TRENDS IN LONG-TERM CARE

HEARINGS

BEFORE THE

SUBCOMMITTEE ON LONG-TERM CARE

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

NINETY-FIRST CONGRESS

SECOND SESSION

PART 10—WASHINGTON, D.C.
(Salmonella)

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Part 1. Trends in Long-Term Care, Washington, D.C., July 30, 1969
Part 2. Trends in Long-Term Care, St. Petersburg, Fla., January 9, 1970
Part 3. Trends in Long-Term Care, Hartford, Conn., January 15, 1970
Part 4. Trends in Long-Term Care, Washington, D.C., February 9, 1970 (Marietta Fire)
Part 5. Trends in Long-Term Care, Washington D.C., February 10, 1970 (Marietta Fire)
Part 6. Trends in Long-Term Care, San Francisco, Calif., February 12, 1970
Part 7. Trends in Long-Term Care, Salt Lake City, Utah, February 13, 1970
Part 8. Trends in Long-Term Care, Washington, D.C., May 7, 1970
Part 9. Trends in Long-Term Care, Washington, D.C., August 19, 1970 (Salmonella)
Part 10. Trends in Long-Term Care, Washington, D.C., December 14, 1970 (Salmonella)
Part 11. Trends in Long-Term Care, Washington, D.C., December 17, 1970.
Part 12. Trends in Long-Term Care, Chicago, Ill., April 2, 1971
Part 13. Trends in Long-Term Care, Chicago, Ill., April 3, 1971

CONTENTS

TRENDS IN LONG-TERM CARE
(Salmonella)

MONDAY, DECEMBER 14, 1970

U.S. SENATE,
SUBCOMMITTEE ON LONG-TERM CARE,
SPECIAL COMMITTEE ON AGING,
Washington, D.C.

The subcommittee met at 9:30 a.m., pursuant to call, in room 3110, New Senate Office Building, Senator Frank E. Moss (chairman) presiding.

Present: Senators Moss and Young.

Staff members present: Val Halamandaris, professional staff member; John Guy Miller, minority staff director; and Peggy Fecik, clerk.

OPENING STATEMENT BY SENATOR FRANK E. MOSS, CHAIRMAN

Senator Moss. The subcommittee will come to order.

This is a continuation of a hearing begun by this Subcommittee on Long-Term Care into the facts surrounding the outbreak of salmonella in the Baltimore nursing home some months ago. The long period between the earlier hearings and this one has been necessary because of an investigation we have asked for, and, of course, because of the recess of the Congress.

It is rather late in this session of the Congress, but we did want to complete our record so that the committee could determine what sort of a report it wanted to file and whether any legislation was indicated to meet the problems that have been identified in this particular instance.

I have a rather lengthy opening statement, but I will forego the temptation to read it in its entirety. I will ask that it be placed in the record in full and I will offer a summary of my statement.

On the completion of our August 19th hearing, I asked the General Accounting Office for a limited audit defining the three questions for investigation in four Maryland nursing homes. These nursing homes were Bolton Hills, Harbor View, Forest Haven, and the Gould Convalesarium.

The questions considered were: Do nursing home administrators buy food at a low price and charge Medicare or Medicaid a higher price representing food purchases?

Second, have nursing homes collected, or attempted to collect, from Medicare and Medicaid for periods after a patient's death?

Third, do physicians having responsibility for nursing home patients sign death certificates without ever having viewed the bodies?

The report of the GAO,[1] which I will try to summarize, first concluded that in order to buy food for a low price and charge Medicare or Medicaid a higher price, operators would have to alter receipts or be in collusion with food vendors. No altered receipts were found by GAO. The possibilities of collusion were not examined.

GAO discovered 39 instances in its limited audit where the four nursing homes named had collected from Medicaid for periods after the patient's death. Most involved the home billing Medicaid for a whole month even though the patient had died during the month. Most of these were discovered by the State.

In the course of this audit, GAO discovered that there were duplicate payments made to nursing homes under Medicare and Medicaid. GAO had already marked duplicate payments as a serious problem in its July 1970 audit of California nursing homes. Commonly, Medicare rejected a claim, which was submitted then to Medicaid which paid it, whereupon Medicare reconsidered and paid a second time.

GAO notes that the States must rely on nursing home operators to notify the State upon receiving duplicate payments. In my view, this is hardly acceptable.

GAO disovered that Medicaid audits were not being conducted in Maryland, citing this as significant, since Maryland reimburses on actual cost plus a profit of 10 percent, up to a maximum of $16 a day. In the 3 years from fiscal 1967 through fiscal 1969, only two Medicaid audits were conducted and these were at the same nursing home.

Lastly, GAO confirmed my worst fears when it says, "Our examination revealed that it was not an uncommon practice for Maryland physicians to sign death certificates, without first viewing the bodies of patients who had died in nursing homes."

The death certificates of 322 people in the four nursing homes were examined. Eighty-nine bodies had been viewed, 50 were not, and 183 did not indicate one way or another. The physician signing 110 of these 183 certificates stated he generally did not view the bodies.

Physicians argued it was unnecessary and impractical to view the bodies of those dying in nursing homes, that the nursing staff was capable of ascertaining death. With all due deference to the medical profession, it appears clear that physicians have deserted the nursing home, and that the medical decisions from administering drugs to ascertaining death are falling more and more on the nursing staff.

By staff, I mean the aides and the orderlies, the most overworked and underpaid members in our health care system.

This is true, because a registered nurse spends most of her time in paperwork, in an effort to aid collection of funds.

The trend is unacceptable; it offends my sense of justice. We owe our ill elderly more than this.

I invite discussion of these questions today.

(The opening statement referred to follows:)

OPENING STATEMENT BY SENATOR FRANK E. MOSS, CHAIRMAN

On July 26 and the days following, a few ordinarily innocuous Salmonella bacteria multiplied themselves into an epidemic claiming the lives of 25 residents

[1] See digest of report app. A, item 2, p. 862.

of a Baltimore nursing home. From every corner of the land there came outrage and concern as the Nation remembered in death those old and ill citizens it had forgotten in life.

This great tragedy has caused at least three forums of public inquiry to be convened. This Committee held a hearing on August 19, which was followed by that of the Maryland Medical Society and the State's blue ribbon panel. Still the elusive questions remain:

What was the cause of the Salmonella outbreak?

Why did the outbreak reach epidemic proportions?

Why was there such a substantial loss of life?

Like so many other difficult questions these will probably go unanswered no matter how many panels of inquiry we convene. There are, however, other questions which emerged from our hearings, and they are National in scope, not solely confined to Maryland.

These broad questions include:

Are nursing home standards adequate?

Does our procedure for the licensing of nursing homes need to be revised and strengthened?

How effective are nursing home inspections?

Are Federal standards being enforced by the States?

Are there duplicate payments to nursing homes under the two Federal programs—Medicare and Medicaid?

What is the role and responsibility of the physician with regard to the nursing home?

To throw some light on these questions and others I asked the Comptroller General of the United States and the General Accounting Office for a limited audit based on a sample of four Maryland nursing homes. These nursing homes were: The Gould Convalesarium, Forest Haven, Bolton Hills and Harbor View.

The specific issues that I asked the GAO to study were as follows:

Do nursing home administrators buy food at a low price and charge Medicare or Medicaid a higher price representing food purchases?

Have nursing homes collected or attempted to collect from Medicare and Medicaid for periods after a patient's death?

Do physicians having responsibility for nursing home patients sign death certificates without ever having viewed the bodies?

Taking these questions one at a time, GAO concluded that at least on the basis of this limited audit, there was no evidence of nursing homes paying one price for food and charging Medicare or Medicaid a higher price. GAO states that since in Maryland both Medicare and Medicaid reimburse for actual costs, for nursing homes to indulge in this type of cheating they would have to alter receipts or collusion would have to exist between the nursing home operator and the food vendor. GAO's audit did not reveal any alterations. The collusion question was not considered.

In the process of this inquiry GAO also discovered that Hospital Cost Analysis Services, Inc. a nonprofit corporation under contract with the State Department of Health, to audit and analyze nursing homes' cost under the Federal Medicaid program "was not making audits on a regular basis. "For example," the report said, "during the 3 year period from fiscal year 1967 through 1969, Analysis Services had made only two audits of nursing home costs under the Medicaid program. These were made *at the same nursing home* in conjunction with audits under the Medicare program."

The report states that the reason given GAO for this failure was that "sufficient State funds were not available to finance these audits." The report continues, "We believe that when payment rates are based on actual cost as reported by nursing homes, periodic audits by an independent source are an essential control over cost reporting."

On the question of nursing home operators attempting to collect payments from Medicare and Medicaid for periods after the patient's death, GAO "identified 39 instances in which payments had been made under the Medicaid program for nursing home care after the deaths of patients. In 34 of these cases the nursing home billed Medicaid for a full month even though the patient had died during the month."

GAO indicates of the total of 39 overpayments discovered in the four studied nursing homes 36 had been discovered by State employees and were adjusted.

In examining this question GAO discovered that six duplicate payments amounting to $2,000 were made to the four nursing homes. This occurred when claims rejected by Medicare were submitted to Medicaid for payment. Following payment from Medicaid, the other Federal program Medicare reconsidered and also made payment. Twenty-seven instances were found where Medicaid had paid claims after rejection by Medicare. Medicare had subsequently reconsidered and paid in six of these cases and had approved but not yet paid four more of the claims.

The State Medicaid official candidly informed GAO that "program officials must rely on the nursing homes to notify them of duplicate payments."

The last question of whether physicians view bodies in nursing homes before they sign the death certificate came in for some substantial discussion at our last hearing when it was disclosed that in at least four instances physician did not view the bodies in the Gould home before signing death certificates and that few of the certificates even listed Salmonella as a cause or contributing cause of death.

This raises the larger question of physicians' medical duties in nursing homes. It has been my suspicion that physicians simply don't get involved. Our Senate hearing and the State's hearing is replete with references to physicians prescribing drugs for their patients over the telephone during the early days of the Salmonella epidemic. Few physicians felt the need to come quickly to the home to see their patients. Presumably, had physicians viewed the bodies of those in the Gould home they would have become suspicious and asked for immediate tests. The result perhaps would have been an earlier isolation of Salmonella as the cause of death and the death certificates would have not been bare of the word Salmonella as they were.

The report from GAO supports my worst fears when it says:

"Our examination revealed that it was not an uncommon practice for Maryland physicians to sign death certificates without first veiwing the bodies of patients who had died in nursing homes."

GAO reports that such practice is not illegal or considered unethical in Maryland. GAO examined the certificates of 322 Medicare and Medicaid patients that had died at the four nursing homes. The records indicate that 89 bodies had been viewed by the signing physician, 50 were not and that the remaining 183 certificates do not indicate whether the bodies were viewed or not.

GAO interviewed the physicians who had signed 110 of the 183 death certificates which did not state whether the physician had viewed the bodies. He stated that he generally did not view the bodies. The consensus of the 17 pysicians interviewed by GAO was that it was either impractical or unnecessary to view the bodies of all patients who died in nursing homes and that the skilled nursing personnel in nursing homes were technically qualified to determine that a patient was dead and to note any unusual developments, other than the illness for which the patient was being treated, which might have caused the death.

In a survey of 305 death certificates from Baltimore County (exclusive of Baltimore city) GAO concluded that this same practice prevails outside of the scope of nursing homes. "In the Baltimore area it is not uncommon practice for a physician to sign the death certificate without having viewed the body."

With all due deference to the Medical profession and the demands on their time and energies I cannot help but state my extreme concern about this practice.

I see every evidence that the medical care in our nursing homes is more and more province of the nursing staff. I underline that Federal Regulations require only one Registered Nurse on the 8 a.m. to 4 p.m. shift and allow Licensed Practical Nurses to supervise for the other two shifts. From my experience the bulk of the time of these nurses is spent with paper work designed at insuring collection of funds. Generalizing once more, the remainder of their time is allocated to supervision so that it is rare for the R.N. to tender services to patients. This means that this responsibility is falling more and more on our nurse's aides.

The nurse's aides are perhaps the most overworked and underpaid group of people in the United States. Most of them make only the minimum wage given the demands of the job. It takes real dedication or the lack of other employment opportunities to keep a person in such a position. It appears evident that it is the nurse's aides who—more and more—will be tendering the medical care in nursing homes from giving drugs (although the regulations cite this as the duty of the R.N.) right down to ascertaining that the patient has died and stating the causes for such death. This practice is less than acceptable; it highly offends my sense of justice and fundamental decency. Surely we can do better.

While I sympathize with the State of Maryland and its financial hardship we must see to it that Medicaid audits are carried out as a cost control. The Federal government yearly contributes more than $14 million to Maryland's Medicaid nursing home program and the Government is entitled to this protection. We also need some better check on duplicate payments between Medicare and Medicaid. Placing the responsibility on the providor to notify the State when he receives duplicate payment is more than ludicrous.

I invite discussion on these questions by our witnesses today.

Senator Moss. We have invited today several distinguished witneses to come before the subcommittee.

I will ask first that the Very Reverend Joseph A. Sellinger, president of Loyola College, Baltimore, Md., chairman of the State of Maryland's board of inquiry convened to investigate the Baltimore salmonella outbreak, to come to the table and if Dr. Tayback, assistant secretary of health and mental hygiene for the State of Maryland, would also come to the table with Reverend Sellinger.

My aide tells me that there may be a delay in Dr. Sellinger's appearance because of some traffic problems. Perhaps we could proceed with you, if you would come forward, Dr. Tayback.

STATEMENT OF MATTHEW L. TAYBACK, M.D., ASSISTANT SECRETARY OF HEALTH AND MENTAL HYGIENE, STATE OF MARYLAND

Dr. TAYBACK. Mr. Chairman, you will recall that 3 or 4 months ago on your invitation, we were asked to appear before you and to answer questions that members of your committee had concerning the event that has now become known as the Gould Convalesarium salmonella outbreak.

At the time that we appeared before you, there were a number of questions which members of the committee had and as a matter of fact, our own inquiry into the matter at that time had not been completed.

We were unable to answer all the questions put before us, but we promised you that certain documents would be presented concerning, (1) issues of safety of water [2] and (2) several other issues. Documents have been sent to your committee in this regard.

In order fully to inquire into the circumstances of this event, the Secretary of Health, Dr. Solomon, convened a special panel consisting of three distinguished members of the Baltimore and Maryland lay and medical community, namely, Father Sellinger, Dr. Rogers, dean of the Johns Hopkins School of Medicine, Dr. Moxley, dean of the University of Maryland School of Medicine.

This was the best manpower to inquire into an event of this type that could be assembled in the State of Maryland. The impartial nature of this group was unquestioned. The special panel had meetings through 2 full days, spent from 2 to 4 weeks considering the evidence accumulated and rendered its report, copies of which have been transmitted to your committee.[3]

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[2] "Trends in Long-Term Care," Part 9, p. 797.

[3] See app. A, p. 837 "Report of an Investigation into the Salmonella Epidemic at Gould Convalesarium."

In the course of the special panel's inquiry, certain things became apparent and the State department of health and mental hygiene immediately took action in connection therewith.

It became apparent that there seemed not to be a clear focus of departmental authority for the program. Because of the urgency of the matter, the focus of authority has been moved right to the Office of the Secretary. The Secretary of Health, Dr. Solomon, takes a personal interest in these matters and as the Assistant Secretary, I have the full responsibility for what is transpiring now in the nursing homes subsequent to the Gould Convalesarium incident.

So, we have given to the affairs of nursing homes and the patients in nursing homes the highest organizational status within our department. There was evidence fairly early that the inspection system was neither acceptable from a quantitative point of view, nor acceptable from a qualitative point of view.

We have identified four major components to the inspection system: First, inspection of the sanitary nature of the environment of the nursing home; second, the matter of provision of and the supervision of patient care; third, the matter of the preparation of meals in terms of dietary adequacy; and fourth, the safety of the facility from a fire point of view.

Each one of these elements now is defined very carefully in terms of a required inspection system. Four inspections are now required for the environment, one each quarter of the year. Four inspections are now required for patient care. Two inspections are required from the point of view of inquiring into the dietary sufficiency of the meals being prepared for and distributed to patients in our nursing homes.

The State fire marshal has the responsibility for the enforcement of the life safety code making recommendations in connection therewith.

We have established a division of licensure where all of the documentation of these various inspections is received. We have now a system where within our own department there will be an internal audit going on in connection with inspections being carried out by sanitarians and nurses.

We have shared with your committee and we have shared with the special panel our concern for what constitutes acceptable medical services, the supervision of medical services within nursing homes.

The inquiry into the Gould incident indicated that at the time of the outbreak there were 146 patients, and these were being treated by 44 physicians. It was relatively impossible to pin down a focus of medical authority within the nursing home, in spite of a requirement that we had which we called the principal physician.

In this regard, quite frankly, we have learned from this incident that what existed before the outbreak is not satisfactory, thus we are moving away from the concept of a principal physician, by and large not paid for this role and not giving the necessary time to it. We are moving from this concept to that of a medical director, who will clearly have the responsibility for the supervision of the medical services within the nursing home, presumably will be stipended for that purpose and can be held to account for that purpose.

In connection with the matter of the physician viewing the body after death, frankly, the circumstances which came to the surface as

a consequence of the Gould Convalesarium event, namely, that physicians do not view the body after death was not known to us prior to the Gould Convalesarium incident.

On inquiring into this situation, we find that the law in Maryland does not require a physician to view the body at death or after death in the certification of the cause of death. The law requires a physician attending an individual to certify to the cause of death, but the requirement as to whether he shall be present at the time of death or subsequent to death and view the body is not in the statutes.

I have discussed this matter very carefully with Dr. Russell Fisher, the medical examiner for the State of Maryland, a man renown in his field throughout our country. It is his feeling that it is not necessary, for responsible and good medical care, that the physician view the body after death, that is, under circumstances where the physician has been attending the individual and is fully familiar with the patient's medical condition and is knowledgeable of the patient's status, particularly when the patient is in a terminal condition.

The concern that you have, Mr. Chairman, and members of the committee, for the utmost of care and attention and generosity of attention from a medical point of view, for the patients in the nursing homes, is a concern with which we feel deeply and we hope, through the innovation of the concept of the medical director, that clear instructions guaranteeing the safety of the patient will come to the fore and be the responsibility of the medical director to carry out.

Nurses in nursing homes, the licensed nurses, the registered nurses, are highly skilled and can perform with safety to patients the task of determining whether the patient is dead or alive.

This delegation of authority is permitted by the law in the State of Maryland and is not viewed as contrary to medical practice by the medical examiner.

In connection with financial matters, the conduct of audits in the State of Maryland has been a fairly overwhelming affair and has been placed in the hands of a contracted service, namely, the Hospital Costs Analysis Service. They have had the responsibility to receive documentation as to the costs of care in hospitals, in nursing homes, and in related institutions giving care both under Medicare and Medicaid. Their first task on receiving these cost statements is to test out the cost statements for arithmetic validity.

After this is done, the cost is then certified to the State as being the cost submitted and correct from an arithmetic point of view.

There then follows the task of a field audit. The field audits in the State of Maryland have until recently been concentrated on the field audits of hospital costs. They have been delayed in connection with field audits of nursing home costs because there has been some confusion as to what is the permissible cost structure permitted under Maryland's formula for reimbursement to nursing homes.

In the legislation guiding reimbursement to nursing homes for fiscal 1968, the statement which appears in our legislative statutes indicates that the cost elements shall be those included under Medicare and in addition, shall include a 10-percent profit factor.

There was dispute actually by the State department of health as to whether this was an equitable procedure, namely, to reimburse for all cost elements under Medicare which includes a 7.5-percent

return on investment and a 1.5-percent reimbursement for unaccountable expenses and then on top of that, to also permit a 10-percent profit factor.

This was a matter of discussion between the State department of health, the agency prior to the one with which Dr. Solomon and I are now associated, a matter of discussion between the State department of health, the nursing home operators and the Bureau of the Budget, and the legislature.

It was not reconciled for some time. We take to the position that if there is a 10-percent profit factor, then a 7.5-percent return on capital, plus a 1.5-percent return on other unitemized expenses is not a proper method of reimbursement.

At the present time, we have authorized the Hospital Cost Analysis to undertake audits in the field. They are now in the field undertaking such audits.

I am told by Hospital Cost Analysis even this morning—and there is a representative from the Hospital Cost Analysis here, its director, Mr. Rutherford Holmes—I am told that as of this date, 24 extended care facilities have been audited and these extended care facilities rendering care under Medicare are also rendering care under Medicaid, so that we now have information on these 24 which is pertinent to the Medicaid program.

We are launched into a systematic review by field audit of the costs and the reimbursement of cost in the Medicaid program.

So far as the duplication of payment of Medicare and Medicaid, this comes about as follows: The patient admitted, 65 years of age and over, presumably is eligible for Medicare.

At the time that the patient is admitted, it is not clear whether Medicare will consent to payment or not.

The nursing home operator with the patient undertakes to secure payment from Medicare. Early in the period of care, there is a notion that such payment will not be approved. The patient is also eligible under Medicaid. Then the forms are initiated for payment under Medicaid.

