examples worthy of mention. For example, reporter Mike Richardson testified about his conversation with a county medical examiner, who said that the only training in the care of the aged he [the doctor] received in medical school amounted to determining death.[25]

The Nader Task Force, arguing that "geriatrics is very much left out of the education of physicians," recommended that medical schools require students and interns to work with nursing homes.[26]

Dr. Cosin told the subcommittee that there is a department of geriatrics in every general hospital service in England and recommended that America follow the English example in developing geriatrics as a specialty in American medicine.[27] He indicated that chronic disease was a much larger part of medical practice than is commonly realized.[28] Dr. Furstenberg added that while medical schools do not emphasize geriatrics each general practitioner practices a great deal of geriatric medicine. He estimated that while senior citizens constitute 10 percent of the population, they constitute 25 to 30 percent of the visits to the doctor's office.[29] Dr. Robert Butler notes that two-thirds of the Nation's health expenditures involve chronic illness.[30]

Dr. Kassel support the view that much of what passes for acute medicine is really chronic disease medicine. He contends that there is very little feeling in academic medical circles that any special training is necessary to care for elderly patients. He rejects this notion, arguing for specialized medical training. Dr. Kassel quickly adds what might be called social factors. He states that it takes a great deal more time to do a physical examination on a 70-year-old man than it does to do one on a man of 20.[31] Moreover, there is also the problem of communicating with patients that were born and lived in a different era—an era of house calls, home remedies, and much superstition. Dr. Kassel said:

> It is unfortunate that too much of his time [the physician's] continues to be spent laying to rest pre-World War II superstitions like "pulling all the teeth as a cure for arthritis." Removing the teeth will cure some things, including the foolish belief that removing the teeth will cure anything.[32]

Most physicians agreed with Dr. Kassel and Dr. Kramer that patients in nursing homes were the most difficult to treat because of their multiple disabilities and lack of motivation.[33]

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[25] P. 183, pt. 2, hearings cited in footnote 7.
[26] Pp. 886 and 899, pt. 11, hearings cited in footnote 7.
[27] P. 1394, pt. 14, hearings cited in footnote 7.
[28] P. 1394, pt. 14, hearings cited in footnote 7; see also testimony of Dr. Michael B. Miller, p. 306, pt. 3, hearings cited in footnote 7.
[29] P. 823, pt. 10, hearings cited in footnote 7.
[30] P. 907, pt. 11, hearings cited in footnote 7.
[31] P. 556, pt. 7, hearings cited in footnote 7.
[32] "*Utah White House Conference On Aging Report*," report by the Utah Division on Aging, May 1971, p. 4.
[33] P. 1446, pt. 15, hearings cited in footnote 7.

Findings: 1971 Survey of Medical Schools

To assess the degree to which American schools of medicine emphasize geriatrics, Senator Moss directed in November 1971 that a questionnaire be sent to all 104 schools of medicine. The questionnaire asked:

> Do you have geriatrics as a specialty in your curriculum?
> Do you have programs in which student interns or residents can serve nursing homes?
> Do you have programs which help serve nursing homes in other ways?

Some 64 responses were received by the subcommittee. No school had yet established geriatrics as an area of specialization or had created a department of geriatrics. Three schools indicated that they would soon implement such a goal and that they had already made significant progress in this regard. They were the University of Minnesota, the University of Nebraska, and the University of Hawaii.

Only six schools reported having programs whereby students worked with nursing homes. Seven schools indicated that they served nursing homes in some other way, largely by providing consultants in some capacity. One school reported students were serving nursing homes as "externs"—apparently a reference to the fact that nursing homes are often a source of employment for "moonlighting" interns.

Typical of the response received by the subcommittee is the following letter from Dean David E. Rogers of the Johns Hopkins University School of Medicine. It should be added that Dr. Rogers is more candid than those deans who told the subcommittee that they included geriatrics in a more general course on "human development," or cited the school's gerontological research programs. Dr. Rogers wrote:

> **I'm afraid, as with most medical schools, we do a thoroughly inadequate job in all the areas that you question me about. Despite being a member of a committee that examined a catastrophe in a nursing home here in Baltimore, the answer to all three of your questions is "no." More specifically:**
>
> **1. No, we do not have geriatrics as a specialty in our curriculum.**
>
> **2. We do not have programs in which students, interns or residents serve in nursing homes.**
>
> **3. We have virtually no contact with the elderly who are in nursing homes—though we are currently exploring ways of developing some kind of program for students which will get them acquainted with the problems of the forgotten—our aging sick.**
>
> **I firmly believe that all these areas are of increasing importance to us—and this school, as well as many others, should be involved in it.**

Further evidence in support of the results of the subcommittee's questionnaire and the contention that schools of medicine neglect instruction in the care of the aged is provided by the research of Dr. Joseph Freeman. Dr. Freeman surveyed the catalogs of the Nation's medical schools and found 124 citations of the words "aging," "senility," or "gerontology" in 48 of the 99 catalogs he reviewed. He states that "indecisive attitudes about geriatrics (the *clinical* side of aging) stand out in contrast to the increased organization, financing, and clarity of gerontological thought (the *research* aspects of senescence). He concludes that the fault may lie with clinicians who have failed to identify geriatrics as a distinct field of which irremediable senility is but a minor fragment. He condemns the failure of medical schools to place greater emphasis on geriatrics since "one-third of the potential lifespan falls in the realm of geriatric medicine." [34]

Findings: 1974 Survey of Medical Schools

In order to provide the most up-to-date information Senator Moss directed a questionnaire to 101 U.S. medical schools asking the same questions as before. The subcommittee is pleased to note some increase in concern and emphasis on geriatrics. The results from the 100 replies were as follows:

Does your program now include, or alternatively are you in the process of making geriatrics a specialty in your curriculum?

Percent
No—87
Yes—13

Do you have a program whereby students, interns or residents can fulfill requirements by serving in nursing homes?

Percent
No—74
Yes—26

Does the medical school in any other way serve the elderly who are in nursing homes?

Percent
No—53
Yes—47

C. MEDICARE AND MEDICAID: REDTAPE AND LOW REIMBURSEMENT

There is little question that the requirements of the Medicare and Medicaid programs constitute a significant disincentive for physicians to visit nursing home patients. The basic problem is inadequate compensation, frequently changing rules, and the general uncertainty of payment. (These problems are discussed in more detail in part V of this paper.)

[34] "A Survey of Geriatric Education: Catalogues of the U.S. Medical Schools," *Journal of the American Geriatrics Society*, September 1971.

D. THE SHORTAGE OF TRAINED NURSING HOME PERSONNEL

It is obvious that the physician does not have the kind of "backup" services in the nursing home that he has in the hospital, and yet in many ways the medical challenge is even greater.

Several doctors mentioned this problem, and Dr. Kassel sums it up:

> Doctors don't want to visit nursing homes for a number of reasons. Too many of the persons working there are incompetent. For example, a doctor takes time to visit a home and the person left in charge by the administrator isn't expecting him.
>
> Then, the aides have a hard time finding the patient's medical chart, or even the patient himself, since sometimes the aides don't know the names of the patients and are unable to direct the doctor to the individual he is to examine.
>
> When he finally locates the patient he sits down on a chair that has been urinated upon. Additionally, lighting in most nursing homes is made for seduction rather than for any kind of examination.
>
> Doctors dislike nursing home visits because everything is against them. It takes them 10 times as long to accomplish anything.[35]

Dr. Thomas H. Clark in a recent issue of *Patient Care*, states that when he transfers patients to nursing homes he's not always certain what to expect for him either in the nature of the appropriateness of care he's going to get or its quality.[36]

Drs. John O. Pastore and Franklin Foote suggest that the uncertainty of the quality of care is often overemphasized. They focus blame on inadequate medical information provided to nursing homes by admitting physicians and hospitals. They report that it is a widely held opinion among the medical profession that nursing home personnel are, uniformly, incapable of providing good care and therefore patients are often referred without adequate medical attention to homes unsuitable for their needs.[37]

E. EMPHASIS ON ACUTE CARE

As noted previously, the primary emphasis of medical education in the United States is acute illness. The acute hospital is the focus of the medical profession. The largest portion of the U.S. health dollar goes to pay for hospital bills. The care of patients in hospitals pays better than the care of nursing home patients. But there is yet another reason which keeps doctors away from nursing homes and that is

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[35] P. 1741, report reprinted in pt. 16, hearings cited in footnote 7.
[36] P. 60, article cited in footnote 20.
[37] P. 317, pt. 3, hearings cited in footnote 7. Dr. Pastore is at Massachusetts General Hospital, Boston, Mass., and Dr. Foote is the former director of the Connecticut Department of Health.

what might be called a sense of status. Dr. Ewald W. Busse, chairman, department of psychiatry, Duke University School of Medicine, has written:

> There are few physicians who are capable of dealing with large members of chronically ill persons with sustained enthusiasm. . . . The physicians like all other people, if he is to live and work effectively, must maintain self-esteem. The physician's evaluation of himself as an individual capable of eliminating pain and restoring function is apt to suffer when he cannot see clearly the patient's improvement as a result of his efforts.[38]

Senator Moss referred to this attitude as the "Marcus Welby syndrome" in a recent speech.[39] The Senator quoted many notable geriatricians to the effect that elderly patients in nursing homes can indeed be aided. Many have staged dramatic recoveries, regaining powers of speech or considerable mobility.