We have a system which will catch up with this on the 21st day or on the 100th day. The 21st day constitutes a time at which the patient must move from 100-percent funding under Medicare to a coinsurance funding. The coinsurance funding for a Medicaid eligible is continued under Medicaid; that is, the coinsurance is under Medicaid while the direct and major payment will be under Medicare.

For the coinsurance to take place under Medicaid, the Medicaid program is informed that Medicare is making payments. This kicks off a signal to our staff who then inquires into whether, in the first 21 days, there is overlap in payment.

Medicare ceases at the 100th day. In this connection, there must then be an application made to Medicaid for reimbursement for care. In its application, it must be noted what has been the prior funding of care.

If the notation is that it is under Medicare, then this once again signals us to determine whether there is duplication in payment.

I do not make a statement that at this time all of our forces and all of our procedures and all of our methods are of such a nature that

every single feature of this program is in excellent shape. That isn't true.

The committee, I am sure, Mr. Chairman, is learning from these events and we are learning from these events.

In the conduct of field audits, we are going to inform our Hospital Cost Analysis Service to go through a careful audit of all individuals who have died, with a view toward coming to grips with excess payments made to nursing homes for individuals subsequent to death.

I would call to your attention one further action which has ensued as a result of the recent events.

I have the sincere and fundamental point of view that never will elderly people receive the sensitive and generous care of which they are deserving, in a nursing home—it is impossible. There are circumstances where there is no alternative.

One solution for the nursing home situation is to create all possible options of care.

The major option is to have families take care of their elderly people. The care of the elderly when they are disabled is very burdensome. Families break under the burden. The question is: Can we create services and indeed, can we create a reimbursement to families so that they will be able to carry out and carry on longer in the care of the elderly at home than at the present time?

In this connection, our procedure launched since our last hearing with you is as follows:

The medical side of nursing homes has been turned over to a part of our department which we call the Directorate of Services to the Aged and for the Chronically Ill. This department is under Dr. Edyth Schoenrich, who is present here this morning and is eminent in her field, the field of geriatrics and the care of long-term illness.

We have told her, "Develop a spectrum of services, the purpose of which is to preserve as long as possible the care of the elderly in the community and their homes." We have authorized her to establish geriatric screening centers. These centers now exist in Baltimore, in Baltimore County, and we propose to establish them on a regional basis in the other areas of the State of Maryland.

Through these centers will pass elderly individuals and their families. When the elderly individual is being considered for institutionalization, either in nursing homes or in State mental hospitals, the fullest possible examination will be given and all possible options will be entertained before there is a recommendation for such institutionalization. That is one thing.

The second thing. We will develop a more ambitious program of home care. These programs in the State of Maryland and throughout the country are far from what they ought to be.

Third, already we have introduced the concept of temporary care for the elderly. Families will be encouraged to take care of their aged relatives. They will be given respite through weekend care and through up to 15 days of care so that they can carry on with the burden, but in a place that is best for the family and best for the aged individual.

We have one such instance of respite here already underway that is on the Eastern Shore of the State of Maryland at which is known as Pine Bluff Hospital.

Here you have in brief the lessons we have learned, the strategy and tactics we have undertaken and the overall point of view.

Senator Moss. Thank you, Dr. Tayback. That was a very excellent statement and I commend you in being able to deliver it as you did without notes and certainly it was most informative.

I believe that you detailed many changes that have been made that certainly are encouraging as far as my view here is concerned.

This Director of Medical Services that you propose to have in the home, he would be an M.D., but he would have overall responsibility for the entire situation, even though a patient might have another doctor. Is that right?

Dr. TAYBACK. Yes. Dr. Schoenrich in 2 to 5 minutes could explain the functions of the medical director, if you would like.

Senator Moss. We would be glad to hear Dr. Schoenrich.

STATEMENT OF DR. EDYTH SCHOENRICH, DIRECTORATE OF SERVICES TO THE AGED AND CHRONICALLY ILL, STATE OF MARYLAND

Dr. SCHOENRICH. Our concept of the medical director, is, as Dr. Tayback said, one with aspects: First, this person will be directly responsible for the quality of all the professional activities in the nursing home rather than to have this delegated to administrative personnel; secondly, the medical director will have responsibility for the care of those patients who do not have their own physicians readily available, or who have no personal physician at all.

We envision a rather complex job for the medical director. We have worked closely with our medical society in designing this task and the society prepared the first draft of the duties of the proposed medical director.

The medical director is to be concerned with both patient care and employee health. We want to be certain that the employees are not suffering from communicable diseases or any other health problems that might be a danger to the patients.

The patient care aspects would include concern with the types of patients to be admitted to the institution, so that persons are not admitted who cannot be properly cared for by the resources of the institution; concern with an evaluation of the true status of the medical and nursing problems at the time of admission; concern that orders are properly written and reviewed; and concern that the appropriate plan for care and treatment of the patient is recorded and carried through.

We realize that there are perhaps unrealistic aspects of aiming as high as we are, because of the problem of funding medical directors for our homes in Maryland. Also, as I am sure you realize, there is a shortage of physicians who are interested and knowlegeable in the fields of adult chronic illness and geriatric care.

We have thought of a possible plan for broadening the impact of the physicians able and interested in doing this work. One way of achieving this is to use physician assistants—either nurse physician assistants or especially trained ex-military corpsmen.

These physician assistants could make regular rounds two or three times a week on the patients in a nursing home, reporting back to a physician who then might be medical director of several homes.

Another point which in all honesty has to be made, is that not everyone will do an equally competent job, and we are not fooling ourselves about this. There are two ways we have thought of to increase surveillance of the kind of task that is performed. One is to involve the Medical Society in a type of peer review system, and the other is to use our own inspectors who regularly go to the homes checking on all aspects of nursing home functions for licensing and certification purposes.

So, that in essence is our plan for the medical director.

Senator Moss. Thank you Dr. Schoenrich.

Dr. Tayback, you said that since June 30, 24 homes have been audited by the State. Is that correct?

Dr. TAYBACK. I indicated that 24 extended care facilities as of this time have been audited.

Senator Moss. Medicare?

Dr. TAYBACK. This is Medicare. But you must understand, Mr. Chairman, that the same facility that is under Medicare also renders care under Medicaid. Under Medicare, the facility is known as an extended care facility. Under Medicaid, it is known as a skilled nursing facility.

Thus, if 24 have been audited under Medicare, that means that 24 facilities that are under Medicaid have also been field audited.

Senator Moss. Because they are the same institution?

Dr. TAYBACK. These same institutions will have participation both under Medicare and under Medicaid.

Consequently, if the audit was carried out for Medicare, there is the necessary spin-off of information to Medicaid.

I will tell you that there are 170 facilities involved in Medicaid-type care. There is another complication, namely, that skilled nursing facilities are under Title XIX and intermediate care facilities are under some other title.

This is another complication. But I would assure you that the Governor is well aware of this and he has also taken the position that he does not want dissipation of authority for this program in too many different hands.

So, the 175 facilities, which we have mentioned, constitute both the skilled nursing home and the intermediate care facilities.

When we carry out audits, the audits will have to include the 175.

Senator Moss. In this report, "Examination into Certain Claimed Practices Relating to Nursing-Home Operations in the Baltimore, Maryland Area," by GAO, it says on page 19, "For example, during the 3-year period of fiscal years 1967 through 1969, Analysis Services made only two audits of nursing-home costs under the Medicaid program. These were made at the same nursing home in conjunction with audits under the Medicare program."

That is a 3-year period. Is what you are telling me now that this indicates the State is going to go forward in making annual audits or semiannual audits of all of them?

Dr. TAYBACK. In order to get the facts clear on this, I would appreciate it if I could have Mr. Rutherford Holmes, who is the director

of the Hospital Cost Analysis Services and represents the specific service with whom we contract to do this work.

Senator Moss. He might come forward, if he would, to answer that question for me.

STATEMENT OF RUTHERFORD HOLMES, DIRECTOR, HOSPITAL COST ANALYSIS SERVICES

Mr. HOLMES. Senator, we have an on-going program verifying the cost in the nursing homes, both under Medicare where the intermediary selected by the home is Maryland Blue Cross, where the Blue Cross plan in Maryland contracts with nursing homes for its patients and where the State of Maryland participates under the Medicaid program with the nursing home.

As Dr. Tayback said, this was given secondary priority in terms of the hospital verification program. But this is now going forward with all due effort that we can put to it.

Senator Moss. Do you have a program of annual auditing or are you going to audit annually these homes?

Mr. HOLMES. Each of the facilities submits an annual cost statement which is verified by us in our office and then in the field in actual visits to the actual institution.

Senator Moss. An actual on-the-scene visit and audit?

Mr. HOLMES. Yes, sir.

Senator Moss. Do you see any reason or necessity for having Federal inspection and audit of these homes?

Mr. HOLMES. Not in addition to the work that we do, sir.

Senator Moss. It would be duplicative of the work proposed to be done by the State?

Mr. HOLMES. Many of these homes also have audits by independent CPA's. Where that is done, we then rely to a large extent on their work, checking out work which they may not have paid as much attention to, which we feel is important.

Senator Moss. Thank you, Mr. Holmes.

Dr. Tayback, you detailed rather fully for us the fact that legally a physician isn't required to view the body of the person for whom he signs a certificate of death. And I believe you gave as your opinion, you didn't really feel that this was required since a doctor very often is familiar with the patient whose death occurs.

Why do you suppose we require it to be signed by a doctor if he doesn't have any firsthand knowledge of that certificate he signs?

Dr. TAYBACK. The firsthand knowledge that appears in documented form on the death certificate has to do with the certification of the cause of death. The certification of the cause of death is not predicated on what the physician may observe after death. It is predicated upon the prior medical history of the patient.

Certainly, in the instance of patients that a doctor has no knowledge of, it would be required that there be some observation, some study of the patient at death or even following death, but for a patient with which a physician has been associated for 30 or more days, the physician is fully familiar of the medical circumstances of the patient and consequently, on the basis of that information, he is able to certify

to the cause of death. And his signature is in connection with what he sets as the cause of death.

Senator Moss. 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, or, like being scalded or something of the sort. 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 some reason that was because of the failing health of the patient and then we would never know what the real cause of death was.

Isn't that right?

Dr. TAYBACK. First of all, we go on the premise that the physician is generally familiar with the circumstances of the individual. If the individual was one who had no evidence leading the physician to believe that the individual was in terminal illness and the death constituted a sudden event in the history of that individual so far as the physician was concerned, the physician would not be likely to sign out that particular patient unless he learned more about the circumstances.

But by and large, what we are dealing with, if not exclusively, are patients with a long history of decline known carefully and fully to the physician and a note if not a confirmed observation in the physician's mind that the patient is moving through the final days of life.

Under those circumstances, when the word comes to the physician that the patient is dying, then this is what has been the expectation of the physician.

So, it really is not contrary, contradictory to good medical care for the physician under those circumstances to sign out the patient and give the causes of death.

The particular circumstance that you describe, certainly, is a possibility. We could have a patient, say, in terminal phases of illness and the patient could fall out of bed and that would constitute the final element in the patient's life, the patient already being in the terminal phases of illness. The fall could represent some element of significance and probably should be represented in the certification of the cause of death.

I would admit, under those circumstances, if the knowledge of the patient's fall from the bed was not given to the physician and if he didn't ask specifically, "What were the circumstances of death?", he would sign out the patient on the basis of his knowledge of the terminal illness.

Senator Moss. If this outbreak of salmonella had been discovered early, would the physicians actually have recorded on the death certificates the cause of death was illness that came from the food poisoning?

Dr. TAYBACK. I note, and Mr. Chairman, it is just this morning that I have your full report, most of my information has been from the newspapers as to what is transpiring—I would differ from the inference made in this report that had the physicians seen the bodies after death, the course of events would have been different.

I think in all fairness to all people concerned, one must say that that is an absolutely false premise.

I myself in trying to understand this event personally read through the 146 histories and I know from the histories what was the time sequence. We have with us today the epidemiologist, Dr. Garber, who has conducted a very careful study of this.

This event broke open in an explosive way on Monday following a Sunday evening meal. On Monday, by Monday night and by Tuesday, the circumstances of an outbreak were known to two or more physicians. The circumstances were known as an explosive outbreak to other personnel. Issues having to do with death and viewing the body after death are completely superfluous to the notion of how effectively to deal with an explosive outbreak of this type.

Senator Moss. What inspections are now being made of nursing homes? I am referring to the fact that Mr. Williar in the State hearing stated he knew of no nursing homes being closed during his 21-year tenure with the State. Have any homes been closed since that time as a result of inspection?

Dr. TAYBACK. No homes have been closed since the time of the Gould incident. In all fairness, I cannot tell you the name, I have one home which is now under orders to be closed. I cannot tell you the name of the home because the individual owner has to be ordered in for a hearing before we are able to proceed any further.

The order to close has been made through recommendation of our Advisory Council on Hospital Licensing.

The concept that homes have not been closed is erroneous. I am told that within the past 10 years there have been as many as 100 homes that have closed affecting 1,500 beds. One must understand the nature of the closure of these institutions.

These institutions have not been closed by a direct order of the State Department. They have closed as a consequence of pressure placed upon them and then by the free will of the owner. But if you were to take a look at a list of nursing homes in the State of Maryland within the past 10 years, you will then note that during the 10-year period, approximately 100 nursing homes have ceased operation involving about 1,500 beds.

Senator Moss. Those are voluntary closures. They might have come from financial problems or otherwise. Is that correct?

Dr. TAYBACK. That is true, Mr. Chairman, but in many instances they came about as a result of pressure, even though there wasn't the conclusive order to close.

Senator Moss. You say there has been one notice already served that will have to be heard?

Dr. TAYBACK. That is right.

I might remind the chairman and the members of the committee of the unusual circumstances that attend to the issue of closing a nursing home, namely, that if you issue an order to close the nursing home and particularly if you are dealing with Medicaid patients, then you have got the obligation of finding other places for these Medicaid patients. This is a great difficulty, finding such places.

Nevertheless, the past pattern has been one where the public agency has frankly temporized because of the difficulty of finding other beds for the patients who would be closed out in a nuring home.

I can tell you that as a result of the work of your committee and various other circumstances that we now take the point of view that

we can no longer temporize. If a home must be closed, we will have to undertake the extraordinary moves that will have to be made to find other beds for the patients.

Senator Moss. Thank you, Dr. Tayback, for your testimony and your responses to the questions.

I appreciate it very much.

We have other witnesses I must get on to. I am very glad to have had you. I hope you will be able to remain during the rest of the morning so if we have questions we may yet direct them to you.

Dr. TAYBACK. I will be glad to do so.

Senator Moss. The Reverend Joseph A. Sellinger, S.J., president of Loyola College and chairman of the Maryland Board of Inquiry is here now.

We will be very glad to hear from you, Reverend Sellinger. We hear you were delayed by traffic.

STATEMENT OF VERY REV. JOSEPH A. SELLINGER, S.J., PRESIDENT, LOYOLA COLLEGE, AND CHAIRMAN, STATE OF MARYLAND'S BOARD OF INQUIRY

Father SELLINGER. I was, Senator and I apologize for being late.

Senator Moss. That is quite all right, sir.

We have a copy of the report which you have prepared. We have read that with some interest. We would like to hear from you as far as our record here is concerned.

Father SELLINGER. Thank you, Senator.

As you know, I was a member of a three-man panel appointed by Dr. Solomon to investigate the salmonella outbreak at the Gould Convalesarium and my appointment by no way constitutes me as an authority on nursing homes. The knowledge that I have gotten has been the result of the investigation as well as discussions with many public officials as well as private individuals interested in the nursing homes.

I think actually the men with whom I served in the panel are far more qualified than I, but by the breaks of the game, they were two medical men and decided I would be the chairman of this panel and here I am.

Dr. Rogers, dean of The Johns Hopkins University Medical School and Dr. John Moxley, the dean of the Medical School of the University of Maryland were the other two members of the panel and really did outstanding work in the formulation of this report.

Since you have seen the report, Senator, I don't want to take up too much time by quoting extensively from the document. I think there are really three points that I would like to insist on this morning, which I think are in the report and hopefully, by my commenting on it, may highlight the seriousness with which we took these points.

The first, really, is the whole contradictory problem in the nursing home situation where it seems that a premium is put on those who are seriously ill. We, as members of the panel, felt that the whole goal of the nursing home would be to try to rehabilitate these patients and get them out of the nursing home and back to normal circumstances.

We get the impression, of course, that it is the desire of the nursing home to keep all of their beds filled. This to us is one of the real serious problems, namely, they are putting a premium by circumstances on the fact of having the beds filled, then they are going to get the full income, and the very purpose of the nursing home seems to be defeated.

The second point that we would like to make, of course, is what we think is a very serious conflict of interest. We see in the situation in Maryland, legislators who have very definite interests in nursing home institutions, in profitmaking institutions. We find this somewhat of a problem.

The same is true for physicians who likewise have interests in these profitmaking institutions. We see this as a second part of the problem.

The third problem, of course, is the responsibility of the physicians themselves. Certainly from the report and from the testimony of the principal physician of the Gould Convalesarium, we found this to be a shocking kind of testimony. The seeming lack of interest on the part of this gentleman in knowing what his responsibilities were as principal physician were something which was difficult for us to understand.

And I think it is important or it was important for us, at least, Senator, that physicians in general, if they are going to do the job for nursing homes, seem to have to take a much greater interest in the problems that are resident in those homes.

These are the main points I would like to make this morning. I don't want to prolong my own testimony. If you have any questions, I would be glad to answer them. As I say, these are touched on in our report, but I personally felt that these would be three that would be important for me to highlight.

Senator Moss. We do thank you, Reverend Sellinger, for summarizing the main points that you think came out of your investigation. They are very helpful to use.

Incidentally, along this line, your suggestion that the homes seem to want to keep their beds filled, I thought Dr. Tayback made a very interesting suggestion, that he said was being examined, and that was how they might keep elderly people in their own homes longer and because this was an expensive and demanding time, when they became unable to care for themselves, there might be some way of supplementing the family financially for doing this.

Have you thought about that as a possibility of keeping more elderly people within the confines of the family and cared for by the family?

Father SELLINGER. I think we felt this way because of what we noticed to be almost a guilt complex even in those testifying about their relatives in the nursing homes. I think very often many of us who would put a relative in a nursing home have some misgivings about it.

Although we manifest great concern about the mother, father, or relative that is in the home, and are trying to convince ourselves that we can't take care of them, I think in many instances with some help from outside sources, we might be much more convinced that we could take care of them at home.

Senator Moss. I can, of course, see all sorts of complexities in trying to administer that sort of a system. So many of our families now with,

both mother and father working, find it is an extreme burden to have somebody available all the time to help the elderly people.

Yet, the human side of it is so demanding that I would like to think more deeply into that and see if there isn't some way that we could stimulate that sort of care for older people rather than have them in a nursing home.

Father SELLINGER. We are all conscious of the fact that we are not doing enough for the elderly. We as members of the panel felt just as convinced of our own negligence in doing something for the aged as anyone else. So that in being appointed to this panel to do this critique, we were really criticizing ourselves as well as all of our society which is so youth conscious and so anxious to forget about the elderly if it is at all possible.

I don't think that we can, especially as the length of life becomes longer and the needs of these aged people are greater.

Senator Moss. I appreciate your comment on that. It strikes me very deeply.

On page 8 of your report, you quote Mr. DeBiak, director of the nursing home licensing and certification for the State of Iowa, who studied the Gould home, who stated he would not recommend it for participation in Medicare and Medicaid.

Yet, you express as a conclusion that the Gould home was and is a better-than-average nursing home. You feel the recent events of the Gould home could be repeated in virtually any home in the State unless broader general problems were faced and corrected.

In view of what Mr. DeBiak of Iowa said, do you still want to have stand that the Gould Nursing Home was better than average?

Father SELLINGER. I think from all we have seen and heard, we would still say that the Gould home is better than average. I think to the credit of Mr. Gould and those with whom he works, the Gould home has been willing to take incontinent patients which certainly other nursing homes don't always do, from what I have gathered from reading and talking about this, so that I would say for the kind of patient that the Gould Convalesarium is taking on the report of my conferees who, as I say, know far more about this than I, we would all agree that the Gould home is above average.

I think Mr. DeBiak's point was that many of these homes are certified initially and the difficulty is that if they lapse into some defects or irregularities, it is so difficult to take away this certification which is part of the whole problem of our legal system, I guess, because everybody demands this right to protect themselves.

As Mr. DeBiak said, it is just impossible to take this certification away once it is obtained. I shouldn't say impossible, but much more difficult.

Senator Moss. Did you, in your investigation, have access to the performance or the records giving the performance of Mr. Gould's previous homes in Ellicott City and Eutaw Street?

Father SELLINGER. We were conscious of them from the testimony, Senator.

Senator Moss. But you didn't examine any of those records to see if they had anything significant?

Father SELLINGER. No.

Senator Moss. On page 6, you conclude that there is a failure by physicians and the administrative staff to report the epidemic in its early stages, that the administrator of the home, who apparently had substantial knowledge of the events, was never called to testify.