"Shouldn't the goal be to help each individual to function to the best of his ability?" asked the Senator.

F. NURSING HOMES ARE UNPLEASANT PLACES TO VISIT

Who can visit a nursing home and not be reminded of his own mortality? Even physicians supposedly calloused by years of dealing with the sick and hopeless will admit to experiencing depression upon entering most nursing homes.

Dr. Clark describes this problem:

> Many patients with "chronic diseases that are not going to get better." . . . The nursing home can be a depressing place, especially if you are approaching the nursing home age yourself. When you see these people, you think "this is going to happen to me," and you may unconsciously avoid the nursing home for this reason. And too, with the elderly patient, it is easy to get frozen into a diagnosis, then stop thinking about the patient anymore.[40]

Dr. Kassel adds:

> I hate to go to a nursing home. It has not been unusual for me to sit on a chair that is covered with urine. You just don't want to sit down. You are afraid to touch things. Patients are confused, and they will wipe stool on a doorknob. The taking care of many of the patients in nursing homes is a difficult job and you have to be very dedicated.[41]

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[38] "Are M.D.'s Wary of Treating Aged Chronically Ill?" *Medical Journal*, Mar. 27–28, 1965, p. 7.

[39] Speech by Senator Moss at a conference sponsored jointly by the Duke University Center for the Study of Aging and the American Association of Retired Persons-National Retired Teachers Association, Oct. 31, 1971.

[40] P. 59, article cited in footnote 20.

[41] P. 560, pt. 7, hearings cited in footnote 7.

G. THE DISINCENTIVES OF TIME AND TRAVEL

Many physicians testified that nursing homes should be built adjacent to hospitals or other health care facilities to save the physician valuable time. Many nursing homes, however, require a doctor to travel for 30 to 60 minutes to see his patient or patients at a fee of usually less than $20 for the visit. Any substantial distance will, therefore, constitute a strong disincentive to visiting nursing home patients.[42]

III. ABSENCE OF THE PHYSICIAN: CONSEQUENCES

The infrequent presence of physicians in the nursing home, very simply stated, results in poor care for the patient. That is not to say that the absence of doctors is the sole cause for poor care; many other factors contribute. Nevertheless, the limited role of doctors is central to many of the serious problems present in today's nursing homes.

More specifically, the doctor's absence results in poor *medical* care. In other words, physicians fail to evaluate patients, fail to monitor therapy, and sometimes fail to diagnose new ailments which occur subsequent to the patient's entry into the nursing home. Many patients go for months without a doctor's attention, and in many homes no one has overall responsibility for the medical care provided throughout the home.

The absence of the physician also has its effect on the quality of *nursing* care. If the patient is receiving only sporadic medical care at best, those trying to provide good nursing care are starting at a disadvantage. Without the attention of a physician, nurses are often forced to fill the vacuum by performing diagnostic and therapeutic functions for which they have little training. In other parts of this report (see Supporting Papers Nos. 1 and 4) there is discussion of the poor care provided by poorly trained aides and orderlies who must give the large bulk of nursing care since nursing homes are often understaffed and nurses are required to handle so many administrative details. At this point, it is sufficient to point out that nursing care provided occasionally by nurses and usually by aides and orderlies directly reflects the quality of medical care provided by the patient's physician.

A. WHAT THE STUDIES SHOW

State and national studies evaluating the quality of medical care received by nursing home patients are uniformly discouraging. Perhaps the foremost study of this type was the 1971 study by Carl I. Flath, a consultant with the Health Services and Mental Health Administration of the Department of Health, Education, and Welfare. A team of health professionals evaluated 75 nursing homes in two eastern cities and reported:

- 37 percent of the patients taking cardiovascular drugs (digitalis or diuretics or both) had not had a blood pressure reading in over a year.
- 25 percent of those taking such heart medications had no diagnosis of heart disease on their charts.

[42] P. 908, pt. 11, hearings cited in footnote 7.

- 35 percent of those taking tranquilizers had not had a blood pressure recorded in more than a year. Some were taking two and often three tranquilizers concurrently.
- Most patients were taking one to four different drugs; many were taking 7 to 12. Some were taking amphetamines (uppers) and sedatives (downers) at the same time.
- 33 percent of the patients being treated for diabetes had no diagnosis of diabetes on their charts.
- 10 percent of those receiving insulin for diabetes were not on diabetic diets; a large number had not had a fasting blood sugar test in more than a year.
- 40 percent had not seen a physician for over 3 months.
- Revised treatment or medication orders had not been written in the past 30 days for 82 percent of the patients.
- Only 6 percent of the patients had had a physical examination in the past year; only 28 percent had had a urinalysis and only 20 percent had had hemoglobin/hematocrit tests in the past year.
- 8 percent of the patients had bedsores; 15 percent were visibly unclean.
- 39 percent of the patients were inappropriately classified and placed.
- No nursing care plans existed with respect to diets and fluids for 19 percent; personal care for 23 percent; activities for 14 percent; and individual treatment needs for 18 percent of the patients.
- Only 39 percent of the homes had inservice training programs for nursing personnel.
- "Gang visits" of individual physicians on multiple patients in a few minutes was not uncommon.[43]

This indictment of the quality of medical care in the Nation's nursing homes is given added weight because, as the report declares: "These findings are neither isolated nor atypical in terms of the rest of the country." [44]

Other reports received by the subcommittee verify this conclusion. In 1968 the Massachusetts Health and Research Institute submitted a report to the U.S. Public Health Service with respect to that State's nursing homes. The report said in part:

- Less than one out of five patients had admission exams noted on their records.
- Less than one out of six had a mental status exam.
- Less than one out of four had an admission diagnosis so that the nursing home staff could even know what treatment to provide patients.
- In barely one-fifth of the cases were admission records signed by doctors.
- Less than one-fifth of the patients had semiannual physical exams.
- More than one out of six patients had doctors orders that were unvalidated or unclear. [45]

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[43] "Implications of Medical Review of Long-Term Care Facilities," paper presented at the conference cited in footnote 39.
[44] See paper cited in footnote 43.
[45] *Boston Globe*, August 3, 1968.

Similar studies were received and evaluated by the 1971 Michigan Governor's report on nursing home problems. The report was critical of physician's recordkeeping habits, indicating a belief in a direct correlation between the adequacy of care extended to patients and the adequacy of records maintained on the patient's condition and progress.[46]

In 1970, Dr. Franklin Foote, director of the Connecticut Department of Health, testified before the subcommittee about his study of that State's nursing homes. He reported:

- Hospitals were failing to send any data concerning the patient's condition for about 40 percent of the patients transferred to nursing homes.
- Physicians in nursing homes gave inadequate information on patient's charts concerning the basis for medical diagnosis and the nature of the patient's changes while in the nursing home.
- Almost 40 percent of those taking cardiovascular drugs (heart medication) like digitalis had not had their blood pressure taken in more than a year.
- Some 35 percent of the patients taking drugs which might lower their blood pressure markedly had not had a blood pressure reading in over a year.