Why was the administrator not called?

Father SELLINGER. Actually Miss Holmes, who was one of the—if not enjoying the title of administrator—was the chief nurse at the Gould Convalesarium. I think the other gentleman was assigned or doing work at another nursing home at the time. So that I think, on the one hand, we thought that we would get all the information we needed from Miss Holmes. But I think on second thought, had we had more time, we would have called the other administrator to testify.

Senator Moss. It was just a pressure of time and he was not really summoned? It wasn't that he refused to come?

Father SELLINGER. That is correct. The only thing we noted about this gentleman was, of course, his own background. We wondered about his qualifications as an administrator. According to the records that we saw, he was a high school graduate who had then been a food salesman, if my memory serves me correctly, and it was some time after his experience in selling food and among his buyers were nursing homes, I think, he was assigned to work at the Gould Convalesarium.

So we did wonder about his qualifications as an administrator, but never had the opportunity to question him about this.

Senator Moss. Was the consultant dietician summoned?

Father SELLINGER. No, she was not.

Senator Moss. Your report talks about ineffective inspections on several pages of the report.

Would you comment on that for me, please?

Father SELLINGER. During the testimony, it became clear that there had been some deficiencies or defects in the operation of the Gould home, especially in food handling, and it seemed that these criticisms or critiques of the food handling at the Gould home had happened or had been made on more than one occasion. So that it would seem that you would have an inspection made with the indication that the remedy should be applied and for all intents and purposes the remedies were applied, but there seemed to have been a lapse then back into some failures a year or so later.

Senator Moss. You talk also about the responsibilities of the medical profession to take more interest in nursing homes. Is there any way you can amplify on that or suggest how this might be accomplished?

Father SELLINGER. I think Dr. Solomon and Dr. Tayback have already moved to put some teeth into this notion of the principal physician or a medical director of a nursing home. We think this is a very important step.

As I mentioned earlier, I think one of the most shocking elements of the testimony was the lack, or seeming lack of interest, of Dr. Harbold for his patients at the nursing home. We, too, wondered about the matter which you discussed with Dr. Tayback in the previous testimony about the seeming lack of interest of the physician, even at the time of death with these patients and the fact that during the out-

break itself, it seemed a lot of the transactions were carried on by telephone without any interest on the part of the physician to come and visit the patients.

Again, we are all aware of the crush of time and so forth. But to us, it was just another indication of his lack of interest in these elderly people.

Senator Moss. On page 26, you mention the possibilities of profiteering in a nursing home. Can you explain this reference?

Father SELLINGER. As I say, this is one of the main points that we felt was involved, namely, there is the contradiction between Gould's, the profitmaking nursing home, and the ideal of our society. Nursing homes, if they are to make a profit, must keep their beds occupied.

On the other hand, the aim of our society must be to move aged patients out of bed and into the community to lead as normal a life as possible.

So, we are really questioning whether or not nursing homes should be completely in the private area. It seems that the private sector has the opportunity to make profits because of the very fact that they have involved their own resources in the building of these homes and consequently after that they are looking for the profit which they would deserve because of their investments.

So, we question whether or not nursing homes should be of the voluntary, nonprofit type, rather than profitmaking organizations. This would be really what we are suggesting—if it is at all possible.

Senator Moss. Do you think, as long as nursing homes are operated in the private sector by investing capital there, that there will always be a nursing home lobby of sorts that tends to be contrary to some of the things you think are needed for the care of our elderly? Is that right?

Father SELLINGER. I think this is pretty much what we concluded from the investigation. It was certainly the testimony of one of the councilmen at the time of the hearing who claimed that there was a strong lobby in Maryland which was protecting the interests of the private homes.

Senator Moss. I think you suggested there were even some members of the legislature who had an interest in nursing homes, some kind of investment in them.

Father SELLINGER. That is right.

Senator Moss. Do you have any idea of the number involved?

Father SELLINGER. No; we don't, Senator. We did call for the boards of directors and the officials of three or four of the big so-called nursing home corporations in the State of Maryland and noticed that there were some members of the legislature who were involved with these boards of directors or officers of the corporation.

Of course, what put us on to this search was the phrase used by one of the doctors in the testimony when he stated that if he tried to fulfill all of his responsibilities as the principal physician, he might be fired by the syndicate which prompted us to ask what he meant by the syndicate. And he quickly cleared up our fantasms, or imaginative wanderings by saying it was merely the corporation that owned the

nursing home that could step in and fire him if he really tried to fulfill all of his responsibilities as a principal physician.

Senator Moss. Your report is, as I say, a very excellent document and is most helpful. Has this been submitted to the Governor and circulated widely in Maryland?

Father SELLINGER. Certainly, it was given to the Governor the day that we submitted it to the public.

Senator Moss. This date of submission on October 27 would be to the Governor and to the Department of Health?

Father SELLINGER. Yes; and to Dr. Solomon.

Senator Moss. And to the Federal units operating in Maryland?

Father SELLINGER. I am sure they did receive copies. It wasn't at our direction. But Dr. Tayback and Dr. Solomon's office handled the duplication of the report and were willing to, and most gracious in, fulfilling all the requests for copies of the report.

So, I am sure all of those who were interested have gotten a copy of it.

Senator Moss. Mr. Miller.

Mr. MILLER. Thank you, Mr. Chairman.

Monsignor Sellinger, you have made an observation that, in your opinion, the situation constitutes, in effect, an indictment of our entire society as it relates to the elderly.

The question arises, however, when you are discussing the matter of the preemption of the nursing home field by persons who are engaging in it as proprietors for a profit, does this not, in your judgment, connote a particularly strong indictment of those institutions that normally enter into the provision of care through voluntary nonprofit institutions?

Father SELLINGER. Meaning that there hasn't been enough interest on the part of those groups to take care of nursing homes the same way they did with hospitals?

Mr. MILLER. That is right.

Father SELLINGER. I think so. And I think as a result of conversations since the report, it has been our intention to try to interest groups such as have been interested in hospitals to get interested in homes for the aged.

Mr. MILLER. Mr. Chairman, you may recall at your hearing in New York several years ago, the current mayor of the city of New York suggested that a simple solution to the problem would be for each voluntary hospital in New York City to undertake the construction of 100 nursing home beds as a part of their facility.

Senator Moss. Thank you very much, Reverend Sellinger. We appreciate your coming to testify before us and for the services you rendered to Maryland in heading this investigation on this very sad event that occurred earlier this year.

We will now hear Dr. Frank Furstenberg, and Dr. Dora Nicholson. We will hear from one and then the other.

We appreciate your coming here, Dr. Furstenberg. You are associate director for program development for Sinai Hospital in Baltimore.

You may proceed.

STATEMENT OF FRANK F. FURSTENBERG, M.D., ASSOCIATE DIRECTOR FOR PROGRAM DEVELOPMENT, MOUNT SINAI HOSPITAL, BALTIMORE, MD.

Dr. FURSTENBERG. Mr. Chairman and members of the committee, I was called just the other day, I haven't prepared extensive testimony, but I have jotted down a few notes.

I am a private practitioner in Baltimore as well as associate director for program development at Sinai Hospital.

For a number of years, I was the medical director of the hospital out-patient department. In this role, I helped develop a number of community programs, including organized comprehensive health care for the aged emphasizing independent living in the community. In addition we began the first hospital-based home care program in Maryland. And more recently, I was acting medical director of our chronic disease facility which is both a chronic disease hospital and nursing home.

I have a special concern about the quality of long term care and the especially difficult problem of rendering good care in nursing homes. I agree with the testimony that is being developed here today, that an objective should be to keep patients out of nursing homes, they should not be admitted to nursing homes because society has failed to bring services to patients which would allow them to live independently in the community.

Maryland nursing home problems are certainly not unique. The commission's report complaisized this. Society has not done its job, it can't feel comfortable now that a million older Americans are receiving care in nursing homes.

Even though we now pay $3 billion for nursing home care, largely Federal funds, we must face squarely that money, necessary as it is for good care, will not alone result in high quality care given sensitivity to these unprotected chronically sick—often depressed aged persons.

We must also accept the responsibility for the present status of nursing home care. We have fostered the proprietary nursing home industry, which necessarily concerns itself with profits, in caring for patients. It is the responsibility of your committee and Congress to work through the States to have these public dollars result in good bedside care. At this time it would be especially meangingful that Congress encourage the voluntary nonprofit nursing homes so that we will have nursing homes that can serve as examples, in on-going care programs of first-class care with innovative services for those patients who must become patients in nursing homes. Most innovative services will necessarily be nonprofitable.

What about the monitoring of nursing homes and its effect on the care given patients? We must insist that the States in their control procedures not only do that which they are doing now, inspecting safety, sanitation, the physical environment; setting standards, for nursing personnel, pharmacy and physician services, but they have to go further.

They must develop controls for uniformly good nursing and physician services delivered at the patient's bedside. Inspection procedures

have to be so sensitive that deviation from proper care becomes apparent promptly. The nursing home patient is often an abandoned, sick, and a depressed person and we cannot expect such a patient as a consumer of nursing home services to exercise marketplace controls on the care he or she receives.

The day must come, and I hope soon, when nursing home inspectors take on the role of patent ombudsmen, and not regress to paper-pushing bureaucrats engaged in proforma inspections, filling out inspection forms.

We should, in addition, promote surveillance of nursing home care by involving the potential consumers of nursing home services among them the older Americans.

We all face the distinct possibility of entering a nursing home in our last years as a patient. There are now 1 million persons 65 and older in nursing homes, 5 percent of that population. The ratio of nursing home patients is much higher at age 80. It becomes mandatory then that we, as the "upright" citizens, participate in the inspection system in some way.

Nursing homes are simply too important to be left to the providers and to the public officials and expect consistently sensitive services for the patients. And I include in such providers the voluntary nonprofit nursing homes, as well.

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.

I am completely understanding of this phenomena. It is very depressing to visit almost any nursing home. The private practicing physician is very busy and he knows he can't do much more than he has done for his nursing home patient. So, he places a very low priority on seeing the patient, a low priority, also, because it may require a time consuming visit.

The result is often no visit or a delayed visit until there is an emergency call for care.

Hasn't it been rather irresponsible of society and hasn't it been really irresponsible of organized medicine not to have changed the delivery of physicians' services in nursing homes up to now? We face a shortage of physicians' services and yet—do we really expect 44 doctors to be responsible for visiting 146 patients in the Gould nursing home when these services could have been given well by two or three interested and responsible physicians working together.

Maryland's move to change the functions of the principal physician in nursing homes, to medical directors, is a move in the right direction. But this move must be more than simply a change in title. These physicians must soon be given the primary responsibility for all the patients in the homes.

They should be competent and show an interest in the nursing home patients and be paid adequately. It is going to be tough to find 175 such physicians for the 175 nursing homes in Maryland.

But, when we do find a cadre of physicians, and we don't need 175, who will give excellent nursing home physician service, we give these physicians the status, the professional stimulation that they must have and we pay them adequately, we will have done much to improve the quality of medical care in Maryland's nursing homes.

Senator Moss. Thank you, Dr. Furstenberg.

What percentage of doctors are in geriatric medicine?

Dr. FURSTENBERG. I don't know, but relatively few as specialists. However, every general practitioner or intern practices geriatric medicine. He may not enjoy it, but many of his patient visits concern sick older persons. While older persons are 10 percent of the population, they comprise 25 or 30 percent of the visits to the doctor's office.

Senator Moss. But there are very few, I take it, that specialize, set out to specialize in geriatrics?

Dr. FURSTENBERG. Yes. This specialty or subspecialty of internal medicine has not been developed. There are some that would like to see it developed as pediatrics developed its specialty at the turn of the century.

Senator Moss. I was very much interested in your suggestion that we ought to have inspectors who had a particular sympathy of older people and understood their problems. It crossed my mind, would it be feasible, do you think, if we might utilize some of our elder citizens who are well and are able to get out and to get in this inspector sort of cadre?

What I am thinking of is, in order to give some of our older people a feeling of independence and worthwhileness and so on, we have had a program called the green thumb, where they are hired to do beautification work along highways, around public buildings, and so on; and this has been extremely popular, particularly in rural areas where people are retired and really don't have enough to do. These citizens suddenly have a job again. They just felt wonderful to go off to work and do something they liked to do.

Is it possible that we might employ this principle with our older people working to improve our nursing homes?

Dr. FURSTENBERG. Emphatically. It is important and older citizens should be involved in this area. We must expect a higher "cop-out" rate. Just as physicians "cop out" of taking care of nursing home patients because they can't stand them, so older people will want to deny what they see in nursing homes. There is so much to be done. I emphasize again that we cannot leave nursing-home care or the care of health services generally, simply to the providers, to the third party payers, or to a government-payment mechanism.

We must have consumer participation in the nursing-home field and the care of the aged in general. I would like to see older persons involved in the nursing-home inspection programs. It would be helpful if they only visited and talked to the patients while the sanitary inspectors were performing their roles.

There are already friendly visitor programs, but I prefer older Americans involved in an official capacity in monitoring nursing-home care, where they will be improving care for older persons.

Senator Moss. You heard the exchange, I guess, on the signing of the death certificates. Do you have any view 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.

Review of care should include ample record in the chart documenting what was going on, the medical care being given. I emphasize that we should be more interested in the care of the patient while the patient is alive than concern ourselves about viewing the body before signing the death certificate.

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.

Are there many patients who suffer falls while in nursing homes? Such data should be available. If the incidence occurs frequently in one nursing home, what kind of care is being given? Monitoring such incidents would be part of the review of care rendered.

Senator Moss. Would there be quite a difference in the procedure of a doctor who signed a death certificate for a patient who expired in a hospital, say, and what he does for one who expires in a nursing home?

Dr. FURSTENBERG. In a hospital the physician will have seen his patient prior to death. At the time of death other personnel may verify death. The personal physician signs the death certificate, but he may not be present at the time a patient dies. It is important that the death certificates be signed accurately. Most important is the need for adequate notes in the clinical record prior to death.

Senator Moss. Thank you, Dr. Furstenberg.

We would like to now hear from Dr. Dora Nicholson, most recently senior staff assistant of the psychiatric hospital at Peirpoint, Md.

We will be glad to hear from you, Dr. Nicholson.

STATEMENT OF DR. DORA NICHOLSON

Dr. NICHOLSON. Good morning, I am Dr. Dora Nicholson. I received my M.D. degree from the University of Athens in Greece, and I have been licensed to practice in the District of Columbia since 1966. In between I have worked in research, hospital administration, and as special adviser to the Greek Government on women's disability. I have had graduate training at the University of Pennsylvania in clinical neurology. I was a research fellow and assistant professor in the anatomy department of the George Washington University Medical School. I have been director of research for the Rosewood State Hospital, assistant professor in pathology at the University of Maryland, and senior staff member of the Veterans' Administration hospital in Peirpoint, Md. Today I am in private practice, and my specialties are neurology, psychiatry, child growth and development, congenital defects, and mental retardation.

The truth, it seems, comes from all sides. My colleague has just said exactly what I was intending to tell you. I am glad we "speak the same language" because our problems are similar across the country.

There are three groups of citizens today, the care of whom has been largely neglected by society. They are the defective children, the mentally ill, and those of old age who have not the means to take care of themselves or even register complaints to their relatives or to proper authorities.

Certainly, I do not know much about the specific incident of salmonella outbreak. But I raise the question, why do we not require of nursing home personnel the same kind of tests required of employees in the general hospital. Even the tests given in the hospital are not enough; but at least we do have some testing of food handlers for TB, syphilis and intestinal infestations. We require cultures to make sure that they are not carriers. I have seen a number of cases of amoebic dysentery. They are quite often found around the harbors of the world; generally, there are no clinical symptoms but the disease can be transmitted if the infected individual handles food.

The whole problem in the United States, as I see it, seems to be that we have allowed the care of the elderly to become a very profitable business and we allow virtually anyone to run a nursing home, regardless of any technical or medical experience. Some of these businessmen are interested only in making money. I know one who has managed to build seven or nine nursing homes in a very short time. It is interesting to me that we say that nursing home care is very expensive and on the other hand that there are people making millions from operating these facilities. Something is wrong there. Where is the money going?

As my colleague said, it is not enough to inspect the buildings and to look at fire safety requirements. We must inspect inside these institutions and look at the quality of care. In most cases, I suspect the records of inspectors are just filled out as a formality in qualification for Medicare payments.

I had the privilege and the misfortune to bring my mother to this country when she was 90 years old. I say misfortune because my mother became very ill and needed nursing services around the clock. She needed more care than I could give her and my friends suggested I place her in a nursing home. They told me that, in America, nursing homes are luxurious institutions and could give my mother much better care than I could give her myself.

I decided to put her into a nursing home in Hyattsville. Unfortunately, 36 hours later I took my mother out again with a broken hip. It is fundamental medicine to take precautions that old people are not subjected to diarrhea or falling. Those are the two things that will kill older people quickly.

At the Baltimore home it is clear the food handlers had not been tested nor had the food caterers who prepared the food. Other homes have impressive stainless steel kitchens, I assume to impress building inspectors. Why can't they prepare the food and special diets on the premises? Why does the unitarian value have to be twice seduced so that the caterer will make some money out of it and also the nursing home?

These expensive enterprises, nursing homes, do not favor nor serve the elderly.

In the Hyattsville home, I found that my mother had not been placed in a private room as I asked but she was in a double room in which

there had been added a third bed. There were also three chairs and three wheelchairs and three patients in this room. The supervisor explained this by saying that they wanted my mother in with another lady who spoke Greek. This other Greek lady told me of the neglect and improper activities in the nursing home, and that only two high school girls had been assigned to this floor at night. How can two young girls take care of 60 old ladies all at the same time? I know nursing homes have difficulty finding personnel; this is a big problem. But older people are humans—they are not animals or livestock.

I think my colleague had an excellent idea when he suggested subsidizing a family to care for the elderly in their own homes. After my bad experience, that is what I was forced to do—take care of my mother at home and at tremendous expense.

In the 2 weeks when I was with mother at the Suburban Hospital, which has a small orthopedic surgical service, I noted that there were 18 women from nursing homes with broken hips in the hospital at the same time. The chief nurse told me sarcastically that there is always an "epidemic" of broken hips in nursing homes. Sometime later I heard that the nursing home association was lobbying for a bill which would have made broken hips a natural hazard in nursing homes, so that nursing home operators or their insurers would not have to pay families or patients in the event of a hip fracture.

When I heard this my stomach turned inside out because broken hips are not a natural hazard in a nursing home or any place. They are an indication of neglect of proper care. At that time I was not in a position to speak out because of my employment. Because my mother suffered from a broken hip they might have suggested that I was biased. At any rate, neither the nursing home nor the insurance carrier ever paid any of the $25,000 expenses of my mother.

After I took my mother out of the nursing home, God bless her soul, I have slept better, consciously today I am peaceful. But the irreparable damage had already been done; because, it was necessary for my mother to undergo a 3-hour operation, which caused her some mental deterioration. When a person is above 60 and goes through general anesthesia the mental capacity is never the same again. My mother was uncontrollable, confused, and lost. I had once again to look for a nursing home.

This time I was more fortunate, I took her to the Citizens Home in Harve de Grace and I can tell you that this is an excellent facility. They have deep respect for nurses there. They gave my mother much care but, even this home, did not have the personnel it needed. Having had previous bad experiences, I stayed with my mother all night and hired two persons to be with her during the day.

During this period I was able to observe firsthand the kind of practices that have been discussed with you here today. Even in this good nursing home, medical care is practiced by telephone. I watched, three times a day, the preparation of a big tray with a large number of tranquilizers on it—thorazine, darvon, and others going into the mouths of patients by the clock. I saw trays of food coming out of patients' rooms unconsumed—3 times a day. The food was not consumed because patients with high doses of tranquilizers suffer loss of appetite. Prolonged use of some of these drugs can have a very

harsh effect on the patient. In prescribing drugs special precautions must be taken for children and those of old age. If you follow the commands of the PDR you are given instructions to reduce the initial dosage of drugs to the lowest optimal dose. In the nursing home I saw patients continuing to receive the initial dosage—no one bothered to reduce it to the minimum beneficial dosage.

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.

You can imagine my frustration, and it was made even worse by the fact that I was practicing at the Pierpoint VA Hospital, and yet I could not prescribe any drugs for my mother across the bridge in Harve de Grace. I suggest, if I had all this trouble getting a fellow physician to visit a nursing home patient, that families would have much greater trouble.

While I am on the subject of Veterans' hospitals it is too bad that no one talks about them any more. Sure, there was an uproar for awhile, but the public has a short memory. We have veterans who have been neglected for years—progress notes are written as a matter of routine and, many times, they cover up mistakes or items which should come to the attention of others.

In one instance, I remember a patient who came two or three times to the hospital and no one came up with the correct diagnosis—as a result the patient died of a tumor of the brain. When a sputem test is required to test for TB—the patients are given a saliva test instead. Mental patients, old and young alike, require gastric washing but VA hospital authorities say it is too time consuming.