Dr. Foote also noted that patients had been found getting digitalis who had no history of heart abnormality, and patients receiving insulin who had no diagnosis of diabetes. He also offered the example of one nurse who knowingly administered an overdose of insulin to one patient daily until the health department intervened. Rather than challenge the physician's order, which she knew to be too much insulin, she would daily administer the prescribed dose putting the patient into insulin shock which she then treated by feeding the patient candy bars all day long.[47]

The above examples are confirmed by yet another Government study. On July 15, 1971, Thomas Tierney, Director of the Bureau of Health Insurance at the Social Security Administration, transmitted to the Senate Finance Committee a status report on the over 4,000 nursing homes participating in the Medicare program. The study shows that 2,068 homes were in violation of one or more of Medicare's nursing home physician requirements. More specifically:

- 374 homes were in violation of the requirement that telephone orders for patients received by the nursing home must be countersigned by the physician within 24 hours.
- 340 homes had treatment orders in effect that were out of date (treatment orders can be prescribed for only 30 days) and some in effect for long periods of time, 6 months or a year.
- 288 homes did not conform to the standard requiring that a medical evaluation of the patient's needs be completed within 48 hours after admission.
- 217 homes failed to carry out the requirement that physicians make arrangements with fellow physicians to care for their patients in the facility in the event of the absence of the patient's primary physician.[48]

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[46] P. 234, report cited in footnote 18.
[47] Pp. 268–69, pt. 3, hearings cited in footnote 7, and interview with Senator Moss on Jan. 15, 1970.
[48] Report reprinted at pp. 2055–79, pt. 18, hearings cited in footnote 7.

B. ADDITIONAL EXAMPLES

The consequences of the physician's absence from nursing homes are just as clear from direct testimony received by the subcommittee and from the statements of experts.

Dr. George Warner, director of New York State's Bureau of Long-Term Care and former president of the Association of State and Territorial Health and Licensure Officials, has stated:

> I'm afraid our findings bear out the complaints of the nursing home people—that many and perhaps most attending physicians don't give their long-term care patients adequate care. We find that they are relying too heavily upon tranquilizers and sedatives in the management of these people; that too often they substitute a vague phrase such as "senile" for a precise diagnosis which might lend itself to treatment; that their records and progress summaries for these patients are wholly inadequate.[49]

Mrs. Daphne Krause, executive director of the Minneapolis Age and Opportunity Center, testified:

> The fact is physicians simply do not view the nursing home as part of the medical continuum. . . . They feel that with limited time and resources they should devote their attention to the younger members of society because the elderly have lived their lives. A direct consequence of the physician's absence is that the registered nurse gives the medical care, or that untrained aides give the needed medical care, or it isn't given at all.[50]

Licensed Practical Nurse Nancy L. Fox provided a sworn statement which included a letter to a physician which said:

> Since you are the house doctor of the Kenwood Nursing Home, I have, for quite some time now, observed your approach to these elderly patients.
>
> Your last visit occurred a couple of weeks ago. On that day you arrived early and I had not yet put on my nurse's cap. The supervisor was off all day and you assumed, obviously, that I was an aide.
>
> All 13 patients had been psychologically prepared for your visit. I had told them you were coming and to be sure to explain all those things which had been bothering them . . . that you would listen and do all you could to relieve their anxiety and pain. They were all awaiting your visit with high hopes.
>
> Unknown to you, Doctor, I timed your visits with them. You started rounds at 9:50 a.m. You finished at 10:10 a.m. That meant that you spent exactly 1½ minutes, on an average, with each patient. Not one of them did you examine. Your satchel remained on a chair in the hall, unopened. You handed out new orders as glibly as one scatters seed to the birds. . . .

[49] P. 59, article cited in footnote 20.
[50] P. 2095, pt. 19A, hearings cited in footnote 7.

> One patient, in particular, you insulted. You said to . . . (him), when he complained legitimately of his chronic severe back and other pains: "All you need to do . . . is to go out and find yourself a nice blonde." . . . The patient can hardly walk and shakes violently nearly all the time.[51]

A nurse's aide, Barbara Lace, testified:

> At the home there are people who have not seen a doctor in 2 years. In the time I have been there, I think I have only seen a doctor three times. I don't see how a doctor can prescribe medications and treatment to a patient over the phone. This is done all the time.[52]

According to the affidavit of nurse's aide Gladys E. Danielson, a patient at the Bryn Mawr Nursing Home was transferred to the nursing home after a bladder operation. The staff told the aides that the stitches should come out in 2 weeks.:

> I talked to the nurse administrator, Mrs. Coleman, and she said it would be taken care of Monday. Then on Monday I asked her if the stitches were to come out and she said, "No, let the doctor do it." So I let it go at that and continued to take care of her every morning. Then I was gone from work there until she died.[53]

Mrs. Gloria Johnson, the daughter of the patient, confirms the testimony of nurse's aide Gladys E. Danielson.

> There was no follow-up by the doctors from Methodist Hospital, nor did Bryn Mawr see to it that her postsurgical condition was checked or her stitches removed by a doctor. . . . On May 12, 1970, my mother entered the Bryn Mawr Nursing Home. At no time from the point she left Methodist Hospital to the day she died on June 12, 1970, did she see a doctor. . . . I have since contacted the Minnesota State Board of Health to complain of the negligent treatment my mother received. I was informed by Mrs. Ruth Larson of the State board that at no time did the Bryn Mawr Nursing Home even have any medical records of my mother. They did not even know what she had been operated on for at Methodist Hospital.[54]

C. POOR CONTROL OF DRUGS—A SPECIAL CONSEQUENCE

The topic of nursing home drugs deserves special attention at this point for two reasons:

First, the prescription of pharmaceuticals continues to be the most common form of medical care offered to nursing home patients.

Second, each and every drug, by law, must be prescribed by a physician before it is filled by a pharmacist and given to the patient.

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[51] P. 2264, pt. 19B, hearings cited in footnote 7.
[52] P. 2309, pt. 19B, hearings cited in footnote 7.
[53] P. 2242, pt. 19B, hearings cited in footnote 7.
[54] P. 2287, pt. 19B, hearings cited in footnote 7.

The important implications of prescribing medications is indicated by the large numbers of drugs taken by nursing home patients. The average patient takes four to seven different drugs, and pays $300 a year for drugs—three times as much as his noninstitutionalized senior citizen counterpart.

Almost 40 percent of nursing home drugs operate on the central nervous system; in other words, they either kill pain, tranquilize, or sedate. Tranquilizers alone constitute almost 20 percent of all nursing home drugs, far and away the largest category of drugs.

When the physician is absent from the nursing home, drug management is left to overburdened nurses and inevitably (in many cases) to untrained aides and orderlies.

Supporting Paper No. 2 has been completely devoted to the topic of drugs in nursing homes. That paper notes many severe medication problems such as adverse drug reactions, tranquilization to control patients and make it easier on staff, drug addiction, and human experimentation without proper controls.

A few related points deserve emphasis in this section. They are considered below:

- **Medical schools do not emphasize geriatric pharmacology.**
- **Because of differences in metabolism, the elderly like children, react differently to drugs. Unfortunately, there is little emphasis on this fact in pharmaceutical courses offered in U.S. medical schools.**

Dr. Amos Johnson states:

> We know, for instance, that if you give the average old person, who is considerably debilitated, sedatives or hypnotics to cause him to sleep, and this is given at 10 or 11 o'clock at night, you might cause him to sleep and be confused for the entire next day instead of the night at hand. The elderly react differently to other medications also, but if we are interested we learn this easily. It is not too hard.[55]

- **Most medications for nursing home patients are prescribed over the telephone.**

One administrator told the subcommittee staff that if it wasn't for Alexander Graham Bell there would be no medicine practiced in U.S. nursing homes. Most States allow prescriptions to be given over the telephone providing the orders are countersigned by the physician within 24 hours (also a Federal Medicare requirement), but there have been a significant number of studies documenting the failure of physicians to validate such telephone orders.[56]

In order to obtain some measure of the extent of this practice, Senator Moss directed a questionnaire to every nursing home administrator in California. The 1972 survey brought 461 returns. Of this number 184 administrators (39 percent) indicated that zero to 24 percent of all drugs used in their facilities were prescribed over the telephone; 124 (27 percent) said that 25 to 50 percent were authorized

[55] "The Physician's Role in the Care of the Aging," *The Gerontologist*, spring 1970, pt. II, p. 34.
[56] See studies cited in footnotes 43, 47, and 48.

over the telephone and 153 (34 percent) answered that over 51 percent of their drugs were prescribed over the telephone.