In some of our VA hospitals we have old men with active TB alongside with younger veterans and then there are the syphilitics. I discovered people who had had syphilis since the first World War—who have been left in the VA hospital to vegetate, without revising their condition for years. They have been stored in the hospital.

It seems our health facilities from nursing homes to hospitals leave much to be desired.

Back to nursing homes, I can tell you I couldn't take very good care of my mother not even with the able help of the nursing staff and the other personnel I hired. The practice of geriatric medicine is difficult. But this is no excuse to allow the patients to be tranquilized right into oblivion.

At the Harve de Grace nursing home I saw a patient, in the room right next to my mother, dying with heavy jaundice from the long usage of high doses of tranquilizers. And no one took the care to decrease the dose to the minimum needed by the patient. The patient was dying a slow death for weeks, but the dosage was high since her admittance.

The death certificate, like the others that have been talked about today, was by long distance telephone. As my colleague before me

said, "Death is the last of the painful consequences, it sulks in nursing homes."

But the care and inspection must be done by dedicated, trained, and scientific people. I served the Greek Government 20 years, sir, and I inspected the hospitals which had been connected with, something that you call over here, Social Security. I had the power to open the door and enter, even at 4 a.m. in the morning, to go in the rooms and see how the patients were doing—by day or by night. It caused me to make some enemies of my personal friends—but it was worth it! As you know, over here the business of nursing homes has grown like mushrooms. Because of this kind of business they make profit from very sick and very old people. Mainly they draw their gain from the uncontrolled storage of human beings for life!

To my way of thinking, the outbreak of salmonella in Baltimore was inexcusable. Everyone realizes that the bacteria is carried in filth and that unclean conditions or contamination in the preparation of food can lead to this kind of epidemic. If nursing homes cannot remedy these bad conditions, then perhaps we must accept the treatment of the elderly in their own homes. In other countries older people stay at home, they are much happier and live longer. At least they die in their own environment from legitimate causes and not from fractures or food poisoning.

We must make some great improvements and particularly with regard to the children, the mental patients, and the older Americans—the segment of society that cannot protect themselves. They have been overlooked too long and exploited lately. I am glad, Senator Moss, that you have undertaken this important work. There is much that you can do. I ask you to continue your investigations of nursing homes and then to look at mental institutions and facilities for children.

Senator Moss. Thank you very much, Dr. Nicholson, for your confirmation of what has been said by the other doctors that we have had; you underscore for us the fact that we ought to, wherever possible, have our older folks at home, but where it is necessary for them to be in a nursing home that they must then have adequate attention and inspection, and that there is no excuse for not having adequate inspection.

Dr. NICHOLSON. Senator we have many fine doctors in America, but America today is a little bit like Nazi Germany—everything for youth. We are neglecting a valuable asset in our senior citizens. Why don't we ask retired physicians to help us with our institutional care? Let them serve as inspectors or as administrators of these facilities. They have much experience that they could bring to their work—experience must be acquired through the years, it cannot be bought. We must not allow the day to come when all work connected with health and welfare becomes a profession or a business; it is also a mission, a God given privilege, and it must be practiced as such.

Senator Moss. Thank you very much. We appreciate having you come to testify before us.

Our final witness will be Mr. Mitchell Gould, executive director, the Gould Convalesarium, Baltimore, Md.

Mr. Gould.

STATEMENT OF MITCHELL GOULD, EXECUTIVE DIRECTOR, THE GOULD CONVALESARIUM, BALTIMORE, MD., ACCOMPANIED BY ARNOLD WEINER, ATTORNEY

Mr. GOULD. This is Mr. Arnold Weiner, my attorney.

Senator MOSS. You may proceed, sir.

Mr. GOULD. Mr. Chairman, I join the many who have commended your committee for its effort on behalf of our aging and infirm. I am here today to add whatever I can to your fund of knowledge about the tragedy which struck our nursing home in July of this year.

As you are probably aware, I have cooperated fully with all interested agencies at every level of government to the end that effective preventative measures might avoid, if possible, a repetition of the sorrow which we experienced. I appear here at your invitation and not pursuant to any subpena or other legal compulsion.

I was born in 1919 and I have lived in Baltimore for most of my adult life. In 1939 I was employed by the U.S. Secret Service and I was stationed in Baltimore, Md., and Charlotte, N.C., with occasional tours of duty at the White House in Washington. I was also employed by the Office for Emergency Management as a special agent and, in addition, a special agent with the Federal Works Agency.

In 1945, following my discharge from the Armed Forces, I attended the Johns Hopkins University in Baltimore. I received a bachelor's degree, as well as a master's degree, in speech therapy. I have also taken courses in special studies at the University of California at Berkeley and at the Teachers College in Milwaukee, Wis. I attended the first semiannual course for nursing home administrators at George Washington University. I have taken most of the annual courses in relevant subjects which have been offered by the Maryland Department of Health, including courses in diet therapy and occupational therapy.

My own career in the administration of nursing homes has followed closely the history of this profession. Shortly after the war, when the demand for new construction was greatly in excess of the ability to build, most nursing homes were opened in structures which had originally been designed for other purposes.

The need for beds for the care of the elderly became acute and, as a consequence, private homes, former hospitals and former schools were frequently converted to nursing homes.

Within the next 15 years, however, funds and supplies for new construction became more readily available, and simultaneously, the standards for public buildings were raised. As a consequence, nursing homes, as other buildings used for public purposes, turned to new structures designed specifically for their special requirements.

In the early 1950's I opened a nursing home in Howard County, Md., in a stone mansion which had been utilized for many years as an exclusive girls' school. This home was licensed and approved for 68 patients. In spite of efforts at remodeling and repairing, however, the rise in the standards for public buildings made it impossible for this structure to meet the new requirements.

As a consequence, and when our lease expired at the end of the 3-year period, this home was closed in August 1957. I also had a similar

experience with a nursing home and a boarding home which had been located at Eutaw Place in Baltimore City.

It was evident to me that only newly designed facilities could provide the services which the times demanded. I sold both of the Eutaw Place homes, and, although they are still being operated today, I turned to modern construction.

As I discontinued my use of the older structures, I pioneered the construction of the first new nursing homes in our area. In 1958 I built and opened the first specially designed nursing home in Baltimore, in the 5800 block of Belair Road. Shortly thereafter, I built and opened a modern nursing home on Belvedere Avenue in Baltimore.

The tragedy struck us at the Convalesarium, our nursing home in the 6100 block of Belair Road in Baltimore. Many have wondered immediately about the quality of this facility. Some have assumed it to be an old plant, inadequately staffed and offering substandard care. Nothing could be further from the truth.

The Convalesarium was opened in December, 1964. It was the first FHA-sponsored multistoried home in Maryland to be planned from the ground up expressly for the care of older people. It was hailed, by the director of the Maryland Program for Occupational Therapy Assistance, as one of the few homes to provide fully equipped occupational therapy facilities.

In November 1965, after the home had been in operation for almost a year, the Baltimore Sun, in a feature article, noted that, "at the Gould Convalesarium * * * there is much to be appreciated." The newspaper made special mention of the "bright and wide halls" which are "easily navigated, even by wheelchairs," the fact that the rooms are "gayly decorated" and that we had provided a number of special areas where the "patients can relax in the sun or play shuffleboard."

We have been visited, as you know, by Mr. Val Halamandaris of your staff. He was received with courtesy and there was no phase of our operation which was not open to him. I wish that it would have been possible for you, the members of this committee, to have visited us as well.

I have brought with me some photographs, which were taken just this past week, which can illustrate for you the kind of place we have. These photographs show the outside of our building, our lounge, a typical room, nurse's station, kitchen and general hallway area.[4]

May I bring this up to the chairman?

Senator Moss. Yes, you may bring them up here, if you would like. We would be glad to see them.

Mr. Gould. This will show the two wide elevators, one for passengers and one for wheelchairs. This is a picture of a lounge.

We took these just this week in contrast to some other older ones to show this building is up to date at this time. The nurses' stations, charts and the charts for nurses. This is a photograph of the building as it exists today. It was taken at that particular angle, Mr. Chairman, to show the relationship of certain properties immediately adjacent to the building which I would like to talk about in a few moments.

This is the physiotherapy equipment. This is a typical two-bed room, showing the fire protection, with 8-inch concrete floors, interior

[4] Photographs retained in subcommittee files.

hoses under high pressure, cubical dividers between the patients for privacy.

This is a picture of a lounge. We have already put up some of our Christmas decorations.

This is an area of the kitchen and the food is being prepared. This is a separate area showing the dishwashing room, completely away from the rest of the food service.

Senator Moss. Thank you.

Mr. GOULD. I should like to tell you something about our staff. Unlike most homes, we have an administrator on duty 7 days a week for 12 hours a day. This doesn't mean it is the same person for the same period of time. But there is some administrative person on duty for these hours.

In addition, we have four registered nurses full time and one part time. We also have three licensed practical nurses. There are also 35 to 40 nurses aides and ancillary staff. Between seven and 11 of our personnel are employed in the kitchen. Our staff, at any given time, is between 75 to 80 persons. When all of our beds are at full capacity, and we are licensed for approximately 150 patients, we have a ratio of approximately one person employed for every two patients.

Our key employees have been with us since the day we opened and the members of our staff have dear ones from their own families as patients. Two of our registered nurses have had their own mothers in the home for several years, and they are still there as of today. Our former principal physician had his mother-in-law in our home as a patient. Several physicians and clergymen in the neighborhood, who have regularly visited or treated patients at the Convalesarium, have also had their own mothers or fathers stay with us.

Services are also supplied to us by outside contractors. The Hamilton Cleaning Corp., under contract, has employees at the Convalesarium 7 days a week. We have a dietician consultant who advises us on dietary problems. We have also engaged an expert sanitarian, Dr. Bernard Krafchick, who, together with his staff, inspects our facility, particularly the kitchen, on a weekly basis. At our instructions, Dr. Krafchick's inspections are without advance notice so as to maintain a constant vigil over our employees.

The distinguished panel which investigated us on behalf of the State health department concluded that:

> All of the evidence suggests that the Gould Home was and is a better than average nursing home.

The panel's report also noted that:

> It must be reiterated that the quality of the Gould Convalesarium equals or is better than most nursing homes in Maryland or the United States.

Dr. John DeHoff, acting commissioner of the Baltimore City Health Department, testified that our records are "of the quality one would expect in a reasonably good hospital." When he was asked to rate our home, Dr. DeHoff replied that only those homes who do not accept incontinent or terminal patients would be rated higher.

In this connection, I should point out as Father Sellinger said, that we have always accepted incontinent and terminal patients in spite of the added burdens associated with such patients. If we did not accept them, where would they go and who would take care of them?

One of the most difficult questions which has faced us has related to the cause of the salmonella outbreak. The panel's report has stated that:

> Despite efforts by members of the Federal, State, and city health authorities, the origin of the outbreak and the source of the salmonella contamination remains unknown.

To the suggestion that the epidemic was "food borne," the panel responded emphatically that there are many features of the epidemic which are not answered by this conclusion, most notably that, for example, many of the patients who were sick were apparently unable to eat and were not receiving food. Indeed, a number of the employees also became sick at the same time and they too had not eaten any of the food.

The only common denominator which anyone could suggest is the city water supply. The Convalesarium is located at the end of an old 6-inch cast-iron waterline. Water samples which have been collected from this line and which have been tested have indicated that there is little or no chlorine in the water when it reaches our area.

So much foreign matter is present in the water that special filters have had to be installed to keep the appliances in our nursing home from breaking down.

It is significant that at the very same time as our patients became ill, there was, in our immediate neighborhood, an outbreak of gastrointestinal illness which was identical in its symptomatology. I have here a document signed by 42 neighboring families which confirms this fact.

Senator Moss. That will be included in the files of the subcommittee.

Mr. GOULD. These are the people who live in the houses that I indicated on the picture immediately adjacent to the nursing home.

The neighbors, unfortunately, were not tested until long after the epidemic, when traces of the infection would not be expected to have remained. The city of Baltimore, in recognition of the danger, has promised to replace the ancient pipeline with a modern one, but we are still waiting. Members of 19 out of 50 neighboring families became ill. We are told this is normal in a city.

If that were so, in the city of Baltimore we would have had an epidemic of perhaps 250,000 persons ill at that same time. One of the ladies whose children were ill asked the city health department what she could do to insure the fact that her children would not become ill. She was told to boil the water—in the city of Baltimore, in 1970.

Symptoms of the illness were first noticed in the early hours of Monday, July 27, 1970. They consisted of various combinations of diarrhea, nausea, and temperature elevations. I should point out that there never was any attempt on our part to hide this fact. As soon as the patients became ill, the physicians were called immediately and they began prescribing treatment.

I have for you a list of the 32 physicians who were notified and who treated the patients for their illness. I have also prepared a chart which summarizes, by patient, the times of the onset of the illness, the notification of the physician and the initiation of treatment.[5] You will find that our staff made every effort to get whatever outside help ap-

[5] See app. B, p. 865.

peared necessary at the time. These charts are attached to the statement.

Senator Moss. They will be included.

Mr. GOULD. Not one of the many physicians who attended patients at the beginning of the outbreak expressed any undue concern or thought it necessary that the State authorities be notified. In fact, several of these physicians volunteered that they were seeing other patients in their own offices with similar symptoms and that we were probably experiencing only an outbreak of a summer virus.

By the second day, Tuesday, July 28, 1970, more patients were taken ill. I telephoned our hospital adviser, the State health department representative who was in charge of our home, and I told her that we had an unusual number of patients with diarrhea.

I did this, not out of legal duty, but as an effort to keep the authorities advised of those things which transpired in our home. You may find it noteworthy, in retrospect, that there are serious deficiencies in the Maryland law with respect to the reporting of infectious illnesses. There is a serious question as to whether nursing homes are required to make any reports. Even physicians are required to report only diarrhea in newborn children. While salmonella is an illness which is to be reported, the existence of this illness can be determined only after laboratory results have been obtained.

Throughout the time of the illness we were in constant consultation with our principal physician. He concurred in our suggestion that a no-visiting sign be posted and that specimens be sent for laboratory analysis.

On Tuesday, Wednesday, and Thursday specimens were taken from ill patients. They were sent not only to private laboratories, but to the laboratory of the State health department as well. On Thursday afternoon, we received the first results, these from the private laboratory, and they were negative for salmonella. Late Friday afternoon however, we received the first word, this from the State health department laboratory, that salmonella was detected.

Officials from the State health department and from other agencies appeared on the scene late Friday afternoon. I think that you should know that these officials, out of some deference to the private physicians who were treating their patients, did little or nothing about the medical treatment which was being administered.

Their suggestions were limited to the removal of certain patients to general hospitals, but only at the discretion of the attending physicians. The patients who were removed, moreover, received the same type of treatment in the hospitals as they had been receiving from their physicians at the nursing home.

Dr. William B. Greenough, III, the chief of the division of infectious diseases of Johns Hopkins Hospital, has investigated the clinical aspects of the outbreak. I have brought with me copies of Dr. Greenough's reports.[6] I call your attention to his conclusions that the staff of the nursing home did all that might be expected of it. Dr. Greenough has concluded that the State health authorities, who are to be expected to know how to handle infectious diseases, failed utterly to generate an appropriate change in treatment.

Perhaps the most significant lesson to be learned from this tragedy, therefore, is that the State health authorities must make themselves

[6] See app. B, p. 867.

knowledgeable about the infectious diseases which they purport to control.

Even after this epidemic, when we once again began receiving patients from the State hospitals, we initiated a new system of taking cultures of all new patients coming into the home. Some have said we were paranoid about this, but we feel it is a precaution that we want to take. One patient came in from a State hospital at 1 p.m. on a Monday afternoon. We are in the practice now of taking specimens of the patients in our nursing home who still have positive cultures to the State health department laboratories on Mondays and on Wednesday so that we had time to take this culture down with us.

Two days later, it came back positive for salmonella. This clearly indicated, of course, that the patient came into the nursing home with salmonella.

Another patient came from the same hospital and again we did the same procedure. This came back positive. So, we had two patients in a week who had come from this hospital. I immediately called Dr. Garber, head of the communicable diseases of the State health department and, of course, I was terribly anxious and concerned.

He assured me that there was no need to be concerned at this time because there were many elderly patients who had positive cultures, but who were asymptomatic. In other words, they had the culture in their blood, but they had no other symptoms and they were not ill.

Nevertheless, we sent in these forms CD 50, which apparently the doctor was supposed to send in originally. We sent one on each patient, to the city health department and to the State Department of Health. To this day we have heard no reply whatever from any of these cards.

However, as a result of our precautions, I understand that the State hospital is now instituting a procedure of screening the patients before they are sent out to nursing homes. So at least that phase produced something positive.

The distinguished panel which investigated our home concluded that the tragedy which we experienced could be repeated tomorrow at virtually any other nursing home. I join with them and with you as well in the hope that no such further tragedy might occur.

Senator Moss. Thank you, Mr. Gould, for your statement and your recollection of what happened.

Do you take these cultures regularly from your personnel, too, food handlers and others?

Mr. GOULD. We are not taking any more stool cultures from the food handling personnel because they have all proven negative. We are instituting, taking these from all new employees, yes, sir.

Senator Moss. A new employee does have a culture taken when he comes on?

Mr. GOULD. Yes, sir; and of course the chest X-rays and so on are just sort of routine for us. We do that regularly.

Senator Moss. How many patients do you have in this particular home now?

Mr. GOULD. I would like to answer that and also add something. It is very significant, sir; that at this outbreak not one family removed any one patient from this nursing home. Not one family took out the patient. Of those that went to the hospital and were able to return, everyone returned to the same nursing home.

We were down to 92 patients at the conclusion of this outbreak. We now have 118. So, we feel that our position in the community is well known and people have a regard for the home.

Senator Moss. Do you operate other homes besides this one?

Mr. GOULD. I have an interest in one other, yes. This was a home that we started through the FHA in 1962 before this Convalesarium was originated and through various procedures it took 8 years for the papers to clear. So, it was not until last year that this home was built. It was opened in April of this year. It is a 100-bed nursing home also built under the auspices of the Federal Housing Administration.

These are the only two homes that I have any connection with.

Senator Moss. Have you had any similar outbreaks or problems like this at the homes that you operated earlier, the one on Eutaw Street?

Mr. GOULD. No, sir. I have been in the business for 18 years and have never had any such incident before.

Senator Moss. We do appreciate having this. Of course, the terrible disaster of losing so many lives has caused us to look rather deeply into this nursing home problem. And the State is now instituting a number of changes that will improve the operation, we hope.

We need to look, I am sure, still deeper. We have here a problem of older people who are very defenseless, of course, and we must make sure they are not imperiled in any way besides the other factors that we have talked about today of giving them care and attention and visitation.

Mr. HALAMANDARIS. As a staff member who did the investigation for these hearings, I want to confirm what Mr. Gould said, in that when I went to his establishment I was very well treated, treated with kindness and courtesy and every effort was made to give me all the facts.

The question of what kind of nursing home the Gould institution was has received much attention. I just wanted to say that after having gone over all of the information available I can confirm the conclusion of the Sellinger report that the Gould home was a better-than-average home.

Mr. GOULD. Thank you very much.

Senator Moss. Thank you, Mr. Gould. We are glad you came to testify. We, at no time, intended to focus exclusively on your home. Still our investigation did reveal to us many deficiencies in the operation of nursing homes generally and brought to our attention the inadequacies of State inspection, the problem of physicians' attendance on patients and signing of death certificates and other matters, which have broadened our view in this field.

Therefore, the study has been helpful to us.

I would perhaps like to prolong this, but unfortunately, I am due down in the city in 10 minutes. We have to terminate at this point.

Thank you very much.

Mr. GOULD. I appreciate your efforts, sir, and I am available at any time.

Senator Moss. We will recess this hearing to reconvene Thursday, December 17, 1970.

(Whereupon, at 11:50 a.m., the subcommittee was recessed to reconvene Thursday, December 17, 1970.)

APPENDIXES

Appendix A

REPORTS: BALTIMORE NURSING HOMES

ITEM. 1. REPORT OF AN INVESTIGATION INTO THE SALMONELLA EPIDEMIC AT GOULD CONVALESARIUM IN BALTIMORE IN JULY 1970 BY A BOARD OF INQUIRY APPOINTED BY THE SECRETARY OF HEALTH AND MENTAL HYGIENE OF MARYLAND, OCTOBER 27, 1970

FINDINGS RESULTING FROM AN INVESTIGATION OF AN OUTBREAK OF SALMONELLOSIS AT THE GOULD CONVALESARIUM

What you are about to read is the story of a human tragedy. This document reports our findings stemming from an investigation into the deaths of 36 men and women in the summer of 1970 at the Gould Convalesarium, a nursing home in Baltimore, Md. The investigation indicates individual failures by physicians, by those who run nursing homes, by State and city health officials, by State and national government. Collectively they add up to the failure of our society to properly concern itself with the fate of its sick old people. The fact that such a tragedy could occur in a nursing home in Maryland that is considered above average clearly indicates the generally serious and unacceptable situation which exists in nursing homes. The evidence presented clearly shows that we have allowed these homes to operate in a bewildering tangle of bureaucratic regulations and inadequate laws where State agency overlaps city agency, where ambiguous lines of authority and the absence of clearly delineated responsibilities create confusion and carelessness, and where lack of adequate supervision potentially endangers the life of every patient in every nursing home. It is clear to the members of this board of inquiry that recent events at the Gould nursing home could be repeated tomorrow at any nursing home in this state unless multiple corrective measures are undertaken.