• There is a tendency for physicians to prescribe medications "PRN" or at the discretion of the registered nurse.

Given the absence of the physician, this procedure comes very close to allowing the nurse to practice medicine. She can decide on her own initiative when, how much, and sometimes which kinds of medicine the patient should receive.

This is all well and good in limited situations where registered nurses have the training and should have the prerogative of administering a sharply limited range of drugs. However, most nursing homes do not exceed Federal standards. This means that a licensed practical nurse or an aide will be on duty in charge of the afternoon and evening shifts. All too often the unlicensed aides and orderlies find themselves administering drugs.

There is a natural tendency for aides who have served in this capacity to feel that they are as qualified as the R.N. If a patient becomes loud and troublesome, the R.N. might authorize a tranquilizer. In the R.N.'s absence, an aide, seeing what looks to be a parallel situation, may treat it the same way. Unfortunately, the aide is seldom trained to look for untoward side effects or to understand that two medications administered at the same time might have altogether different effects.

The pattern occurs often enough in U.S. nursing homes to be viewed with great alarm. Mr. Nelson Cruikshank, president of the National Council of Senior Citizens, has been especially critical of the indiscriminate use of tranquilizers—the "chemical straightjacket" as he calls it.[57] This practice is made possible by physicians who prescribe drugs over the telephone. Nursing home personnel also refuse to discard discontinued drugs. Drugs belonging to dead or discharged patients are "saved" becoming a minipharmacy within the nursing home from which drugs are taken and given to patients without physician's orders.

Finally, Dr. Bernard A. Strotsky and R.N. Joan R. Dominick in a recent issue of *The Gerontologist* described a few of the difficulties in administering drugs to nursing home patients which are exacerbated by lack of close supervision by physicians:

> Patients who are on maintenance doses of medication for chronic conditions should be re-evaluated regularly. Digitalis toxicity: diuretic-induced dehydration, weakness, hyperglycemia, hypokalemia and hypochloremia; and phenothiazine-induced Parkinsonism, hypotension, blood dyscrasias, dermatitis, and mood changes occur with alarming frequency in patients. One case well illustrates the problem of proper management with drugs.
>
> A 64-year-old former secretary admitted to a nursing home on December 17, 1961 with a diagnosis of "psychotic depressive reaction, cerebral arteriosclerosis, chronic phlebitis left leg, left hip fusion" was found to be immobile, silly, confused, with poor contact and severe memory defect. Repeated visits

[57] *The Machinist*, Dec. 3, 1970, p. 2.

revealed that she sat in one place all day long, never being ambulated. She wore a surgical stocking on her left leg. One day, at the suggestion of the junior author, the stocking was removed. She showed inflammation, swelling, redness, and tenderness of the entire lower region of the leg to the ankle. The condition was diagnosed as a cellulitis, and the patient was placed on penicillin, anhydrin, diuril, digitalis, deprol, and mercuhydrin (the last twice a week 1 cc. I.M.). Her cellulitis cleared somewhat. Her weight dropped from 165 to 120 pounds in 2 mo. Her mental status improved markedly. She was no longer silly and confused, and her memory improved. Penicillin was discontinued after 2 weeks. Two-and-a-half months later she again became confused, disoriented, silly, and underactive. She appeared weak and unresponsive. On examination she appeared dehydrated. Electrolyte analysis showed her to be hypokalemic. Taking her off all drugs resulted in alleviation of symptoms; however, she became agitated. She was placed on thorazine 50 mg. P.R.N. She became somnolent and confused. Thorazine was discontinued, and this time her symptoms disappeared temporarily.[58]

IV. THE BALTIMORE SALMONELLA EPIDEMIC: A CASE HISTORY [59]

The Baltimore salmonella epidemic of 1970 illustrates dramatically the dangers inherent when physicians shun nursing homes. Salmonella is a family of bacteria that causes an infectious disease marked by nausea, diarrhea, and dehydration. It can be particularly serious to the elderly and the very young.

The epidemic apparently began on Sunday night, July 26, 1970, when the 146 patients and some employees of the Gould Convalesarium consumed a meal containing a virulent strain of salmonella. On Monday the home was confronted with a mass outbreak of diarrhea. More and more patients became ill on Tuesday and Wednesday. The physicians of some patients were called.

Some of the 44 physicians who had one or more patients in the facility came to visit them. Dr. Harold Harbold, the doctor designated by Maryland law as the "principal physician" for the home, was on vacation. The physicians who did visit the facility chose to accept responsibility only for their own patients. Not one doctor reported an infectious disease or in any way alerted the State to the possibility of a major epidemic.

By Friday, July 31, when the State first learned of the salmonella outbreak, it had a full scale epidemic on its hands. By Sunday, 25 patients had died.

In the final tally, 95 of the home's 144 residents showed symptoms of the disease and 36 died. Thirty of the 76 employees in the home showed some signs of salmonella, but no deaths.

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[58] "The Physician's Role in the Nursing Home and Retirement Home," *The Gerontologist*, spring 1970, pt. II, p. 41.

[59] See pts. 9 and 10, hearings cited in footnote 7.

The epidemic alerted the subcommittee to several facts including:

• In most States, no one physician has responsibility for the kind of medical care offered in a nursing home. Everybody and nobody is responsible. Sometimes titles like medical director or principal physician exist in regulations but they are seldom more than paper requirements. [This point is considered in more detail in the next section which discusses Government policies and regulations.]

• Physicians in the United States are lax in reporting infectious diseases, and nursing homes need to give greater attention to the isolation of patients with infectious diseases.

• Physicians in the United States routinely sign death certificates of patients who have died in nursing homes without having viewed the body.

The Baltimore salmonella epidemic therefore brought to light several very important consequences stemming from the absence of the physician in nursing homes, which are considered further below.

A. LAX REPORTING OF INFECTIOUS DISEASES

In hearings conducted by the subcommittee, the issue of the reporting of infectious diseases was discussed in detail. The importance of reporting is obvious from the statement of Dr. John V. DeHoff, acting City Health Commissioner of Baltimore, who testified that earlier reporting of the incident would have prevented some of the deaths.[60]

A committee of the Maryland Medical Society investigated the incident and found that the attending physicians violated two State laws by failing to report the epidemic immediately. The committee recommended no disciplinary action. The reasons for this decision, according to Dr. Matthew Tayback of the Maryland State Health Department, were: (1) no single physician could technically be held responsible for the totality of the health care in the home, (2) the medical society committee found nothing malicious in the failure of doctors to make the report, and (3) the committee in their actions found nothing contrary to usual medical practice.[61]

The extent to which failure to report infectious diseases is usual medical practice was reinforced at the hearings by Dr. David Sencer of the Communicable Disease Center in Atlanta and by Dr. Jesse Steinfeld, then Surgeon General of the United States. They reported that less than 1 percent of all infectious diseases in the United States are ever reported. They stressed that penalties for failure to report such diseases are often low as in Maryland where the fine is less than $100.[62]

Under these circumstances, Dr. Steinfeld and Dr. Sencer agreed with the blue ribbon panel appointed by the State of Maryland to investigate the epidemic which concluded that the tragic incident could be repeated in any nursing home in Maryland and in the United States unless current practices are changed.[63]

Witnesses at the hearings stressed the particular vulnerability of the elderly, and especially nursing home patients, to infectious dis-

[60] P. 127, report cited in footnote 18.
[61] P. 131, report cited in footnote 18.
[62] P. 766, pt. 9, hearings cited in footnote 7.
[63] See report of the Sellinger panel reprinted at pp. 837–47, pt. 10, hearings cited in footnote 7.

eases. They emphasized the need for proper food handling procedures and periodic lab tests for employees who work in nursing homes.