This board of inquiry was appointed by the Secretary of Health and Mental Hygiene of the State of Maryland, Dr. Neil Solomon, to discover the facts surrounding the outbreak of salmonellosis at the Gould Convalesarium. We accepted appointments to this panel with the clear understanding that we would act as public servants on the behalf of the citizens of Maryland and the patients who occupied not only the particular nursing home under consideration, but all patients in nursing homes throughout the state. Thus, we do not, and have publicly so stated, regard ourselves as responsible to any agency or group with direct or indirect responsibilities for the operation, management or regulation of nursing homes.

At the opening of the public hearings, the panel stated that from our incomplete and fragmentary knowledge of the complex problems posed by the long-term care of the helpless and aging, we felt it quite possible that this tragedy in one nursing home might be but the tip of an iceberg—an alarm signal indicating that as a society we had failed to deal responsibly with the problems of our elderly citizens who require care not given in their homes or by their families. Our investigation confirms this suspicion and points up the crying need for an in-depth study of nursing homes in Maryland. This panel's report, which should not be mistaken for the exhaustive study that is demanded, is offered at this time because of this panel's profound obligation to make known to the families

of those persons who died during the salmonella epidemic at the Gould Convalesarium, and the public, its general findings.

Thus, the report of this board of inquiry will raise more questions than it answers. Our short investigation strongly suggests that nursing homes in general are not doing the job they should be doing for our elderly citizens, that they may be managed by poorly trained administrators, that their standards of cleanliness may not meet either the letter or the spirit of legal standards, that their personnel are often insufficiently trained and sometimes insensitive to their patients. Further, there is much to suggest that medical practices of physicians and other personnel in the nursing homes are at times not good, that the public health agencies which monitor the practices and the conditions in nursing homes are not doing their jobs, and that the legislation that controls nursing homes needs dramatic overhauling.

In the course of its investigation, this panel held public hearings, at which it heard from the top public health officials in Maryland and Baltimore, the owner of the Gould Convalesarium and one of his administrators, city and state health officials directly responsible for inspecting and licensing the Gould Convalesarium and other Maryland nursing homes, and from several persons with relatives in the Gould Convalesarium.

We have also utilized additional information made available to us. This included information from officials of the Medical Services Administraton of the U.S. Department of Health, Education and Welfare, from concerned persons in Maryland who are knowledgeable about nursing homes in this state and the country as a whole, and data received from the American Nursing Home Association in Washington, D.C. and its Maryland affiliate, the Health Facilities Association of Maryland. In addition, this panel also reviewed testimony of various State Health Department officials before a United States Senate Investigating Committee, and other documents and reports from public and private sources. Documents considered important have been attached to this report as exhibits.

Our objectives at the outset of our hearings and throughout our subsequent study included the following:

To determine the events surrounding the particular tragedy occurring at the Gould home.

a. How did it happen?
b. Where did the infection come from?
c. Was the epidemic adequately investigated by proper authorities?
d. Did problems and delays in reporting influence the number of deaths arising from the outbreak?
e. Was treatment of individual cases appropriate?

During our investigation it became increasingly apparent that a much more important and broader series of questions also faced the panel. These included:

1. How does the Gould home compare with other nursing homes throughout the state and the nation?
2. How are standards for nursing homes set?
3. What are the procedures for licensing?
4. How are the standards and practices in nursing homes monitored?
5. What is the frequency and thoroughness of inspections?
6. Were responsibilities for medical practices within the home clearly fixed and delineated?
7. Where do ultimate responsibilities for a catastrophe such as that occurring in the Gould home reside?
8. How are nursing homes actually developed? How are they financed? Who owns them? Is it a profitable business? Are there possibilities for undue political influence—or other potential hazards stemming from the way nursing homes are established?

Our report is divided into two sections.

1. Findings about the Gould nursing home and the events surrounding the epidemic.
2. Findings relating to problems which plague nursing homes in general.

We have initiated this report with an assessment of the Gould home and the specific events surrounding the salmonella outbreak. This has been done to develop the necessary data on which to base more general conclusions. *The panel must state at the outset, however, that it firmly believes that specific failures evident in the current tragedy are but symptomatic of the serious problems of nursing homes in general. All of the evidence suggests that the Gould home was and*

is a better-than-average nursing home. Thus, we feel that the recent events at the Gould home could be repeated at virtually any nursing home in the state, unless the broader, general problems are faced and corrected.

THE GOULD CONVALESARIUM

The Gould Convalesarium is a three-story, brick nursing home in Northeast Baltimore that was built at a cost of $1 million. It opened in the latter part of 1964. Its principal owner, Mr. Mitchell Gould, advertises it as a "new concept in nursing and convalescent home care . . . built to provide, not a 'last stop' for our senior citizens, but a home-like yet ultra-modern establishment with the ultimate in efficiency, comfort and service." In the same advertisement, Mr. Gould notes that his nursing home has been approved by Medicare, the Joint Commission on Accreditation of Hospitals, the Maryland State Department of Health, the Maryland Blue Cross plan, and the United Auto Workers Health Plan. The home has had its state license renewed with little difficulty each year since it opened. It is also worth noting that two of the registered nurses that work in the Gould Convalesarium have their mothers in the home, and the mother-in-law of Dr. Harold Harbold, the principal physician of the Gould home, was in the home at one time for 18 months.

The nursing home is organized so that the first floor houses approximately 40 patients, most of whom are ambulatory and able to care for themselves. On the second floor are some 50 patients, who require occasional nursing care, and on the third floor are 56 patients, all of whom require regular nursing attention. The Gould Convalesarium has a very liberal admissions policy—which many homes do not—and accepts both incontinent patients and patients who are terminally ill. At the time of the epidemic there were 60 incontinent patients in the nursing home.

The home, which is licensed for a maximum of 146 patients, appears to exceed slightly state staffing requirements. There is an administrator on duty 12 hours each day. There are four full-time registered nurses and one part-time, as well as three licensed practical nurses; in addition, there are 45 to 50 nurses aides and other ancillary help. The kitchen staff ranges between 7 and 11 persons, to give the home an overall ratio of approximately one employee for every two patients. The maintenance and heavy cleaning inside and outside the nursing home are done by an outside cleaning firm.

Like other homes, the Gould Convalesarium is regularly visited by state and city health inspectors. Between July 1, 1968, and July 1, 1970, 22 inspection visits were made. The nursing home, which was consistently termed average or above average by public health officials in their testimony before this panel, has had a continuing problem in the all-important areas of food handling and kitchen sanitation.

Particularly important were violations noted by a consultant dietician for the State Health Department. On August 19, 1969, the dietician reported finding tapioca pudding standing at room temperature, and on May 4, 1970, the consultant dietician reported pudding was again found standing unrefrigerated in the kitchen.

Mr. Robert Williar, principal sanitarian for the Baltimore City Health Department's Bureau of Food Control, put the critical nature of food handling into perspective in his testimony: "Any defect in handling of food can lead to disaster," he said. The importance of the error can seem petty to the uninitiated, such as leaving food standing at room temperature for long periods of time before meals, in a kitchen that might otherwise be clean. If the food happens to be contaminated with salmonella bacteria, for example, leaving it unrefrigerated sets up an ideal breeding ground in which the salmonella will multiply. The kind of explosive outbreak of salmonellosis that occurred at the Gould home can be the unfortunate result.

Still, it must be reiterated that the quality of the Gould Convalesarium equals or is better than most nursing homes in Maryland or the U.S. In response to a request from this panel, Mr. John W. DeBiak, director of nursing home licensing and certification for the State of Iowa and a recognized expert, conducted a survey of the inspection records of the Gould nursing home, talked with a number of public health officials and inspected the nursing home itself. Mr. DeBiak, whose services were arranged through the Medical Services Administration of the U.S. Department of Health, Education and Welfare, provides in his report

a very clear perspective upon the Gould home's performance and how it fits into the general nursing home picture.

Mr. DeBiak states categorically that he would not consider recommending this home for participation in either Medicare or Medicaid programs, if that decision had to be made now. But since the home is already certified for participation in these public programs, his report states, it would be very difficult to decertify because the inspection records maintained by the State Department of Health are inadequate. Also, he points out the difficulty of withdrawing certification from any home because the courts choose to view decertification as depriving the nursing home operator of his livelihood, which Mr. DeBiak declares to be "a greater sin in the eyes of the judge" than depriving "an old person of his right to life safety and good care."

"What should elicit concern," he emphasizes, "is that the nursing home was not an exceptionally bad one and that the potential for such an occurrence is even greater in one of the many substandard homes we have in this country."

THE EPIDEMIC

There were 144 patients in the Gould Convalesarium on Sunday, July 26, 1970, all between the ages of 50 and 100 years of age. The average age of the patients was 78, and many of them were seriously ill. In the evening they were served cream of potato soup, shrimp salad, deviled eggs, and bread pudding. At 2:00 a.m. the next morning a patient became ill with diarrhea. By 7:30 a.m., when Mrs. Romaine Holmes, one of the administrators and a registered nurse, called the nursing home, an "unusual number" of patients had developed diarrhea.

When she arrived at the home later that morning, Mrs. Holmes began to search for "the common denominator" which might explain the growing number of patients with diarrhea. She inspected the kitchen and inquired about the previous day's food preparation, which she found to have been satisfactory. At that time, however, she took the stringent measure of closing the dining room and "reminded people to wash their hands, particularly well, because we didn't know what we were dealing with." She also took the unusual step of posting a NO VISITORS sign.

Meanwhile, Dr. Harold Harbold, the principal physician of the Gould Convalesarium, was being informed by telephone that five of his patients had developed diarrhea. According to Mrs. Holmes, many of the 39 other physicians with patients in the home were also called throughout the day as their patients came down with diarrhea. Dr. Harbold, with 42 patients in the home and Dr. Albert Bradley, with 22 patients, both made rounds that day. (Dr. Bradley is the principal physician at another Baltimore nursing home.) On his rounds, Dr. Bradley found seven of his patients with varying degrees of diarrhea. He commented to the nurse accompanying him that "this seemed unusual" and told her to keep in touch with him. By the close of Monday, July 25, 55 patients and the first of 19 employees, had developed various symptoms of salmonella infection, including diarrhea, vomiting and fever.

During the day, Mrs. Holmes told Mr. Mitchell Gould, the principal owner of the home, not to send any new patients to the home. She also had put into effect a special nursing routine, which included a "person who went around to each patient to force fluids every hour."

On Tuesday, July 28, 29 more patients developed symptoms of salmonella infection, which brought the rapidly growing total to 84. Around 7:00 a.m. that morning, Mr. Gould telephoned Miss Sarah Hawkins, a nursing home inspector for the State Health Department: He wanted to arrange for her to inspect some beds in the nursing home and he wanted to inform her that there was an outbreak of diarrhea in the Gould Convalesarium. He told Miss Hawkins, according to her testimony, that "he was not admitting patients at the present time due to the outbreak of diarrhea." She also said that he did not tell her it was a massive outbreak nor did he describe the full extent of it. But Mr. Gould did tell her that fecal specimens from some stricken patients had been sent to a laboratory, and reiterated to her that the home was not admitting patients and was not allowing visitors. She told the board of inquiry that she did not consider the diarrhea report unusual and she did not inform her superiors. She did, however, ask Mr. Gould to make a written report of the outbreak to the State Department of Health. (This conversation was to become controversial. In his testimony, Mr. Gould told the panel: "We knew we had an unusual situ-

ation, and we reported it to the proper authorities." The public health authorities, on the other hand, would insist that the outbreak was never properly reported until several days later.)[1]

That same afternoon, Miss Hawkins went to the Gould home to inspect the beds for the purpose of approving an administrative change in their status, as Mr. Gould had requested. The Gould Convalesarium was a nursing home Miss Hawkins happened to know well. A patient there was a close friend, and she visited her at the home every Tuesday and Thursday night and talked with her on the telephone on the days she didn't visit. At the home, Miss Hawkins spoke with Mr. John McKenna, another administrator, but they did not discuss the extent of the diarrhea outbreak, according to Miss Hawkins. She did take notice of the NO VISITORS sign before she left. She later testified that she "thought they were going overboard in their protection," and that she considered the sign "unusual."

Meanwhile, 10 more of Dr. Harbold's patients had become ill. Mrs. Holmes called him at his office that afternoon and they discussed the situation. Dr. Harbold told her "that this thing might be an epidemic" and suggested no visitors be allowed (a step that had already been taken) in order to prevent the disease from being carried out of the home. Dr. Harbold visited patients at the home in the afternoon and returned at 10:15 that night, Tuesday, and worked with his patients until 1:45 a.m., Wednesday, July 29.

On the 29th, after Dr. Bradley made rounds again, he stopped by the administrator's office at the nursing home and told Mr. Mitchell Gould that the situation "looked like it might be real trouble" and asked that fecal specimens from his patients with fever be sent to a laboratory for analysis.

Miss Hawkins saw Mr. Gould again the next day, July 30, at the Hilton Nursing Home, a second nursing home he owns—by that time more than 100 patients at the Gould Convalesarium had symptoms of salmonella infection—but apparently the extent of the outbreak was again not discussed.

On the morning of July 31, five days after the first case of diarrhea developed at the Gould Convalesarium, a relative of a patient in the nursing home called the office of Mr. Herbert Fritz, chief of the Division of Medical Facilities Development of the State Department of Health, to report that there was a "quarantine" at the Gould Convalesarium and that many patients were vomiting and had diarrhea. This telephone call opened the second chapter of the Gould catastrophe.

Mr. Fritz asked Miss Hawkins, who is the member of his staff in charge of Baltimore nursing homes, if she knew anything about the situation. She told him that she was aware of the diarrhea outbreak at the Gould home, that no visitors were being allowed, that no new patients were being admitted and that fecal specimens had been sent to laboratories. One reason she offered to Mr. Fritz for not reporting the matter was that she had been too busy helping film a documentary on nursing homes for television. Miss Hawkins then telephoned Mr. Gould to find out why the report to the State Department of Health she had requested had not been received. Mr. Gould told her he was waiting for reports from the laboratories. Miss Hawkins instructed him not to wait but to send it immediately; Mr. Gould personally delivered the report to Mr. Fritz's office during the lunch hour that same day, July 31.[2]

After talking with Mr. Gould, Miss Hawkins telephoned Dr. Harbold, who told her that 60 patients and 13 employees were ill. She then called the food control section of the Baltimore City Health Department to report the outbreak and ask that someone be sent to the nursing home. Sometime after 12:00 p.m., Mr. Robert Williar, principal sanitarian of the City Health Department, arrived at the Gould nursing home. Mr. Fritz had meanwhile been telephoned by another state health official and told that a death had apparently occurred at the home. Mr. Fritz called the Gould home and talked with Mr. McKenna, and when he found nine persons had already died—all apparently with diarrhea—he "felt it might be a matter for the epidemiologist." At this point, he called Dr. Jean Stifler, Acting Commissioner of Health for Maryland. Dr. Stifler contacted Dr. Howard Garber, chief of the state's Division of Communicable Diseases. Dr. Garber discovered from his immediate telephone call to the Baltimore City Health Department that The Johns Hopkins Hospital had reported earlier in the afternoon that its laboratory had found salmonella, group D, in the stool

[1] See exhibit 1, p. 847.
[2] See exhibit 1, p. 847.

specimen of an employee of the Gould Convalesarium. At the same time, the state laboratory was informing Dr. Stifler that a specimen received from the Gould Convalesarium had showed definite salmonella enteritidis, and that six other specimens were highly suspect. Dr. Garber became concerned that expertise might be needed in addition to the Baltimore and state health officials, so he placed a long-distance call to Dr. Gene Gargo, chief bacteriologist for the federal Center for Disease Control in Atlanta, to ask for assistance. At 6:00 p.m. that evening, the Center dispatched Dr. Robert Kohler, an epidemiologic intelligence officer, to Baltimore.

Dr. Neil Solomon, Maryland's Secretary of Health and Mental Hygiene, had been out of town during the week. He found out about the salmonella epidemic just after he returned to Baltimore—at 6:00 p.m. on July 31. By that time, 13 patients had died at the nursing home, the public health forces had begun their mobilization, and the first city health officials were already at the Gould Convalesarium. The news had also reached the Baltimore newspapers and Dr. Garber was receiving persistent telephone calls from reporters.

The next day, August 1, six days after the first patient became ill, the Gould Convalesarium was crowded with city, state and federal health officials. They inspected the kitchen, the plumbing, the water supply, the patient records, and interviewed patients and employees. Specimens of eggs and shrimp on hand at the home, although not a part of the suspect meal, were taken from the nursing home for laboratory analysis, and an attempt to compile patient dietary histories was made. Clinical histories were taken and stool samples from employees were sent for examination.

On August 3, Dr. Harbold, the principal physician, left for a vacation, which he had postponed for two days.

At Dr. Garber's request, the federal Center for Disease Control conducted a telephone survey on August 8 of 38 Baltimore nursing homes to find out how many patients had been ill with diarrhea in the previous two weeks. Among the 3,000 patients in the homes, there had been 50 cases, but salmonella was not implicated.

In the eight days immediately following the intervention by public health officials, 15 more patients died at the Gould Convalesarium and, by August 23, a total of 36 were dead—at least 25 were certain victims of the salmonella outbreak. Help had reached the nursing home too late to have any significant effect upon the outcome of the first salmonella epidemic in a nursing home in Maryland.

THE BOARD OF INQUIRY CONCLUSIONS REGARDING THE OUTBREAK OF SALMONELLOSIS AT THE GOULD CONVALESARIUM

Review of the testimony, coupled with the other information made available to the panel, leads us to the following observations:

1. The inspection reports of the Gould home of the past two years show repeated minor failures in sanitation practices, including food storage, delivery of meals to patients, dishwashing equipment, housekeeping, and many other infringements of the state inspection code.[3] *The panel concludes that the Gould home was not exacting in its handling of food and its sanitation practices.*

2. Throughout the testimony there is clear evidence of failure by the officials and physicians of the Gould Convalesarium to deal effectively with the epidemic. *Those who testified, Mr. Mitchell Gould, Mrs. Romaine Holmes, Dr. Harold Harbold and Dr. Albert Bradley, appear to have been at fault in their failure to report the explosive outbreak of diarrhea at an early point. Even if unaware of the specific legal requirements for reporting the epidemic to public health officials, as experienced professionals they should have called for help when the majority of patients throughout the nursing home exhibited symptoms of serious illness within a very short period. The argument was advanced that the dimensions of the crisis were not clear and that it did not occur to those in positions of responsibility at the Gould home that they were in the throes of a disastrous epidemic that required expert assistance as quickly as it could be obtained. The panel rejects these contentions out of hand. It seems probable that other individuals were also at fault—it has come to the attention of the board that Mr. John McKenna, apparently the administrator of record of the home, was*

[3] See exhibit 2, p. 848.

clearly in consultation with Miss Hawkins and in a position of responsibility during the epidemic but was never called to the stand.

3. *It appears that Miss Sarah Hawkins, an inspector for the Division of Medical Facilities Development, although not legally responsible, was derelict in her failure to notify her superiors of the outbreak of diarrhea at the convalesarium, although it was brought to her attention on at least two separate occasions.*

4. *It appears that the Division of Medical Facilities Development of the State Department of Health, under the leadership of Mr. Herbert G. Fritz, has been ineffectual in its nursing home inspection practices.*

5. *The source of the outbreak was not satisfactorily determined.* Despite efforts by members of the federal, state and city health authorities, the origin of the outbreak and the source of the salmonella contamination remains unknown. Although Drs. Garber and Farber stated their belief that the epidemic was food-borne, there are many features of the epidemic which are not answered by this conclusion. For example, many of the patients who were sick apparently were unable to eat and were not receiving food. Further, although it was stated that most of the employees did not partake of the foods in question, 19 of the employees became sick almost simultaneously with the patients. A report submitted by Dr. Kazuyoshi Kawata, an environmental health expert from The Johns Hopkins University School of Hygiene and Public Health, suggests the possibility of water and contamination, but the data presented were inadequate to allow a judgment to be made. Meaningful dietary histories were not obtained, and the panel was not given a clear picture of the precise location of patients who became ill. Dr. Kawata's survey of the Gould home suggests that contamination of the water supply might have occurred on the third floor, which would mean that patients on the first and second floors would have been those infected. *Recognizing the late hour at which public health investigators entered the scene, it is the conclusion of the panel that the epidemiologic studies were not adequate to determine the source of the outbreak and perhaps could not have been.*

6. *Did delays in reporting influence mortality? Was appropriate treatment rendered?* The mortality from salmonella gastroenteritis is usually 1-in-409 to 1-in-500 patients, but this particular epidemic carried a mortality of almost 1-in-4. This extraordinary fatality rate is one of the most important and difficult problems this board of inquiry has had to consider. The public health officials who needed to know were not informed until five days after the outbreak began, and the question "would earlier reporting have meant fewer deaths?" is of serious concern. The data presented by Dr. Tayback at the investigation, the report of Dr. Greenough, and the report of the Ad Hoc Committee on Salmonella of the Medical and Chirurgical Faculty,[4] do not satisfactorily answer these questions. Further, whether therapy for individual patients was adequate and appropriate is also left in doubt.

It should be noted that this panel recognizes that the majority of patients in the Gould nursing home were seriously ill with disease such as cancer, stroke, advanced cardiovascular disease, and other illnesses from which recovery was unlikely. Thus, as a group, they were extraordinarily susceptible to death from virtually any infection. Further, the management of the aged patient who is terminally ill is recognized as an extremely difficult problem in modern society. The panel thus recognizes that thoughtful decisions by a patient's physician and family to forego heroic measures to sustain the life of a hopelessly ill patient might logically be made under such circumstances. However, there was no evidence presented to indicate careful decision made in this manner. Clearly, death from failure to recognize a problem is an entirely different matter. The report done for the Gould Convalesarium by Dr. William B. Greenough, III, in our judgment, does not settle this point. While it is quite clear from his study that the majority of patients dying were fragile and seriously compromised by disease of the heart and blood vessels, the argument that patients transferred to a general hospital experienced the same high mortality as patients remaining within the Gould home does not answer the question of whether treatment was or was not appropriate.

Logically, those who were most at risk of dying would be transferred to a hospital and simple comparison of mortality rates in each setting does not settle

[4] See exhibit 3, p. 848.

the problem of whether (a) more rapid reporting might have reduced mortality, (b) whether therapy was optimal or the therapy that would have been utilized if appropriate consultations had been made. As noted in a chart constructed by the panel, of the 55 patients who became ill between July 23 and the 27th, 22—or 40 per cent—died. Of those who became ill from July 28 through August 3, only 12 of these 59 patients, or 20 per cent, died. While the panel recognizes that the earlier onset of illness may indicate these patients received a more massive number of salmonella, leading to higher mortality, these data can also be interpreted to suggest that a patient was at a greater hazard of dying if he or she got sick early in the epidemic before its seriousness was recognized. *The panel concludes that the question of whether earlier reporting and awareness of the seriousness of dehydration would have reduced the mortality rates remains unsettled, but reason dictates that earlier awareness would have altered the outcome.*

THE GENERAL PROBLEM OF NURSING HOMES IN MARYLAND

We now turn to the broader problems which we believe underlie the Gould Convalesarium tragedy and, indeed, almost inevitably assure its recurrence in other nursing homes in Maryland. The problem surrounding nursing homes is a problem for all of American society today. The shamefully low priority our society places on the care and comfort of its aging and infirm is obvious throughout all of the testimony and the material we have reviewed.

There is a general lack of concern about the elderly people of the United States, the problems they face and the problems they create. America today is a culture fascinated with youth and vitality, and not an easy place in which to grow old. But the number of old persons in the United States is increasing steadily. At the turn of the century, four per cent of our population was 65 years of age and older; today, that figure is nearly ten per cent. It is estimated that we will have 25 million people over 65 years of age by 1980. Millions of these elderly persons continue to lead normal lives in familiar surroundings, pursuing interests and jobs they enjoy. But some are sick, feeble, poor, depressed and alone and far too many of them end up forgotten in nursing homes. These old people are a major challenge for medicine and for society, a challenge whose answer will help define America in the 1970's.

A. The development of the nursing home industry

Nursing homes in America and Maryland are big business. Most nursing homes are proprietary, which means they are private, profit-making organizations, whose primary reason for existence is to make money for their owners or stockholders. Nursing homes, at the same time, are financed for the most part by city, state and federal government funds. In 1969, Medicaid programs paid to nursing homes in this country some *$1.3 billion.* Medicare, in 1969, paid to nursing homes another *$320 million.* Add to these figures the many millions of dollars paid to nursing homes by the approximately 25 per cent of nursing home patients who do not qualify for government aid, or by their families. *Nursing homes, in fact, are an industry.* Last year there were 23,013 nursing homes in the U.S., with a total of 1,014,510 beds. These homes employ more than 500,000 persons.

Councilman Robert Douglas of Baltimore told his panel, in his testimony, of the high prices nursing homes' common stocks have until recently brought upon the national stock exchanges. The reasons, he said, are simple: Medicare and Medicaid. There is a "guaranteed paycheck for each patient," Mr. Douglas said. If you can care for that patient that cheaply, he testified, "you will make a profit out of it."

Nursing homes have developed into an industry from so-called "Mom and Pop" homes, which were homes to care for three or four elderly persons operated by a man and wife, who themselves were getting on in years. Ten years ago construction of nursing homes accelerated, and in Maryland alone in the past six years, 5,000 nursing home beds have been built. But today, however, the chain organization so common in banks, hamburger drive-ins and drugstores, is a growing phenomenon in nursing homes, and in Maryland three corporations own 22 homes.

It is a normal pattern in American business for a corporation to grow bigger and bigger. A large corporation with many assets can operate more efficiently through joint purchase of supplies and services, and it can compete more effectively in the big money markets to raise capital. This is as true of a corporation that owns nursing homes as it is for General Motors. In business terms such

growth is rational and, perhaps, even desirable. The question we in this society must ask, however, is: Will our elderly people benefit?

B. The licensing and inspection of nursing homes in Maryland

It has become evident from this investigation that mechanisms for licensing and inspection of nursing homes, while superficially appearing thorough and penetrating, are inadequate in Maryland. Licensing and the major inspection responsibility rest with the Division of Health Facilities Development of the State Department of Health, which also investigates complaints about nursng homes, since such complaints have a direct bearing upon the nursing home's license.

Working within the Division is a group of hospital advisors, who are registered nurses with college degrees. Each hospital advisor has a certain area of the state in which she is responsible for inspecting nursing homes. These advisors are the main link between nursing homes and the State Health Department. The advisors make an annual all-day inspection of each nursing home to determine whether its license will be renewed. These visits, which are announced, come within 60 days before the current license expires. The advisors, who try to make at least two unannounced visits to each home during each year, are also charged with coordinating all inspection reports of other agencies and insuring that all reported violations are actually corrected.

The inspections the advisors make are designed to be thorough. The inspector looks at the quality of housekeeping in each home, the social services provided patients and she checks notes made in patients' records by doctors and nurses to see if there are regular entries. She investigates the way patients are given medicines and the way the pharmacy is operated. She examines the nursing home's laundry to see if adequate clean linen is on hand. Most importantly, the advisor talks to patients and physically examines them to determine whether, in fact, they have been receiving good nursing care. In addition, the Division has consultant dieticians who periodically inspect those Maryland nursing homes, such as the Gould Convalesarium, which participate in Medicare, to examine closely the way food is ordered, stored and cooked, and to determine whether the procedures for washing food trays and kitchen utensils and equipment are sanitary. Also, at the request of the State Health Department, local health departments send food sanitarians to every nursing home in the state once each year during the 60 day annual licensing period to examine the same areas of food handling.

In addition to the state and local health department inspections, each home is also inspected for safety by local fire departments. The fire inspection is also a licensing requirement.

Lastly, for licensure each nursing home must have an agreement signed by a so-called principal physician. That this is meaningless to the physician, and largely meaningless to the state authorities, was vividly illustrated in the testimony included in Appendix 11 [5] which should be read in its entirety.

While on paper the rules for licensure and the criteria for inspections seem reasonable and thorough, there was abundant evidence at the hearings that inspections were infrequent, that nursing homes generally knew when they were to take place, that inspection reports were sometimes in conflict with one another, and that violations almost never resulted in revocation of licensure. *Indeed, the panel felt at certain points in the testimony that inspections were a bureaucratic ritual carried out in a fashion which led to a tidy series of papers which were duly filed as evidence of accomplishment rather than signals for action.*

C. The responsibilities of the medical profession

It also appears to this board of inquiry that the medical profession, as the group in society charged with rendering medical care and providing medical advice, has not, in the final analysis, shouldered its proper responsibilities for nursing homes and possible abuses. Clearly doctors and their organizations have not exercised the high level of leadership needed to set adequate standards for nursing homes in Maryland and insure that medical care in those homes is of acceptable quality. The Medical and Chirurgical Faculty of the State of Maryland, as spokesman for organized medicine in this state, should have insisted long ago upon the stringent inspection of nursing homes by the State Health Department. Instead the Faculty and its members have tolerated ineffectual inspections and have taken no action to insure that the quality of medicine practiced in nursing homes is consistent with the high ideals of the medical profession.

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[5] Not printed.

GENERAL RECOMMENDATIONS REGARDING NURSING HOMES IN MARYLAND

1. *The potential problem of profiteering in the nursing home industry.* It seems to this panel that there is a fundamental contradiction between the goals of profit-making nursing homes and the ideals of our society. Nursing homes, if they are to make a profit, must keep their beds occupied. On the other hand, the aim of our society must be to move aged patients out of beds and into the community to lead as normal a life as possible.

Further, the concomitant of substantial size in business in America is political power. In the hearings held by this panel, various indications were heard of influence upon the state government by the nursing home industry. Testimony suggested a very strong "nursing home lobby" exists in the Maryland State Legislature, and that this lobby has had sufficient political power to prevent passage of legislation in Maryland that might set stricter standards for nursing homes. Our investigation disclosed evidence suggestive of political interference with a nursing home inspection. Witnesses testified that an unannounced inspection of Harbor View Nursing and Convalescent Center in Baltimore was called off during the actual inspection. Explanations by the officials involved in the incident about the innocence of the cancellation remain singularly unconvincing.

This board of inquiry notes that Harbor View nursing home is owned by a corporation whose president and director is a member of the Maryland House of Delegates. We do not question that legislators are entitled to have business interests. We do, however, suggest that the possibility of conflict of interest should be examined. Given this kind of worrisome information, this panel must raise the question of how to control such powerful monetary interests. Have we opened our nursing homes to profiteering?

2. *Responsibilities of State and City Health Departments.* The panel is concerned by the bewildering tangle of bureaucratic regulations and inadequate laws which govern licensure and inspection of nursing homes. As stated during the hearings, the confusion between responsibilities of state officials and city officials, differences in reporting forms for infectious disease, and many other evidences of overlapping and potentially conflicting areas of monitoring have led to a situation where "everybody is responsible yet *nobody* is responsible."

(a) *The panel concludes that lines of authority must be clearly drawn for state and local health officials, responsibilities clearly fixed at a high level, licensing practices strengthened—and the system of inspection and penalties for failing to meet inspections be made clear, strong and unequivocal. It notes with pleasure the interim steps already taken by the Secretary of Health and Mental Hygiene to move in this direction, which we hope will result in genuine reform.*

(b) The panel also believes that standards of acceptable training for nursing home administrators and personnel must be developed along the lines outlined by Dr. Farber. That personnel meet acceptable training levels is a standard that must be enforced.

(c) Immediate steps should be taken by the State Department of Health to clarify to physicians and nursing home administrators exactly what their responsibilities are in reporting outbreaks of infectious diseases. We would hope that new regulations would include strong penalties, including heavy fines and revocation of licensure, for failure to report such diseases.

(d) We applaud the Secretary of Health and Mental Hygiene's decision to replace the principal physician with medical directors of nursing homes. The responsibilities of such physicians for the welfare of every patient in the nursing home should be clearly and unequivocally stated. Such medical directors should have clear authority over nursing home staff and personnel in all matters relating to health and be immune to the kinds of pressure to modify standards of care which Dr. Bradley suggested could be applied by the "syndicate."

3. During its inquiry the panel received testimony suggesting that improper influence could be applied to those responsible for the inspection of nursing homes. Clearly the inspection system must be above reproach, and individual inspectors must be free to inspect nursing homes without fear. This commission recommends, therefore, that an independent nursing home inspection board be created

in Maryland that will include physicians, members of the community, and specifically representatives of local senior citizens groups.

4. *Responsibilities of the Medical Profession.* The medical profession and its organized spokesman, the Medical and Chirurgical Faculty, must insist upon stringent inspection and adequate standards of care in all nursing homes in Maryland. We urge the Faculty to strengthen its existing committee on nursing homes and insist that it dependently develop acceptable standards and methods of supervision to insure that Maryland nursing homes are the best in the nation.

5. *Establishment of Independent Commission on Nursing Homes.* Our brief examination of nursing homes in Maryland has shown us the serious deficiencies of how we provide for our aging and infirm who can no longer manage their own affairs. It is clear that the citizens of Maryland need to know more about nursing homes. We strongly urge, therefore, that the Secretary of Health and Mental Hygiene encourage the Governor of Maryland to appoint an independent commission to explore the problems of nursing homes in depth. This commission must explore how nursing homes are operated; who owns them; the nature of the profits involved in this essentially public industry; and, the qualifications of their personnel. We would hope such a commission would also explore alternatives to long-term custodial care in nursing homes and develop a detailed plan for immediate improvements and a long-range plan for more satisfactory care for the aging. This commission obviously must have staff and funds to conduct a complete inquiry.

The elderly sick are particularly vulnerable to neglect in today's youth-dominated culture of America, where they have great difficulty articulating their needs. A truly humane society must insure a system that meticulously guards the dignity of its old people. It must also provide for their comfort and a high quality of medical care for them in their later years. It is the hope of this panel that its recommendations may help in moving us toward this goal.

JOSEPH A. SELLINGER, S.J.
JOHN H. MOXLEY, III, M.D.
DAVID E. ROGERS, M.D.

[Exhibit 1]

THE GOULD CONVALESARIUM,
Baltimore, Md., July 28, 1970.

(Received July 31, 1970, Division of Medical Facilities Development)

Mr. HERBERT G. FRITZ,
Chief, Medical Facilities Development, Maryland State Department of Health, 301 W. Preston Street, Baltimore, Md.

DEAR MR. FRITZ: I am writing to advise you that an unusually large number of guests at this facility have been experiencing a gastro enteritis type of ailment, which apparently began during the late hours of Sunday evening, July 26. The symptoms have been vomiting, diarrhea, and temperature elevation. The doctors were immediately notified, of course, and have been prescribing medications and antibiotics. The diets have been changed for those patients to modified diets or as tolerated.

I contacted our hospital advisor, Miss Hawkins, to advise her and to secure guidance, and it is at her suggestion that I am writing to you.

In addition, cultures were taken and have since been forwarded to the Maryland State Department of Health laboratory at East 23rd Street. Further, three specimens were sent to the private laboratory. As yet, no results have been received from the State Laboratory. We have received two reports from the private laboratory which disclosed evidences of colorless proteus and colorless pathogens.

We have discontinued visiting hours temporarily and will renew them as soon as the situation is completely ameliorated. A rather large number of employees seem to have the same ailment and have called in ill, and Doctors Jandorf, May,

Stevens and Benson have reported seeing many patients in their offices with similar complaints.

We are doing all we can to alleviate the situation, but if you have any suggestions, I would appreciate hearing from you.

Sincerely yours,

MITCHELL GOULD,
Executive Director.

This letter was hand delivered by Mr. Gould at lunch time on the 31st.

Rosanne.

[Exhibit 2]

AUGUST 4, 1970.

From: JANE HARTMAN, R.D., Director of Dietetic Services.
To: Mr. HENRY S. GOOD, Chief, Support Services Management.

ACTIVITIES FOR AUGUST 3, 1970

There was a meeting with Mr. Samuel Althoff and Frances Buckler at 9 A.M. at Rosewood State Hospital concerning regionalization. Attached is a summary of recommendations made by Miss Buckler. In summary, the recommendation is that 10 positions be deleted from Mt. Wilson State Hospital somewhere in the area of food production. In the event that centralized tray service is included in the 1972 budget as was recommended, about 6 Dietary Aide positions could be deleted, too. All agree that breakfast preparation, therapeutic diets, and nourishments for Mt. Wilson patients should be prepared in the kitchen at Mt. Wilson. It was recognized that the food storeroom at Mt. Wilson is under the Business Manager and that some economics in personnel labor hours might be realized from centralization.

In the afternoon, in the office there was a conference with Ruth Murphy, Division of Medical Facilities Development, concerning the salmonella situation at the Gould Convalesarium. It was decided that the facility should not be visited during the present week but that an unscheduled visit should be made during the week of August 10. *This facility has never met the State's Standards and Regulation with respect to food distribution. Food is not distributed in enclosed carts. It is not known whether or not this fact enters into the present emergency situation.*

After my conference with Mr. Noll, I spent some time reviewing the budget for the Regional Institute for Children and Adolescents. At the end of the day Mr. Knight and Mr. Meadows approved the revised specifications for the Department of Mental Hygiene food conveyors.

I volunteered at the People's Free Medical Clinic, 3028 Greenmount Ave., in the evening. While this is not a State facility, there is good opportunity to counsel people concerning proper diet as well as good food purchasing practices. The MDA Community Nutrition Section will assume responsibility for this project in the future.

[Exhibit 3]

MEDICAL AND CHIRURGICAL FACULTY
OF THE STATE OF MARYLAND,
Baltimore, Md., September 16, 1970.

NEIL SOLOMON, M.D., Ph.D.,
Secretary of Health and Mental Hygiene, 701 State Office Building, 301 West Preston Street, Baltimore, Md.

DEAR DR. SOLOMON: I have the pleasure of enclosing a copy of the Report of the Ad Hoc Committee on Salmonella which was formed as a result of your communication with the Faculty office and your letter addressed to the Commissioner of Baltimore City Health Department on August 7, 1970.

Please feel free to call upon us for any clarification on this that may be needed.

Sincerely,

JOHN SARGENT,
Executive Director.

[Enclosure]

Report of the Ad Hoc Committee on Salmonella

PREAMBLE

The Committee is deeply distressed by the unfortunate epidemic of Salmonella that occurred in the Gould Convalesarium which involved an age group that was particularly susceptible to the ravages of this disease. We sincerely hope that out of this tragedy and out of our study and recommendations, there will arise an awareness on the part of all attending physicians, nursing home administrators, and Health Department personnel, of the problems involved and the need for prompt diagnosis and reporting in future outbreaks.

This Committee was named by the Faculty President, Henry A. Briele, M.D., on August 7, 1970, in response to a request from the Secretary of Health and Mental Hygiene. Its charge was:

". . . those aspects of the investigative proceedings where examining physicians, treating and caring for the stricken patients at the Gould Convalesarium may not have submitted reports to the Baltimore City Health Department as required by statute and regulation."

And

". . . so that it (The Medical and Chirurgical Faculty) may direct its attention to the question of taking its own action against those physicians, if any, who may not have submitted reports as aforesaid."

In order for this special committee to understand its responsibilities a careful examination of the pertinent laws and regulations was undertaken. The specific laws are:

Article 43, Section 78, provides that: (Italics ours)

"Whenever any physician knows or has reason to believe or suspect that any person under his professional care is infected with smallpox, diphtheria, scarlet fever, typhoid fever, typhus fever, yellow fever, malarial fever, *or any other contagious or infectious disease dangerous to public health,* he shall immediately give notice thereof in writing over his own signature to the health officer of the city, town, county or district in which such disease exists, giving the name of the disease or suspected disease and the name, age, race, sex, place of abode of each person believed or suspected to be sick of the disease; and if he neglects, fails or refuses to give such notice he shall be fined not less than ten dollars nor more than one hundred dollars. (An. Code, 1951, § 77; 1939, § 77; 1924, § 77; 1912, § 64; 1904, § 51; 1898, ch. 436, § 34B; 1914, ch. 644, 1916, ch. 243.)"