Subcommittee files also contain considerable evidence that communicable diseases are poorly handled in many U.S. nursing homes. There are several examples of undiagnosed cellulitis and staph infections, both of which are highly contagious. In each instance, the disease was not reported—nor were the patients isolated. In one case a patient had active tuberculosis, a fact not disclosed to the nursing personnel. The disease was not reported, nor was the individual isolated.[64]

Clearly, infectious disease can be controlled only if physicians take a more active interest in the care of nursing home patients and if they will begin reporting the diseases. The problem is important for all Americans, but it is critical for the infirm elderly in U.S. nursing homes.

B. SIGNING DEATH CERTIFICATES WITHOUT VIEWING BODIES

The central emphasis of this paper is that physicians should make every effort to see nursing home patients while they are alive. However, it is also of great importance that physicians view the bodies of patients who have died in nursing homes before signing death certificates.

The investigation of the Baltimore epidemic revealed that some physicians signed certificates without ever seeing patients. It also revealed that there is no Maryland law requiring the attending physician to be present at death or to view the body before signing the certificate.[65] In fact, all States require the signature of physicians on death certificates but only two States require that physicians view bodies of patients before signing death certificates.

The General Accounting Office which reported to the committee on issues stemming from the Baltimore epidemic confirmed that it was not an uncommon practice for physicians to sign death certificates without first viewing the bodies. GAO interviewed physicians most of whom felt it was "either impractical or unnecessary to view bodies of patients who had died in nursing homes." [66]

Senator Moss questioned Dr. Matthew Tayback, deputy director, Maryland Department of Health, about this practice. Senator Moss noted the paradox of requiring a physician's signature on the death certificate without the prior necessity of observing the body. Dr. Tayback responded that in the case where a physician sees patients regularly (within the past 30 days), he knows the conditions and disabilities of the patient; that death under such circumstances is not an unexpected event and is generally attributable to the diagnosis which occasioned the patient's entry into the facility in the first place. Dr. Tayback also stated that registered nurses were perfectly capable of ascertaining death and cause of death.

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[64] Pp. 2236, 2247, 2275, and 2293, pt. 19B, hearings cited in footnote 7.

[65] As a result of disclosures in the *Baltimore Sun*, Senator Moss requested an audit by the U.S. General Accounting Office to determine if the practice of signing death certificates without viewing bodies was common practice. The report entitled: *"Examination Into Certain Claimed Practices Relating to Nursing-Home Operations in the Baltimore, Maryland Area,"* was issued Dec. 4, 1970.

[66] P. 8, audit cited in footnote 65.

Senator Moss disagreed with this position:

> Yes, but it is easy to think up a situation that wouldn't fit that. Suppose an elderly patient died because some negligent treatment was given him in the nursing home. . . . The person who is responsible for that would want to cover his guilt. So, he would never report it. The doctor simply got the certificate to sign and he would say . . . that was because of the failing health of the patient and then we would never know what the real cause of death was.[67]

This exchange points up the necessity for the physician to pay greater attention to the needs of nursing home patients both alive and dead. This is true for three reasons.

First, Dr. Tayback assumes that physicians are generally familiar with the health circumstances of the individuals in nursing homes. The major thrust of this Supporting Paper is that physicians are not as a rule familiar with the facts about individual nursing home patients.[68]

Second, Dr. Jesse Baron states:

> Some studies have shown that [the elderly] patients will die because the doctor will say the patients are too old to be operated upon. The death will be attributed to old-age diseases like arteriosclerosis but the autopsy will show that it was diabetic coma or peptic ulcer—something which could have been treated.[69]

Dr. William J. Curran of Harvard University, an expert on legal medicine, makes the same point. Dr. Curran reports that the United States regards death a bit more casually than European countries. He indicates an "urgent need" for more mediolegal investigations particularly because of the increased use of drugs in American medicine. Given the loose control of drugs in the U.S. nursing home generally, there is ample reason to pay more attention to the needs of patients both dead and alive.[70]

Third, there is a disproportionately large number of physical injuries and accidents in nursing homes, often the result of negligence. Dr. Furstenberg underscored this point in response to a question from Senator Moss as follows:

> Senator Moss. You heard the exchange, I guess, on the signing of the death certificates. Do you have any views as to whether a doctor ought to be required to personally view the body before he certifies the cause of death?
>
> Dr. FURSTENBERG. Yes. While it is advisable generally, it is much more important that there be evidence in the record, of physician examination and care ordered, for the last days of that patient's illness.

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[67] P. 811, pt. 10, hearings cited in footnote 7.

[68] P. 812, pt. 10, hearings cited in footnote 7: Dr. Tayback said, "First of all, we go on the premise that the physician is generally familiar with the circumstances of the individual."

[69] *Minneapolis Morning Tribune*, July 15, 1969, p. 7.

[70] *New York Times*, Jan. 15, 1971, p. 38C; see also The Autopsy in Geriatrics, p. 1, and The Pathologist and the Geriatric Autopsy, p. 11, *Journal of the American Geriatrics Society*, Vol. XXIII, No. 1, January 1975; which reinforce these points.

> The importance, though, in your exchange with Dr. Tayback is the fact that nursing homes, as other providers of medical care, do not document unfortunate incidents in the care of patients.[71]

Fortunately there are a few States such as New Jersey that have more rigid requirements than Maryland. The New Jersey statute requires that a physician sign a death certificate within 24 hours of death.[72] This is strictly enforced and encourages viewing of bodies. By and large, however, physicians in most States do not view bodies of patients who have died in nursing homes before signing death certificates.

V. THE ABSENCE OF PHYSICIANS: GOVERNMENT POLICY

How do present Government policies contribute to the absence of physicians from the nursing home setting, and what are the present Federal standards?

The Federal Government currently pays almost 50 percent of the cost of nursing home care through its Medicare and Medicaid programs. About 16,000 of the 23,000 nursing homes in the Nation participate in one or both of these programs and therefore must conform to Federal standards. With respect to physician's services present Federal regulations require the following.[73]

For Skilled Nursing Care

- Every patient must be under the supervision of a physician.
- A written plan of care must be established, based on a physical examination conducted within 48 hours of admission.
- Patients must be seen by their physicians at least once every 30 days for the first 3 months and thereafter at the discretion of the physician but in no case at intervals exceeding 60 days.
- Written procedures must be in place in the nursing home specifying the arrangements the facility has made to make available a physician in emergencies.
- Physicians must participate (1) in utilization review committees to determine whether the present level of care is appropriate to the patient's needs, (2) in medical review committees with other representatives of health care professions to assess the quality of medical and nursing care, and (3) in professional standards review organizations (PSRO's) to test both the appropriateness of care and its conformity to established professional standards. Current regulations suggest that PSRO's when in place will supersede the other two reviews.
- Each facility is required (1) to have a full-time or part-time medical director who is responsible for the overall coordination of the medical care in the facility, (2) to insure the appropriateness of medical services, and (3) to maintain surveillance of the health status of employees. This requirement will become effective beginning in 1976. The Secretary of HEW may waive the requirement "for such periods

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[71] Pp. 823–24, pt. 10, hearings cited in footnote 7. See also Supporting Paper No. 1.
[72] New Jersey Statutes Annotated, 26 :6–8.
[73] *Federal Register*, Jan. 17, 1974, vol. 39, No. 12, pp. 2220–57.

as he deems appropriate" if he finds the supply of physicians in the area where the home is located is not sufficient to permit compliance with this requirement.

INTERMEDIATE CARE FACILITIES

- Each facility must assure that each resident is under the continuing care of a physician who sees the resident "as needed," and in no case less often than every 60 days unless justified otherwise and documented by the physician.
- In addition to the above, those ICF's which house the mentally retarded or those with related conditions must provide for an annual physical examination and provide emergency medical coverage 24 hours a day, 7 days a week.

It is obvious that the existing regulations do not require physicians to participate actively in the care of nursing home patients. This is particularly true in the case of the Nation's 8,500 intermediate care facilities where physicians' visits are almost completely discretionary. And even greater cause for concern are those 7,000 facilities that do not participate in either Medicare or Medicaid. These facilities are often small so-called personal care homes. There are no Federal requirements affecting these facilities and few State requirements. Moreover, the subcommittee has serious reservations about the directions and the implications of many of the regulations enumerated above.

A. MEDICAL DIRECTOR REQUIREMENT: LIMITED TO SKILLED CARE

On October 10, 1973, spokesmen for the American Medical Association testified before the Subcommittee on Long-Term Care, urging that long-term care facilities have a medical director or an organized medical staff or both. Smaller facilities should be allowed to provide for such services part time. Such services, the spokesmen stated, were essential to help insure the adequacy and appropriateness of the medical care provided to patients in nursing homes.

As part of the so-called Nixon nursing home initiatives, the AMA received $172,000 to develop seminars, to define the role of the medical director. The early guidelines, as developed, vest in medical directors the following responsibilities:

(1) To help define the scope and characteristics of the services provided at each level of care.

(2) To share in developing standards of care for each discipline such as nursing and rehabilitation.

(3) To help insure quality controls.

(4) To assume responsibility for overall management and delivery of patient care services—by agreement with the administrator.[74]

AMA testimony was supported by senior citizen and consumer groups. As a result, HEW agreed to reinstate this requirement which had been contained in early drafts of the proposed Medicare-Medicaid standards for skilled nursing facilities as announced on July 12, 1973.

[74] "AMA Seminar Seeks Ways To Improve Medical Services in Nursing Homes," *Modern Nursing Homes*, December 1972, p. 18.

This development was one of the constructive results of the catastrophic Baltimore food poisoning epidemic. As noted above, the subcommittee's investigation of the events of the outbreak proved that not one physician had notified the State of the potential epidemic despite substantial evidence. Each physician felt responsibility only for his own patients. No one physician was aware of the total picture of the home.

A closer examination of the Baltimore epidemic illustrates the importance of a medical director requirement and the inadequacy of State efforts.

Maryland's Secretary of Health, Dr. Neil Solomon, told the subcommittee: "I think it is fair to state that there was a fair amount of apathy." [75]

Maryland law required the home to have the services of a principal physician. But the role of such principal physician was obscure. Most doctors served in such position without compensation. Most physicians signed their names to pieces of paper whose chief import was that it allowed the nursing home to state that it was in conformance with the State regulation.

State regulations require that the doctor give guidance to the home with respect to medical care given to patients and on admission policies. Dr. Harold V. Harbold, the principal physician of the Gould home, insisted that the term was "a paper title." He was supported by Dr. Albert Bradley who noted that if principal physicians did try to advise nursing home administrators, they would be quickly fired by the home.[76] The State investigatory panel was critical of Dr. Harbold for "failure to find out what his responsibilities were." [77] Eleven of the 25 who died in the nursing home (in the first week) were patients assigned to Dr. Harbold.[78]

The State department of health moved vigorously, requiring nursing homes to have the services of medical directors with duties similar to that proposed by the AMA committee. Unfortunately, the Maryland Legislature refused to enact this requirement into the State's nursing home code in part because of estimates that the requirement would add 40 cents per patient per day to the total nursing home bill paid by the State.

As Dr. Gladue, observed, that 40 cents per patient per day is a comparatively small sum especially viewed in the context of what could be accomplished if every nursing home had a medical director. He called it the best investment the Nation could make to improve the quality of care in U.S. nursing homes.[79] He and other consumer advocates have therefore been pleased that HEW regulations of October 3, 1974 required medical direction.[80]

The October 1974 Regulations

However, there are some serious concerns with respect to these regulations:

[75] P. 747, pt. 9, hearings cited in footnote 7.
[76] *Baltimore Sun*, Sept. 18, 1970, p. 22.
[77] Pp. 840–41, pt. 10, hearings cited in footnote 7.
[78] P. 22, article cited in footnote 75.
[79] P. 2782, pt. 22, hearings cited in footnote 7.
[80] *Federal Register*, Oct. 3, 1974, vol. 39, No. 193, pp. 35774–78.

First, regulations require "a medical director on a part-time or full-time basis as is appropriate for the needs of the patients in the facility." There is no guidance in the regulation explaining which facilities require full-time or part-time medical direction. In this respect, the standard is vague and ambiguous. HEW should specify with precision the size of homes which require full-time medical direction.

Second, and just as important, compliance with the medical direction requirement is postponed until December 2, 1975.

Third, liberal waivers can be granted under the provisions of the regulations. The Secretary of Health, Education, and Welfare may waive the requirement "for such periods as he deems appropriate" if he determines that the facility is located in an area where physicians are in short supply.

Fourth, and equally important, the medical director requirement applies only to skilled nursing homes. Intermediate care facilities are not covered by this requirement. In fact, ICF's have very little regulation regarding physicians. More discussion of this point is found below.

B. FREQUENCY OF PHYSICIAN VISITS

As noted above, physician visits to patients in skilled nursing facilities are presently required once every 30 days for the first 3 months, and thereafter at the discretion of the physician (provided that the patient is seen no less often than once every 60 days).

This standard reflects the unhappy compromise of previous Medicare and Medicaid standards, which required physicians to visit patients in skilled nursing facilities at least once every 30 days.

Not everyone agreed that the flat 30-day standard was helpful and desirable. Some physicians classified the rule as "arbitrary," an invasion of their professional prerogatives, and refused to comply with it. In fact, the American Medical Association house of delegates in 1968 passed a resolution calling the 30-day rule excessive and charging that it would result in unnecessary expenditure.

Spokesmen in defense of the rule countered by saying the primary problem was getting physicians into the nursing home rather than too frequent visits (unnecessary expenditures).

In November 1970, the Bureau of Health Insurance which establishes regulations for the Medicare program made an important concession. Through intermediary letter No. 70–32 it turned Medicare's 30-day requirement on its head. Where before the regulation had required doctors to see patients at least once every 30 days, the new rules stated that physicians would not be paid for more than one visit a month. What had been a requirement encouraging physician visits became a limitation.

Under this new rule, physicians were asked to justify in writing the details of any visits more frequent than once a month. In protest Dr. Gladue wrote to the Bureau of Health Insurance:

> In an apparent move to lower costs of the financially burdened Medicare program and under the guise of eliminating abuses, the Bureau of Health has arbitrarily limited physicians' visits to the aged part B beneficiary in nursing

homes to one per month. The letter (BHI intermediary letter No. 70–32) refers to the nonacute nature of the illness as warranting infrequent physician's observation—to say the least, an unthinking, uninformed and very negative attitude. Instead, the Bureau of Health Insurance (Medicare) should know that chronically ill aged patients are less resistant to all forms of stress, physical, psychological, and emotional, and that therapy must be brought to bear quickly to prevent irreparable damage and/or death. Studies show that morbidity and mortality are favorably affected by frequency of physicians' visits. Are you aware that, from a physical standpoint, the bedridden or physically inactive chronically ill patient (who needn't even be old, but advanced age certainly doesn't help!) is always subject to, and must therefore be constantly watched for, a number of conditions:

1. Heightened susceptibility to illness of any type, epidemic or otherwise, and the fact that even a minor cold or virus caught from an attendant or visitor could quickly and easily escalate into a major or fatal disease unless promptly noted and treated.
2. Kidney diseases or other urinary difficulties.
3. Bed sores, skin irritations, etc.
4. Cardiac failure and irregularities of rhythm must be recognized early and treated promptly.
5. Bowel difficulties which, unless watched and corrected, are far from minor problems to the patient.
6. Dietary deficiencies which may be brought about by the patient's condition or because he, even though offered a proper diet, may for various reasons not eat as he should. Diseases of teeth and gums are often implicated.
7. Changes which may occur in the effectiveness of medication, even though it may have been given over a long period of time without apparent difficulties. Such changes could be the result of changes in the patient's condition or of the fact that sometimes (many examples come to mind) effects are cumulative and difficulties take months or years to become apparent. Many medications are still too new to assume that everything is known about them.
8. Changes in brain function, very common and resulting in confusion, disorientation and depression and/or agitation. These conditions can be treated effectively by the physician with the use of understanding, psychotherapy, and psycho-active drugs.
9. Deterioration of vision and hearing. The physician must be alert to changes which can affect the patient's ability to communicate. Most are correctable or can be helped.[81]

It is to be emphasized that the November 1970 regulations from the Bureau of Health Insurance threw into conflict the physician's visit requirements for the two programs, Medicare and Medicaid. Medic-

[81] Letter to Senator Moss, Dec. 7, 1970, in subcommittee files.

aid's requirements for Skilled Nursing Facilities continued to require physician visits at least once a month while Medicare's requirements for Skilled Nursing Facilities would pay for no more than one visit each month.