"§ 52. SAME—DUTIES OF HEALTH OFFICERS AS TO SUPPRESSION OF DANGEROUS DISEASES: COOPERATION OF STATE DIRECTOR

"Whenever any local or county health officer shall receive reliable notice, or shall otherwise have reason to believe that there is within the limits of his sanitary jurisdiction a case of cholera, smallpox or other disease dangerous to the public health, he shall immediately report such notice to the local board of health and upon obtaining the approval of such local board of health investigate the matter and take all proper steps for the restriction or suppression of such disease or diseases; and the local boards of health shall incur and pay, as other expenses are paid, the necessary and legitimate expenses thereof; he shall promptly notify the Director of the State Board of Health of the existence of any epidemic or unusual sickness or mortality that may come to his knowledge within his own sanitary jurisdiction or contiguous thereto, and when thus informed, it shall be the duty of the Director of the State Board of Health to cooperate with and aid the local health authorities in making scientific and practical investigation into the cause or causes of any existing disease, and in devising the most efficient means for its restriction or suppression or for the exclusion of any threatened disease, and to take such steps as may be necessary to prevent the spread of such disease or diseases; and to this end he may exercise all the powers of the State Board of Health. (An. Code, 1951, § 52; 1939, § 52; 1924, § 52; 1912, § 40; 1904, § 29; 1888, § 14; 1886, ch. 22, § 7; 1920, ch. 314)"

"§ 53. SAME—SAME—ATTENDING PHYSICIAN: EXCEPTION AS TO BALTIMORE CITY

"Any physician called to attend a person suffering with any disease embraced within the provisions of § 52 of this article shall have the power to exercise all the powers conferred by said section upon the health officers of the several counties to restrict or suppress such disease or diseases until the health officer of

the county wherein said disease may occur shall investigate the matter as directed in § 52. Said attending physician may exercise said power without securing the prior approval of the board of health of the county; but said power shall be exercised only during the emergency existing until the county health officer shall make his investigation, and immediately upon said investigation, the power hereby conferred upon the attending physician shall cease. This section shall not apply to Baltimore City. (An. Code, 1951, § 53; 1939, § 53; 1924, § 53; 1922, ch. 271)"

"§ 80. DUTIES OF HEALTH OFFICER ON RECEIPT OF NOTICE

"Whenever any health officer of city, town, county or district shall be notified of the occurrence of a case of smallpox, diphtheria, scarlet fever, typhoid fever, yellow fever, malarial fever, or any other contagious or infectious disease, within his sanitary jurisdiction, he shall take immediate steps to prevent the spread of the disease. He shall give notice in writing to the school authorities of any contagious or infectious disease affecting school children, or likely to endanger the health of school children. He shall within twenty-four hours transmit to the State Board of Health such information as he has obtained concerning every case of infectious or contagious disease which has come to his knowledge. It shall be his duty to cooperate with the State Board of Health in the enforcement of §§ 78 to 80 within his jurisdiction. *The State Board of Health shall prepare and distribute to all local health officers, the printed forms necessary to carry out the provisions of §§ 78 to 80.* (An Code, 1951, § 79; 1939, § 79; 1924, § 79; 1912, § 66; 1904, § 53; 1898, ch. 436, § 34D; 1916, ch. 243)"

"§ 81. DOUBTFUL CASES RESOLVED BY STATE BOARD OF HEALTH

"*All questions of doubt concerning the cause or nature of any sickness believed or suspected to be of an infectious or contagious character shall be referred to the State Board of Health for such disposition as it may deem proper.* (An. Code, 1951, § 80; 1939, § 80; 1924, § 80; 1912, § 67; 1904, § 54; 1898, ch. 436, § 34E; 1908, ch. 399; 1951, ch. 75, § 80)"

"§31. PREVENTION OF INFECTIOUS OR CONTAGIOUS DISEASES

"It shall be the duty of the Commissioner of Health to recommend to the Secretary of Health and Mental Hygiene for *adoption and to enforce such rules and regulations as may be necessary* to prevent the introduction of any infectious or contagious disease into this State, or *to prevent the spread of any infectious or contagious disease whether or not* such disease shall exist within this State at the time of the passage of this act, and any *person* or *persons* or *corporations* refusing or neglecting to obey such rules and regulations, upon promulgation thereof to the Secretary, shall be deemed guilty of a misdemeanor, and upon conviction thereof shall be fined not more than five hundred dollars for every such offense. Whenever necessary, the Secretary may call public conferences of health officers; . . ."

"§33. REPORTS OF COMMUNICABLE DISEASES TO STATE BOARD; CONTROL OF CAUSES; CONTROL OF EPIDEMICS AND NUISANCES; MONTHLY BULLETIN

"The State Board of Health shall secure accurate and complete returns of communicable diseases in Maryland; it shall examine into the prevalence and causes of such diseases and devise means for their control: it shall examine into and investigate epidemics and nuisances and devise means for their control; and it shall publish monthly a bulletin for health officers. (An. Code, 1951, § 33; 1939, § 34; 1924, § 36; 1912, § 25; 1910, ch. 560, § 21B, p. 141; 1951, ch. 75, § 34.)

Cross reference.—As to employees with communicable diseases being prohibited in laundries, see article 55, § 4.

The applicable regulations are:

COMMUNICABLE DISEASES

0301—"It shall be the duty of every *physician and every superintendent or manager of a dispensary, hospital or clinic in attendance on a case of reportable disease* to report the case, upon the *forms provided for that purpose by the State Department of Health,* to the local health officer, who shall in turn report on the prescribed forms to the Commissioner, State Department of Health, all such cases reported to him."

0302—"Reportable diseases:

Amebiasis
Animal bites
Anthrax
Botulism
Brucellosis
Chancroid
Chickenpox in adults
Cholera
Diarrhea of newborn
Diphtheria
Encephalitis:
  Primary
  Post infection
Food poisoning
Gonococcal infection:
  Urethritis
  Vulvovaginitis
  Ophthalmianeonatorum
Granuloma inguinale
Hepatitis:
  Infectious
  Serum
Industrial or occupational diseases
Leprosy
Leptospirosis
Lymphogranuloma venereum
Malaria
Measles
Meningococcal infection:
  Meningitis
  Meningococcemia
Meningitis, other
Mumps
Plague
Poisoning or adverse reactions from drugs or other toxic agents
Poliomyelitis
Psittacosis
Rabies
Rheumatic fever
Rocky Mountain spotted fever
Rubella
Rubella syndrome, congenital
Salmonellosis, including typhoid and paratyphoid
Shigellosis
Smallpox
Staphlococcus infection, newborn
Streptococcal infection, including scarlet fever
Syphillis
Tetanus
Trichinosis
Tuberculosis
Tularemia
Typhus fever
Whooping Cough
Yellow fever

030201—"The above list of reportable diseases was adopted by the Board, December 30, 1965, and may be changed at any time by action of the State Board of Health and Mental Hygiene."

030202—"All cases of the following are to be reported to the local health department immediately by telephone:

"Animal bites, Anthrax, Botulism, Chickenpox in adults, Cholera, Food poisoning, Leprosy, Plague, Rabies—in animal and man, Smallpox, Typhus.

"On receipt of notification of any of the above diseases or occurrences, special instructions for control will be issued by the local health officer."

030203—"*An outbreak of any disease or condition, of known or unknown etiology,* which may be a danger to public health, *occurring in three or more persons,* or any unusual manifestation of a disease in an individual are *to be reported to the local health officer* who shall in turn notify promptly the Commissioner of the State Department of Health."

030204—"The following diseases are to be reported weekly by the total number of cases and not by individual case reports in accordance with instructions issued by and on forms provided by the State Department of Health: Measles, Mumps, Rubella, Streptococcal infections, including scarlet fever."

030205—"All other reportable diseases not mentioned in 030202 and 030204 are to be reported promptly to the local health department or the State Department of Health by individual case reports, *in accordance with instructions issued by and on forms provided by the State Department of Health.*"

REGULATIONS APPLICABLE TO HOSPITALS, NURSING HOMES/EXTENDED CARE, NURSING HOMES/LONG TERM CARE AND TO PERSONAL CARE HOMES

2402—"Reports of Disease. The occurrence of an infectious disease, food poisoning or dysentary, shall be reported immediately by the examining physician to the local health department and to the Department."

In addition to the examination of these laws and regulations, the Committee also received and examined copies of the Communicable Disease reporting card

distributed by the Department of Health and Mental Hygiene, as well as the one used by the Baltimore City Health Department.

It also examined the Principal Nursing Home Physicians Agreement, as well as the Patient Care Policies that are required to be posted in each nursing home by State Regulation. A copy of a memorandum at Gould Convalesarium dealing with emergency communicable diseases and mental illness regulations was also made available.

For the purposes of this particular charge, the Committee determined that an absolute minimum of 48 hours was required before a confirmed diagnosis of Salmonellosis could be made and the appropriate action taken in accordance with these regulations.

CHRONOLOGICAL SEQUENCE OF THE PROBLEM

On Sunday evening, July 26, a few cases of diarrhea were noted in the Gould Convalesarium. On Monday, July 27, about 50 cases were present, followed by 25–30 additional cases on Tuesday, July 28. The number of cases then increased in smaller numbers until a total of 108 patients out of the 144 in the nursing home were symptomatic. While diarrhea was noted in several persons on Sunday evening, July 26, the examination of the medical records at the nursing home indicated that one patient had such diarrheal symptoms on Friday, July 23; and another patient had been bothered with diarrheal symptoms since April of 1970.

On Tuesday, July 28, one of the physicians at the home ordered cultures taken on two of his patients. Another physician also ordered a culture taken on his patient on the same date. These cultures were transmitted to a private laboratory on Wednesday, July 29. On July 29, an additional two cultures were taken and sent to the State Department of Health Laboratory; and four more cultures were sent to the State Department of Health Laboratory on Thursday, July 30.

In an interview with the administrator of the nursing home, it was stated that the Principal Nursing Home physician was notified of the outbreak on Monday, July 27; and that all individual physicians with diarrheal patients in the institution were notified on the same date. All responded promptly in initiating treatment for their patients.

On Monday, July 27, at 6:00 a.m., an employee of the nursing home presented herself to The Johns Hopkins Hospital with symptoms similar to those of the patients in the nursing home.

On Tuesday, July 28, Mitchell Gould, the owner of the nursing home, contacted Miss Sara Hawkins, Hospital Advisor of the State Department of Health to request a transfer of beds from one category to another. During this conversation which occurred early in the morning (approximately 7:00 a.m.), Mr. Gould indicated to Miss Hawkins there was a large number of cases of diarrhea in the home. Miss Hawkins, in the afternoon of that same day, visited the Gould Convalesarium for the purpose of verifying the suitability of the bed transfer application (this was done promptly because of already scheduled nursing home activity in that area). On arrival, she noticed a posted sign "No Visitors" on the door of the home.

In discussing this with Mr. McKenna, assistant administrator, she requested the nursing home operator to notify the State Department of Health of the epidemic in writing.

She stated to the committee that, although she knew about the outbreak of diarrhea, she was not alarmed sufficiently to report it to her superiors, and in addition, she was under the pressure of filming a documentary on nursing homes.

On August 4, the organisms sent to the private laboratory were reported as one "Proteus Mirabilis" (Negative as to Salmonella); and two were identified as positive for Salmonella Group D.

On Friday, July 31, Mr. Gould hand-carried a letter to the State Department of Health, dated July 28th, communicating information as to the epidemic outbreak of diarrhea. On this same date, at about 3:00 p.m., the City Health Department was notified by Johns Hopkins Hospital through a telephone communication that the employee from Gould Convalesarium had been identified as having Salmonellosis.

At about 4:00 p.m., the same day, Jean Stifler, M.D., Acting Commissioner of Health for the State was notified by the State Laboratory Division that Salmonella Group D had been isolated from the culture grown on the specimen from the nursing home collected on Wednesday, July 29.

The Division of Communicable Diseases, headed by Howard Garber, M.D., was then contacted by Dr. Stifler, who in turn contacted Dr. Harbold for permission to bring in experts from the U.S. Communicable Disease Center, in Atlanta, as well as a consultant from the University of Maryland School of Medicine to advise on treatment of the patients. Permission was immediately granted and from that time on a specific disease entity was being treated.

COMMITTEE ACTIVITY

The Committee held a total of four meetings. The first meeting was devoted to orientation given by its two consultants, John B. De Hoff, M.D., of the City Health Department; and Howard Garber, M.D., of the State Health Department.

The second meeting was held at the Gould Convalesarium for the purpose of examining the material indicated earlier in this report; as well as examining the patients' records.

The charts of 30 patients who died were examined by the Committee members present; as well as 10 charts of patients who were ill during the epidemic but survived. These charts were all selected at random.

There was no essential difference in the therapy provided the two different categories of patients. As was indicated earlier in this report, all physicians, when notified of the illness of their patients, responded promptly and initiated therapy.

The Committee selected four physicians, two of whom were responsible for the majority of the patients in the home. Each was interviewed personally and asked to describe, to the best of his knowledge and recollection, the events as he saw them. All responded to the questions posed to them.

A fourth meeting was held to discuss the final action and recommendations of the Committee.

It has been ascertained that:

1. Communicable Disease Reporting regulations are published by the State Department of Health and according to the State Department of Health, communicated to all Principal Nursing Home Physicians and to all nursing homes.

2. References are made in the law and in these regulations as to the manner of reporting. In some cases it is by telephone and in others "upon the forms provided for that purpose by the State Department of Health," and in other cases the method is not specified.

The State Department of Health form varies from that provided to the physician by the City Health Department. The essential differences are:

(a) The State form requires reporting of "food poisoning outbreak"; the City form does not.

(b) The State form requires reporting of "an outbreak of any disease or condition of known or unknown etiology . . . occurring in three or more persons . . ."; the City form does not.

References can be found in the law and regulations to physicians reporting, to local health officers reporting; regulations are specific as to reporting, but do not specify in all cases who should do the reporting. Here again, reference is found to reporting on ". . . forms provided for that purpose by the State Department of Health, to the local health officer, who shall in turn report on the prescribed forms to the Commissioner, State Department of Health."

COMMITTEE FINDINGS

The Committee finds there is considerable confusion as to what should be reported, how it should be reported and by whom. This is particularly true for patients who are in an institutional setting such as a nursing home or hospital where it is quite feasible that physicians could be treating their individual patients, some of whom could have a "disease or condition of unknown etiology." It is conceivable that there could be many more than three cases of such "unknown etiology" in an institution before it could be recognized as of "epidemic proportions."

In the specific case under investigation, the owner of the institution apparently felt he had, indeed, reported to the State Department of Health when he discussed this with the Hospital Advisor on Tuesday, July 28.

While the Committee believes there was violation of the State Health De-

partment's regulations in not reporting an "outbreak of . . ."(a) condition of unknown etiology . . . occurring in three or more persons . . ." this must be shared equally by the owner of the Convalesarium, the Administrator at this institution and those physicians who had three or more patients under their care with diarrheal symptoms. There was no violation of the Baltimore City Health Department's regulations in this regard as manifested by the absence of this category on the physicians' reporting form.

The Committee further believes there was a violation of Section 2402 of the Maryland State Department of Health Regulations Governing Nursing Homes, i.e.:

"2402—Reports of Disease. The occurrence of an infectious disease, food poisoning or dysentery, shall be reported immediately by the examining physician to the local health department and to the Department."

The Committee further notes that a copy of this Regulation is sent only to the Principal Nursing Home Physician.

Insofar as the reporting of the Salmonella outbreak is concerned, it was evident that all involved City and State Health Department officials were aware of this on Friday, July 31, when the first positive report of Salmonella, Group D, was identified by the State Health Department. It would have been redundant on the part of the physicians or others to notify the City or State Health Department of a fact they already knew.

The Committee does not recommend any disciplinary action to the Commission on Medical Discipline but this report is being referred to the Commission for its review.

The Committee feels that certain recommendations should be considered by the appropriate authorities.

RECOMMENDATIONS

1. Laboratories which identify specimens positive of Salmonella or other diseases that have the potential of Salmonella should report this promptly by telephone to the patient's physician.

2. Communicable Disease reporting forms published by the City and State Health Departments should be uniform as to procedure, content and subject.

3. Procedures should be established for institutions so that when incidents occur involving three or more patients, there will be a definite responsibility on the part of the Administrator of that institution to notify appropriate authorities in accordance with regulations in effect.

4. Penalties should be added to the Nursing Home Regulations to provide for effective enforcement of reporting requirements on the part of institutions.

5. All regulations and statutes dealing with reporting should be reviewed to ensure conformity, repealing those sections that are redundant; and updating others with language that is clear and concise.

6. The Board of Medical Examiners and the Board of Examiners of Nursing Home Administrators should include in their examinations a section dealing with knowledge of communicable disease reporting laws and regulations.

7. Every effort should be devoted to education of all professions involved so as to recognize fully their responsibilities under any reporting regulations or laws that are adopted.

8. Nursing Home regulations should clearly define the responsibilities of the Principal Nursing Home Physician. It is suggested that this title be changed to that of Medical Director; and that he be responsible for all medical policies within the institution. The Faculty's Nursing Home Liaison Subcommittee has already developed a protocol outlining the responsibilities and duties of the Medical Director in Nursing Homes.

Respectfully submitted,

JOHN F. SCHAEFER, M.D.,
Chairman for the Committee.
J. RAYMOND GLADUE, M.D.
PAUL F. GUERIN, M.D.
WILLIAM A. PILLSBURY, M.D.
GEORGE SHARPE, M.D.
JOHN B. DE HOFF, M.D., *Consultant.*
HOWARD GARBER, M.D., *Consultant.*

[Exhibit 4]

OCTOBER 8, 1970.

To: NEIL SOLOMON, M.D., Ph.D., Secretary, Department of Health and Mental Hygiene
From: RUTH L. MURPHY, Medicare Coordinator
Re: The Gould Convalesarium Hearings

In response to your request and because of a desire on my part to explain my testimony I am giving you the attached report.

It would be much easier for me to explain my comments if I had a copy of the transcript before me. Since I do not, if I may later receive a copy I should like to have the opportunity to make further comments.

Here are the facts:

As Medicare Coordinator I must coordinate the activities of surveyors who perform services for Title XVIII certification. These surveyors include: four physicians, nine hospital advisors, two consultant dietitians, one public health nurse, one radiation specialist, one laboratory scientist IV, one occupational therapist, one medical secretary.

I serve as liaison between the Maryland State Agency and the Social Security Regional Office. Also, I must work with Blue Cross, Mutual of Omaha, G.H.I., etc., intermediaries in the Medicare Program.

Certifications cover hospitals, extended care facilities, home health agencies, independent laboratories, and physical therapy outpatient services. Since the inception of Medicare I have received education from the Federal Government as to procedures and documentation necessary to accompany a recommendation.

I coordinate activities of professional personnel but I make no professional judgments. All but one of the surveyors involved in the program do their utmost to cooperate with me and with the facilities. It is my belief that the major portion of the facilities are surveyed properly. I do not agree that our program has been a "toothless tiger" but in my opinion it has had an "uneven bite" in certain areas.

My testimony referred to the various *surveys* appearing in the folders of the Gould Convalesarium. I believe your review of the folders would reveal that there are some "lenient" surveyors and some "strict" surveyors. It is my belief that the facility which has assigned to it a "lenient" surveyor is being cheated by not receiving necessary guidance, consultation, and surveillance. How can a home improve its services if there is not "one voice" coming from the various disciplines of the State Agency which requires the home to provide the proper level of care for all patients admitted?

How can monies spent by the State Agency for dietary consultation be justified if no action is required after recommendations are made?

The forceful, tenancious but understanding surveyor is the friend to the facility and the State Agency, and a source of comfort and protection for the patient.

[Enclosure]

DEPARTMENT OF HEALTH AND MENTAL HYGIENE,
DEPARTMENT OF HEALTH,
Baltimore, Md., October 9, 1970.

To: NEIL SOLOMON, M.D., Ph. D., Secretary, Department of Health and Mental Hygiene.
Through: HERBERT G. FRITZ, Chief, Division of Medical Facilities Development.
From: RUTH L. MURPHY, Medicare Coordinator, Division of Medical Facilities Development.

On August 21, 1970, I received at my desk a release which stated in part "The inquiry, Dr. Solomon said, is to develop all the facts involving persons connected with the operation of the home, the treatment of the patients, and inspection of the facilities."

Prior to your order for the fact finding inquiry, Mr. Fritz, on August 14, 1970, gave Mr. Noren, Special Assistant Attorney General, a list of persons and agencies associated with the operation of the home or responsible for inspections and/or consultation to the staff of the home.

MR. FRITZ'S LIST OF PERSONS CONNECTED WITH THE OPERATION OF THE HOME

"Miss Sarah Hawkins, Hospital Advisor on the Division staff is responsible for the geographic area in which the Convalesarium is located.

"Mrs. Del Lloyd, Consultant Dietitian for the Division has been inspecting food service.

"Baltimore City Health Department personnel have been inspecting sanitary conditions.

"The Principal Physician is Dr. Harold V. Harbold, 4706 Harford Road, Baltimore, Maryland. His relief is Dr. Albert Bradley. Also, the personal physicians of the affected patients.

"Key personnel in the home: Mr. Mitchell Gould, Mr. John McKenna, Mrs. Romaine H. Holmes, R.N., Charge Nurse.

"Attached is a list of vendors of food which was compiled by Mrs. Lloyd on a recent visit to the Convalesarium.

"If the investigation is planned to extend beyond the Salmonella outbreak, you may wish to call the following:

Mr. William F. Lang, Chief, Division of Physical Therapy.

Baltimore City Fire Prevention Bureau.

Blue Cross as the Intermediary for Federal payments."

Although Mr. John McKenna's name was submitted to Mr. Noren, Mr. McKenna never testified.

Attached to this memorandum is a form entitled "Pre-License Application Supplement". This form was submitted to the Division of Medical Facilities Development on April 15, 1970, indicating that Mr. John Patrick McKenna had been named Administrator of the Gould Convalesarium.

The Hospital Advisor's report of July 28, 1970, states "Mr. McKenna was advised to return his current license and request it be increased to include the 8 ICF A beds. He was requested to send not only the staff for the ICF A unit but for the skilled section as well". This indicates that the Health Department representative recognized Mr. McKenna as the administrator of the facility. Mr. Fritz's memorandum of August 6, 1970 contains the following statement about his telephone call to Mr. McKenna on July 31, 1970.

"A call to the Convalesarium to Mr. McKenna produced the following information on deaths: July 28, 1; July 29, 3; July 30, 3; July 31, 2.