Congress acted in 1972 to end this confusion. It mandated that there should be only one unified set of standards for Skilled Nursing Facilities which participate in the Medicare or Medicaid programs.[82]

In July 1973, the interim unified regulations were announced by HEW. These regulations were sharply criticized by consumer advocates and senior citizen spokesmen as a retreat from the rudiments of proper care. Of particular interest was the adjustment of the physician's visit requirement.

The July standards required visits by physicians at least once every 30 days for the first 3 months and thereafter at the discretion of the physician. Consumer and senior citizen spokesmen reacted strongly, arguing in favor of reinstituting the flat 30-day rule.

This issue became a central focus of the October 10 and 11, 1973 subcommittee hearings. HEW reacted to its critics by offering a compromise: language to the effect that in no case shall a patient go more than 60 days without a visit from a physician.

Senator Moss at the hearing and in his October 30, 1973, letter to Secretary of HEW, Caspar Weinberger, argued strongly in favor of the reinstatement of the 30-day requirement. HEW refused to make this change, standing by its compromise which became and is now the final regulation on the subject. Senator Moss reacted by announcing his intention to introduce legislation requiring that patients be seen at least once every 30 days.

In a related matter, Senator Moss was successful in his effort to have HEW reinstate certain other provisions which were deleted when HEW announced its unified Medicare and Medicaid skilled nursing facility regulations. These requirements were:

- **That patient information be obtained by the nursing home from the hospital or elsewhere within 48 hours.**
- **That a medical evaluation be completed within 48 hours of admission unless the patient had been examined within the previous 5 days.**
- **That a physician make arrangements with fellow physicians to cover his nursing home patients when he is out of town.**
- **That written procedures be established to be followed in an emergency.**
- **That, insofar as possible, each patient should be guaranteed the right to select his own physician.**

The foregoing requirements, like the requirements for medical direction and physician's visits, apply only to the 7,300 skilled nursing facilities. The question is what standards do Intermediate Care Facilities have?

There are some 8,500 of the Nation's 23,000 nursing homes classified as Intermediate Care Facilities (ICF's). These facilities presently

[82] Sec. 246 of Public Law 92–603.

care for about 400,000 patients. The precise number of patients is in question in view of the present (and some say "dangerous") trend of reclassifying patients from skilled nursing (a higher and more expensive level of care) into ICF's (a second and less costly level or care). This issue is discussed in detail in part 3 of the subcommittee's Introductory Report.

Those who claim the trend is dangerous point to the high incidence of mortality and morbidity associated with the transfer of nursing home patients from home to home and sometimes from room to room. They suggest the motive is cost-cutting and that it is "false economy" because patients transferred to ICF's will, they charge, deteriorate for lack of proper medical and nursing care.

As an illustration, consumer advocates often point to the ICF nursing and physician standards. With respect to nursing, only one licensed practical nurse is required 8 hours a day (plus 4 hours consultation from a registered nurse).

The physician standard is even more anemic. It requires physicians visits "as needed" but no less often than "once every 60 days" (unless justified otherwise by the physician). In essence, it allows for full discretion.

For all the twists and turns, the end result is that there is virtually no physicians standard with respect to Intermediate Care Facilities. There is no requirement compelling his presence in the nursing home. Past experience indicates that physicians will not visit nursing homes with any frequency unless required to do so—even then they might not do so. In fact, the U.S. General Accounting Office, in a May 1971 audit of three States, disclosed that physicians were not making the required physician's visits in over 50 percent of the homes surveyed.[83]

The clear need for a more effective standard is evident. Moreover, it is of little comfort that ICF's that treat the mental retarded (or those with related conditions) require annual physicals and a physician on call in emergencies 7 days a week, 24 hours a day. Patients who are physically ill deserve these same protections.

C. OTHER PROBLEMS WITH GOVERNMENT POLICY

In addition to the subject of standards and regulations, there are other aspects of Government policy with respect to nursing homes that discourage physicians from visiting patients.

Cutbacks in Reimbursement

In 1969, there was a flurry of publicity suggesting that doctors were abusing Government programs. In July 1969, Dr. Gerald D. Dorman, newly elected president of the American Medical Association, charged "A national scandal is underway because of cheating in the Medicaid program."[84] This followed on the heels of tough new regulations announced by HEW which had the effect of paying the doctor no

[83] "Problems in Providing Proper Care to Medicaid and Medicare Patients in Skilled Nursing Homes," a report of the U.S. General Accounting Office, May 28, 1971.
[84] *Minneapolis Morning Tribune*, July 18, 1969, p. 18.

more than what is customary among 75 percent of the doctors in his area or his customary fee, whichever is less.

At this same time the Internal Revenue Service announced it would audit the income of any physician who made more than $25,000 a year from Medicare or Medicaid.

By February of 1970, Richard S. Wilbur, M.D., of the AMA, appeared at a news conference accompanied by Dr. Andrew Thomas of the National Medical Association to state that the "Congress was going in exactly the wrong direction if it places more limits on physician's fees as a cureall for problems besetting Medicare and Medicaid." [85] Dr. Thomas said that in limiting fee structures all Congress would do would be to limit access to the poor.

In February, the Senate Finance Committee also released its report: "Medicare and Medicaid: Problems, Issues, and Alternatives." The report listed 4,300 individual practitioners who made more than $25,000 from Medicare or Medicaid in 1968; 68 of whom had made more than $100,000.[86] The report asserted that many physicians were resorting to "gang visits" and unnecessarily frequent visits to nursing homes in order to increase their Medicare payments. "Under this practice a physician might see as many as 30 or 40 patients in a day at the same facility regardless of whether the visit is medically necessary or whether a service is actually performed. The physician will often charge the patient his full fee, billing Medicare for as much as $300 or $400 for one sweep through a nursing home." [87] The Finance Committee declared that most of the services were probably medically necessary but that reimbursement did not discourage high fees.

The General Accounting Office, in its February 2, 1971, audit of California, indicated that California physicians had been overpaid by $426,000 in 1969 under the Medicaid program. Medicaid regulations mandated a reduced fee for visits made on the same day to a number of patients in the same nursing home. GAO said that physicians and X-ray services had billed (and were paid) for the higher single-patient visit fee.[88]

The adverse publicity given to the minority of physicians who abused the Medicare and Medicaid programs and the corrective action (i.e., lower payment to physicians) has been a significant obstacle to physician participation in nursing home care.

Dr. Kassel commented:

> We have all become labeled as dishonest, thieves, robbers, by the newspapers all over the country. I don't want to go into this too deeply, but I do feel that it is about time the medical profession stood up and specifically stated what they feel should be an adequate net income for a physician based on the 40-hour week, remembering the amount of training, the cost to go to medical school, the fact that it took 5 years to bring money home. But, not only on the 40-hour week, what about those of us who work an 80-hour week? What about time and a half for overtime, and double time for holidays? [89]

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[85] *AMA NEWS*, February 16, 1970, p. 1.
[86] Feb. 9, 1970, p. 13.
[87] P. 9, report cited in footnote 86.
[88] Audit No. B–164031(3).
[89] P. 557, p. 7, hearings cited in footnote 7.

Retroactive Denials [90]

In 1969, the Nixon administration announced new rules which narrowed the scope of the Medicare nursing home program. The Bureau of Health Insurance, which promulgates Medicare regulations, announced restricted and specific definitions for the term "skilled nursing" which by statute is a precondition of qualification for Medicare nursing home coverage.

The effect of these regulations was that thousands of patients previously eligible for Medicare nursing home benefits were suddenly deemed ineligible. To make matters worse, these new regulations were applied retroactively to the beginning of the Medicare program. This meant that individuals served by nursing homes in 1968 and for whom the nursing home had been paid were suddenly deemed incompensable on the basis of revised criteria announced in 1969.

The effect was to require that nursing home administrators pay back sums they had received in final payment for patients. It also meant that physicians had to explain to families why their relatives were no longer eligible although placed in nursing homes upon the reliance that Medicare would pay the bill.

Payments to physicians were similarly affected; many were denied payment for services rendered. Physicians were in the position of having their judgments as to whether a patient was "sick" enough to qualify for Medicare challenged and overruled by clerks in insurance offices who paid Medicare claims after reviewing papers.

To many physicians, the superimposition of restrictive insurance principles upon the health needs of the elderly was nothing short of catastrophic.

D. PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS (PSRO's)

The enactment of the Medicare program in 1965 brought with it new burdens and new responsibilities for physicians. Physicians were required to participate in "utilization review" activities in hospitals and nursing homes. Utilization review includes review of the necessity for admission, the necessity for continued stay, and medical care evaluations of a sampling of Medicare patients.

In 1967, physician responsibility was extended to the Medicaid nursing home program. An amendment introduced by Senator Moss required that the States conduct annual "medical reviews." Medical review examines (1) the necessity for admission and continued stay, (2) the appropriateness of the facility for the patient's needs, (3) the possibility of meeting the patient's needs short of institutionalization, and (4) the quality of care and services delivered.[91] In contrast to utilization review, which is performed by doctors, medical review (while led by physicians) is conducted by a team of health professionals (including nurses, social workers, therapists, etc.).

The efficacy of utilization review and medical review programs has differed greatly from State to State. In fact, some States have yet to implement medical review. These and other shortcomings were part

[90] See pt. 3 of Introductory Report, p. 29.
[91] Public Law 90-248, sec. 234.

of the reason Congress (in 1972) authorized a third layer of review—professional standards review organizations (PSRO's) which according to HEW interpretation are destined to supersede the other two reviews.[92] The heavy responsibility that goes with PSRO's rests almost entirely on the shoulders of physicians. This fact has produced both praise and concern. The Nader Task Force and other consumer and senior citizens groups have argued strongly for wider consumer representation on review boards. Others have argued that PSRO's will force doctors to assess quality of care and look closely at patients.

At the present time PSRO's are made up of a community-based group of physicians (usually outgrowths from the State's medical societies). The three primary objectives of PSRO long-term care review are:

(1) To assure that each patient seeking admission to a long-term care facility receives a medical, nursing and psychosocial evaluation and is placed in the facility (most appropriate to the patient's medical, nursing, and medically related social and emotional needs).

(2) To assure that each patient admitted to a long-term care facility has a comprehensive care plan and that there is continued reassessment of the patient's needs and the appropriateness of the care delivered.

(3) To assure that each patient admitted to a long-term care institution receive the quality of care necessary to maximize his/her medical and related functional status.[93]

It is still too early in the development of PSRO's to make any objective evaluation. By the end of 1974 there were only 14 PSRO's in operation (the latest in New Mexico). By the summer of 1975, there are expected to be 30 to 40 more officially underway, and by 1976 some 203 such organizations should service the whole country.[94]

Significantly, the first PSRO began in Utah built on the success of that State's "peer review" program. As a result of this success in Utah, Senator Wallace Bennett, of Utah, introduced the 1972 amendment requiring PSRO's in every State of the Union. Not everyone in Utah shared Senator Bennett's appreciation for peer review or PSRO's. Dr. Richard Morris of Salt Lake City was strongly critical:

> From bitter experiences in the extended care facility since 1968, many people have grave doubts about the thoroughness and fairness of peer reviews. They know how those usually work: One overworked, hurried, practicing physician temporarily assumes the role of reviewing peer and perfunctorily looks through the often incomplete chart of another practicing physician. The reviewing peer then—without further effort to examine all the evidence or to interrogate vital witnesses or to discuss the matter with patient, family, or attending physician—makes a snap judgment based on an uncandid law. This decision then largely becomes irrevocable because of the absurdity that the reviewing outranks the reviewed peer. Weeks or months later if the judgment is adverse, the patient learns for the first time that he has been tried and sentenced.

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[92] Section 249F of Public Law 92–603.
[93] Unpublished draft of PSRO regulations as related to long-term care facilities, Aug. 26, 1974.
[94] "PSRO's: How the First Ones Are Working," *Medical World News*, Oct. 25, 1974, p. 53.

Trial by peer review, in this instance, is based on the principle that "only a physician should review a physician." Note well, however, what happens when this principle is applied to determining eligibility of patients for Medicare benefits: Whenever the reviewing peer's opinion is adverse, it is not the reviewed peer who is sentenced and fined but the innocent patient!

Peer review, perhaps intentionally, eliminates the single most important figure in any fair trial—the noumpere or umpire. This is akin to vigilantism.

Peer review when it is used to determine eligibility of a particular patient for Medicare benefits, postulates that qualification should be based on expert opinions rather than measurable and definable laws. Physicians and legislators who favor regulation of this vast program with its millions of anxious dependents by differences of opinion between two experts must accept the cost of an increasingly large police force, haphazard judgments, and resentment of patient against physician, physician against physician, and finally the public against organized medicine. Those who believe the real role of experts is to formulate clear laws which can then be easily used by all, even the inexpert, can expect policing costs and discord to decrease in proportion to the candor and clarity of these laws.

The time has come for Medicare to begin policing its own program rather than paying outside organizations to perform this vital function. The magnitude of this task requires the employment of full-time personnel who are responsible to and controllable by Medicare; who have adequate motivation, training, time, legal and medical knowledge to carry out this work in a uniform and fair manner in every part of the Nation; and who will continue in this job until and after they become expert.[95]

While there has been criticism of the PSRO approach, the subcommittee will view with interest this program as it develops. It deserves a thorough test before definitive judgments can be made.

SUMMARY

The hard, cold fact is that nursing homes suffer from the lack of medical care and supervision. What patient care there is, is given by nurses. Even then it must be admitted that professional nurses are few and far between (only 53,000 out of some 583,000 nursing home employees). In the end, 80 to 90 percent of the care is given by untrained aides and orderlies, paid the minimum wage, and showing a turnover rate of 75 percent a year. Until physicians accept greater responsibility for the care of nursing home patients, the endless stories of negligence, poor care, and abuse will continue.

[95] Mar. 14, 1972, letter to Senator Wallace Bennett.

RECOMMENDATIONS

1. U.S. schools of medicine should place greater emphasis on geriatrics in their general curricula.

2. Continuing education programs in geriatrics should be established for physicians.

3. Funds should be provided to help establish departments of geriatrics in schools of medicine.[96]

4. U.S. nursing homes should be required to have either a medical director or an organized medical staff. Smaller facilities could have medical directors serving part time. The medical director should bear overall legal responsibility for the care of patients in the facility.[97]

5. Funds should be provided to train medical corpsmen discharged from the armed services with the intent that they could serve in nursing homes under the physician's direction assuming some of the duties of the physician in caring for nursing home patients.[98]

6. A program should be enacted providing training in geriatrics for physician's assistants and nurse practitioners to work in nursing homes.[99]

7. A program should be enacted providing funds to schools of nursing to establish training programs for nursing home personnel.[100]

8. Comprehensive health planning agencies should give preference to nursing homes so they can be built near hospitals and physicians' offices to reduce the distance doctors have to travel to visit patients.

9. Physicians should be required to view bodies of patients who have died in nursing homes. Death certificates should be required to be signed within 24 hours of death.

10. Physicians should make greater efforts to report infectious diseases. State statutes should provide appropriate fines and penalties for failure to do so.

11. Physicians should exercise greater control of medications for nursing home patients. Only emergency medications should be prescribed over the telephone. Medications so prescribed should be ratified by the physician within 24 hours. Thirty-day stop orders for medication and treatment orders should be enforced.

12. Physicians should be required to see patients at least once every 30 days under the Medicare and Medicaid nursing home programs.

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[96] See S. 764, 93d Congress, to be reintroduced in the near future.

[97] Regulations promulgated by HEW on Oct. 3, 1974, require all skilled nursing facilities to have the services of a medical director. Unfortunately, compliance is postponed until January 1976, and there is no precise rule spelling out which homes must have full-time directors and which may have only part-time.

[98] See S. 765, 93d Congress, to be reintroduced in the near future.

[99] See S. 766 and S. 2052, 93d Congress, to be reintroduced in the near future.

[100] See S. 512, 93d Congress, to be reintroduced in the near future.

13. Medicare and Medicaid should establish reasonable fees for visits to nursing home patients based upon the amount of the physicians' time invested and the medical arts performed.

14. Utilization review should be continued and provisions for medical review should be enforced. If PSRO's are to be continued then HEW should require wider representation of consumer and other health professions on PSRO's.

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