"Eight of the nine deceased had had diarrhea and vomiting."

It would appear that Mr. Fritz recognized Mr. McKenna as the Administrator of the facility. The writer is of the opinion that Mr. McKenna had more first-hand information about the salmonella outbreak than Mr. Gould. Mr. Fritz had to speak by telephone to Mr. Gould who was *away* from the Convalesarium on July 31, 1970 while Mr. McKenna was on the scene administering the home.

Who decided to omit testimony by Mr. McKenna?

THE ROLE OF THE CONSULTANT DIETITIAN

Mrs. Del Lloyd, Consultant Dietitian, whose name was sent to Mr. Noren, *was never asked to testify* although she was present at the hearing.

Mrs. Lloyd has more than likely made more official visits to the Gould Convalesarium than any person who was asked to testify. I am attaching copies of reports by her so that you may see that she was patient but persistent in her efforts to upgrade the dietary services of the home. She got no support from the Hospital Advisor who recommends the licensing of the facility. The Dietitian went to the Hospital Advisor with the request that some of the nursing staff (it was reported by the Advisor that there were hours in excess of the minimum) be assigned to the dietary service which was short of the required personnel. This was desirable in order that the confusion as to responsibility could be eliminated and it would have paved the way for better dietary inservice training. No cooperation was given and the Hospital Advisor on November 26, 1969 made recommendation for license to be issued without assuring herself that there were qualified nurses on an around-the-clock basis and without a review of the State Consultant Dietitian's report.

Mrs. Lloyd and the other two Consultant Dietitians in the State Health Department are familiar with the names of food vendors to nursing homes and hospitals. They have general knowledge gathered over a number of years as to the quality provided by vendors to the various homes.

It is inconceivable to me that a new employee in the Department would be asked to testify on vendors when he has not worked in the nursing home field nor in the dietary area.

Who made the decision to omit the dietitian's testimony and include an investigator unfamiliar with nursing home requirements?

THE SIGNING OF THE PRINCIPAL PHYSICIAN AGREEMENT

A Principal Physician agreement, dated October 31, 1969, signed by Harold V. Harbold, M.D. states:

"As Principal Physician I will respond to calls for emergencies when patients' personal physicians cannot be located.

I will serve in an advisory capacity on medical policies with regard to the ordering and administration of medications and the maintaining of adequate medical records.

I will also assist in making medical decisions, such as whether or not a patient is ambulatory or non-ambulatory; whether or not a patient should be admitted; and when patients should be removed from the home.

Dr. Artigianni has agreed to serve in the capacity mentioned above when I am unable to respond."

The "relief physician" named on this agreement is Dr. Artigianni. *Should he have testified?*

It is true that Dr. Albert Bradley's name appears on the application for license as Relief Physician, but he had not signed an agreement. *The differences in this information should have been reconciled by the Hospital Advisor* prior to issuance of a license to the facility.

RESPONSIBILITY FOR REPORTING

Early in the hearing, Mr. Fritz was questioned by Mr. Noren as to where the responsibility lies for the reporting of communicable disease. Mr. Fritz's answer was with the institution and that the Principal Physician was an agent of the institution. Mr. Noren sharply questioned Mr. Fritz to the point that Mr. Fritz was unable to quickly find (in addition to Section 2402) a regulation (-0502) which states:

"Licensees shall keep such records and make reports as the Board shall prescribe and all such records shall be open to inspection by the Board".

When the regulations governing nursing homes were revised (January 1, 1967), it was with the advice and approval of the Health Department legal counsel that the above quoted regulation would cover an old regulation which stated:

"031501—Any occurrence, such as epidemic outbreaks, poisonings or other unusual occurrences which threaten the welfare, safety or health of any patient admitted to any institution covered by the hospital licensing law, or the Regulations and Standards pertaining thereto, shall be immediately reported to the State Board of Health and Mental Hygiene. The institution shall furnish such information related to such occurrences as the State Board of Health and Mental Hygiene may require".

A review of the licensing folders would indicate to you that this is *still* an administrative procedures which is followed by many homes and which Hospital Advisors have full responsibility to enforce.

During the hearing, the regulations were sent up to Mr. Noren with Section 0502 bracketed. He tossed the regulations on the table and made no mention of the reference although previously he had questioned Mr. Fritz as to why he felt the institution had any responsibility.

REGULATION 43G02, SECTION 0701 STATES: LEGAL RESPONSIBILITY, THE LICENSEE SHALL BE LEGALLY RESPONSIBLE FOR COMPLIANCE WITH APPLICABLE LAWS AND REGULATIONS

As an example of a report of an "incident", there appears in the folder of the Granada Nursing Home a report from the Administrator regarding an incident when the police had to be called upon. This is a new home but apparently the Hospital Advisor has already advised them of the importance of reporting "incidents".

Had Mr. Noren questioned Miss Hawkins with the same gusto he questioned Mr. Fritz about the responsibility for reporting, I believe he would have learned that she knows that the home is responsible for reporting incidents, accidents, epidemics, etc. Also, Mr. Noren could have spoken with Mr. Hubert, the person who is making the nursing home documentary to determine how much of Miss

Hawkins' time was required by him during the period from July 27, 1970 to July 31, 1970. Mr. Hubert was present at the hearing.

Mr. Fritz's memo to Mr. Noren (August 14, 1970) also contains this statement:

"Baltimore City Health Department personnel have been inspecting sanitary conditions."

On May 26, 1970, a sanitarian for Baltimore City, Mr. W. Norman Glenn, made this recommendation to Mr. McKenna, Administrator.

"Thoroughly sanitize by scrubbing and washing all rooms, including the furnishings, that harbor urine or other nuisance odors (Second Floor rooms 211–227 and some third floor rooms."

Why was Mr. Glenn omitted from the hearing procedure? (Mr. Williar is the sanitarian for food service.)

In summary, the only persons on the list submitted to Mr. Noren who were asked to testify were:

Miss Hawkins, Hospital Advisor.

Mr. Williar, Sanitarian (Food Service) from Baltimore City Health Department.

Dr. Harbold, Principal Physician.

Dr. Albert Bradley, Relief Physician.

Mr. Gould (who was at the time administering his new Hilton Nursing Home).

Mrs. Romaine Holmes, R.N.

Six persons testified out of a possible 14 or 15 on the list who had firsthand experience with the home. I think this is in conflict with your request that the inquiry should develop all the facts.

I do not know what the criteria was for witnesses to participate as "consumers". I do know though that as a follow-up on a complaint regarding the facility, Mr. Louis E. Schmidt, Assistant Attorney General (February 27, 1970) wrote a letter to Charles S. Armetta, 1624 Loch Ness Road. This letter states in part:

"The State Department of Health as a result of your complaint has placed Gould Convalesarium under additional survey."

"Your complaint set forth variable situations that could happen at any home, but this is no excuse for the unkempt area of the home."

The background of this complaint is:

September 15, 1969.—Mr. Schmidt sent the complaint to the Division of Medical Facilities Development.

March 6, 1970.—Miss Hawkins investigated the complaint and wrote:

"If there were reasons for complaint, they did not exist at the time of the visit."

Mr. Fritz reported on the complaint to Mr. Schmidt March 10, 1970.

I have not seen a transcript of the hearing. I believe Miss Hawkins reported that she visits a friend in the facility every week on Tuesday and Thursday evenings. If this is so, why did it take her almost six months to investigate a complaint? During the interim period there were reminders (both telephone and written) which took time of employees who could have been accomplishing their own work instead of checking on Miss Hawkins' activities and making attempts to locate her.

Miss Hawkins provided names of witnesses for the home. If she felt there was no reason for complaint she should have suggested Mr. Armetta's name.

I do not know whether or not the consumers who testified were given written questions prior to the hearing. I do know that Mr. Fritz was given a list of questions on which he prepared answers. Also, on the morning of the hearing, I was told by Miss Hawkins that she would have to have available the letter from Mr. Gould, dated July 28, 1970. I removed this from the file in order that she could respond to a request to make it a part of the record. This appeared to me to be a "staging" and in my definition of "whitewash", I would include "staging" or a "glossing over of flaws". I have never before attended a hearing in which the entire record of the licensed facility was not made available to those making inquiry. The survey report from reflecting the team visit to the home was not even made a part of the record.

One afternoon, prior to the hearing, Mr. Fitz called me into his office to give him an explanation of the comments which appeared in an activity report (8/4/70) prepared by Jane Hartman, R.D. Prior to that time I had not seen this report:

The second paragraph of the report states:

"In the afternoon, in the office there was a conference with Ruth Murphy, Division of Medical Facilities Development, concerning the salmonella situation at

the Gould Convalesarium. It was decided that the facility should not be visited during the present week but that an unscheduled visit should be made during the week of August 10. *This facility has never met the State's Standards and Regulations with respect to food distribution. Food is not distributed in enclosed carts. It is not known whether or not this fact enters into the present emergency situation.*"

I explained to Mr. Fritz that on August 4, 1970, Miss Hartman had told me she was available to visit the Gould Convalesarium. I replied that since Mrs. Lloyd had been working with the home I believed it better for her to make the survey requested by Social Security. I told him that I would not have commented on open carts as I was very much aware of Mr. Fritz's policy of requiring closed carts only when a new home was involved.

Mr. Fritz told me that Mr. Rosebaum wanted to know who I was and what this was all about.

I told Mr. Fritz I would rather defend myself personally rather than have an intermediary or interpreter. I did not get the chance to do so and I do not know "who" Mr. Fritz said I was.

Mr. Fritz chastized me several times about two comments Mrs. Lloyd had made in unofficial reports on the Gould Convalesarium. He also told Mrs. Lloyd she should not make this type of comment (see example which is in italic).

"It was obvious that State Consultant was being detained in Administrator's office—while kitchen was 'tidied up'."

"Mr. McKenna was in kitchen dripping with perspiration when we (Mrs. Holmes and R. D.) arrived. Sanitation was poor—wet cardboard on kitchen floor in dish room—silverware being handled incorrectly. Cooks' uniform and apron soiled. Tapioca half served—standing at room temperature.

"(At the time of this visit (August 19, 1970, 3 to 4 p.m.) there were *two* dietary employees to complete lunch; clean up; prepare and serve supper and wash dishes and clean kitchen).

"(Jelly omelette was all prepared, sitting at 3:45 p.m.)"

Although Mr. Fritz showed his displeasure to me and Mrs. Lloyd about this type comment, I do not see the harm in a consultant making a note for our own file *unless a member of the staff divulges information which is confidential.* It would seem that Mr. McKenna needs to realize that just being "in order" at the time of a visit from the Health Department is *not* the answer for nursing home administration. We have no reason to disobey orders about discontinuing such comments but I still do not understand it.

HOSPITAL ADVISORS' REPORT

Attached to this memorandum is a report of a visit to the Gould Convalesarium made by a "substitute" Hospital Advisor. She was sent to make the survey because of annual leave status of Miss Hawkins and Mr. Tarutis on December 4, 1968. Even though a Hospital Advisor is usually reluctant to make recommendations in the home covered by another advisor, on this occasion, this Hospital Advisor was compelled to request improvement.

After making the visit on December 4, 1968, the Hospital Advisor marked the log sheet "Hold license for another visit". She made 10 recommendations for improvement in operation of the home:

1. Put social service records on all charts.
2. Put patient care policies in better order.
3. Have pharmacist properly label all drugs.
4. Destroy all outdated drugs.
5. Move all beds away from the wall.
6. Keep linen closets in better order.
7. Remove equipment from bathing areas after use.
8. Keep floors clean and free from urine.
9. Keep janitor's closets clean.
10. Improvement must be shown in care of patients on the third floor before a license can be granted.

Mr. Gould and Mrs. Holmes signed the copy of the above recommendations left at the home.

A follow-up letter from Mr. Fritz dated December 10, 1968 was sent to Mr. Gould, setting forth the recommendations and stating: "Report to this office

when corrections have been made. A follow-up visit then will be made to establish a basis for a decision on the renewal of your license."

Eight days later, December 18, 1968, Mr. Gould responded that he had accomplished the needed corrections. On December 23, 1968 the license was issued without the recommended revisit.

If you will review the report of the Hospital Advisor which accompanied the above recommendations, you will find that this Hospital Advisor was of the opinion that there was insufficient nursing care on the third floor of the facility. She remarked:

"As I made rounds through the home, I found several patients on the third floor who apparently are not receiving the needed care. Some patients who were incontinent had not been changed for a period of time. In some rooms the odor of urine was strong. Decubiti were found on the buttocks, and/or heels, and/or ankles of several of these patients. Some were wet and others also were lying in fecal matter. Seventeen patients are feeding problems and must be fed."

Throughout the file folders of the Gould Convalesarium there are references, complaints, reports, etc. as to the lack of care on the third floor of the facility. This was also a concern of the Hospital Advisor who visited in 1968.

If a revisit had been made instead of accepting a letter from Mr. Gould that everything had been completed, the following recommendations probably would not have appeared in the comments made by the survey team in August, 1970.

HOSPITAL ADVISOR DECEMBER 1968

There is no policy requiring routine physicals on personnel. Routine chest X-rays are required.

Destroy all outdated drugs.

Some drugs were not properly labeled and some were outdated.

Put Social Service records on all charts.

SURVEY TEAM AUGUST 6, 1970

Physical Therapist Consultant commented that there is no evidence of adequate health supervision such as results of pre-employment and periodic physical examination, including chest X-rays, and records of all illnesses and accidents occurring.

Dietitian found food handlers' health records not current.

Discharged patients' medications were given in case of emergency.

Social Service notes not maintained for each patient.

When Miss Hawkins made a survey of the facility November 21, 1969 she made no recommendations for the improvement of the home.

Although, I had only a few minutes to scan the photocopies of the patient care policies given to Dr. Tayback, they appeared to fit the description made by the Hospital Advisor in 1968. Her comment was:

"Patient care policies are in writing but need improvement. Policies, job descriptions, routines, etc. are mixed together in several folders. Policies do not have a heading at present; no meetings are held routinely on policies."

PHYSICIAN SERVICES

In order to participate in the Title XVIII and XIX programs, the following standard *must* be met:

"The extended care facility has written policies which are developed with the advice of (and with provision for review of such policy from time to time by) a group of professional personnel, *including at least one or more physicians* and one or more registered professional nurses, to govern the skilled nursing care and related medical or other services it provides. Policies reflect awareness of and provision for meeting the total needs of patients (1) These are reviewed at least annually. (Italic supplied by writer).

Although I do not have a copy of the transcript, it was rather clear to me that the Principal Physician was telling us he had not and would not participate in the activities mentioned above. Miss Hawkins had marked this "met" and stated the last annual review was November, 1969.

NURSING SERVICE—MINIMAL COVERAGE

A computation of hours of nursing coverage is included with this report. This report reveals when the home was operating at its full capacity the coverage

was "short of the required minimum". This is contrary to Miss Hawkins' references that hours given were in excess of those required and therefore were available for dietary services.

At a meeting with Social Security representatives, after the team survey visit, Miss Hawkins was present when there was discusison and agreement on making the recommendation that because of the number of floors in the facility (3), an additional R.N. or L.P.N. should be employed to serve on the 11–7 shift. Since this recommendation was made, we have received a memorandum from Mrs. R. Holmes, R.N., that it is her professional opinion that there are enough licensed nurses employed to fill their needs. (See copy attached.)

DIETARY SERVICES

On August 18, 1967, Mr. Gould agreed to recruit a Consultant Dietitian. This agreement was not fully and satisfactorily met until *after* the salmonella outbreak.

MISS HAWKINS' REPORT OF VISIT, JULY 28, 1970

I should like to know whether or not Miss Hawkins looked at the entire facility on July 28, 1970 or whether she looked only at the terrace level. In order to properly report and recommend the certification of a distinct part for Medicare the following procedure is to be followed by the surveyor:

"Distinct part ECF's—Documentation of nursing services—"

"In order to assure that there is proper documentation for a determination on the nursing service requirement, the SSA–1569 should not only show the staff assignments and the staffing pattern for the distinct part, but also for the entire institution as well. When assignments are shared, the extent of sharing should be shown as to the percentage of time, the number of patients involved and staff responsibilities. The surveyor should, of course, supplement the information furnished him by the institution relative to assignment and staffing patterns through personal observation and interviews with nursing personnel. In addition, the basis for the determination should be explained in terms of the criteria described above in narrative form on the SSA–1569."

"Survey guides—"

"The chief criteria to be use to determine the adequacy of nursing services are the qualifications of nursing personnel and whether the nursing services provided (in terms of numbers and categories of personnel and scope of services) are sufficient to meet the nursing needs of patients."

"Information may be obtained by interviewing the director of nursing or her representative, one or more supervisors, and charge nurses assigned to different tours of duty. Visits should be made to nursing units to talk with head nurses and other nursing personnel and to observe nursing practices on the units. Some patient units should be visited to determine the physical and emotional well-being of patients and the adequacy of the patient care services being administered. Conversations with patients and one or more physicians who frequently admit patients to the facility are encouraged."

"Documentary sources of information are nursing service organizational charts, policy and procedure manuals, personnel records (for qualifications of personnel and licensure records), in-service and other educational programs, staffing schedules, patient care assignments, nursing care plans and clinical records. Job descriptions are evaluated in terms of the qualifications of personnel.

If such observations were not made in the entire facility to substantiate the recommendation for licensing and certification proper documentation was not obtained.

If she did look at the entire facility, it would seem that the distressed patients would have impressed her sufficiently to want to notify her supervisor.

Documentation for memorandum to Doctor Solomon from Ruth L. Murphy (October 9, 1970).

1. News Release—August 21, 1970.
2. Memorandum from Mr. Fritz to Mr. Donald Noren (August 14, 1970).
3. Pre-License Application Supplement (April 12, 1970) (completed by John Patrick McKenna).

4. Report prepared by Miss Hawkins on visit made July 28, 1970.
5. Memorandum from Mr. Fritz (August 6, 1970).
6. Consultant Dietitian's Reports—December 30, 1969; December 8, 1969; October 14, 1969; August 19, 1969.
7. Activity Report August 4, 1970.
8. Report by "substitute" Hospital Advisor (December 4, 1968).
9. Report by Hospital Advisor (November 21, 1969).
10. Computation of nursing hours.
11. Memorandum September 25, 1970 to Mr. Gould from R. Holmes, R.N.
12. Copy of Survey Report Form—August 6, 1970 (updated by Miss Hawkins and Mrs. Lloyd).

ITEM 2. COMPTROLLER GENERAL'S REPORT TO THE SUBCOMMITTEE ON LONG-TERM CARE, SPECIAL COMMITTEE ON AGING, UNITED STATES SENATE

(Examination into certain claimed practices relating to nursing home operations in the Baltimore, Md., area—Department of Health, Education, and Welfare B-164031(3))

DIGEST

WHY THE EXAMINATION WAS MADE

At the request of the Chairman of the Subcommittee on Long-Term Care, Senate Special Committee on Aging, the General Accounting Office (GAO) obtained information relating to certain questions raised during hearings held on August 19, 1970, by the Subcommittee regarding a salmonella outbreak in nursing homes in the Baltimore, Maryland area. The questions related to the claimed practices of:

Physicians' signing death certificates without viewing the bodies and perhaps charging the Medicare or Medicaid programs fees for signing the certificates,

Some nursing-home operators' collecting payments under the Medicare or Medicaid programs for nursing-home care for periods after patients' deaths, and

Nursing-home operators' purchasing food at prices lower than the amounts billed the Medicare or Medicaid program.

The Medicare program is administered by the Social Security Administration, Department of Health, Education, and Welfare; and the Medicaid program is adminstered at the Federal level by the Social and Rehabilitation Service, Department of Health, Education, and Welfare.

In accordance with the Subcommittee's request, GAO examined into these questions at four nursing homes in the Baltimore area. GAO did not obtain formal comments on this report from the Department of Health, Education, and Welfare; the State of Maryland; or the nursing homes visited.

FINDINGS AND CONCLUSIONS

GAO's examination revealed that in Maryland it was not an uncommon practice for physicians to sign death certificates without having viewed the bodies of patients who died in nursing homes.

GAO examined 627 death certificates, of which at least 322 were for nursing-home patients. Of these 627 certificates, only 196 indicated that a private physician had viewed the body prior to signing the certificate. GAO's inquiries revealed also that such a practice was not illegal in Maryland, nor was it considered unethical by the Medical Society of Maryland. The consensus of 17 physicians interviewed by GAO was that it was either impractical or unnecesary to view the bodies of all patients who died in nursing homes.

Most of the physicians expressed the view that the skilled nursing personnel at the nursing homes were technically qualified to determine that a patient was dead and to note any unusual developments, other than the illness for which the patient was being treated, which might have caused the death. They agreed that, if a patient's death was unexpected or otherwise suspect, the body should be examined to determine the cause of death.

Regarding physicians' charging the Medicare or Medicaid programs fees for signing death certificates, program officials informed GAO that such a fee was not reimbursable under either program.

GAO's examination of Medicare and Medicaid billing and payment records for 110 patients who died during the first 3 months of 1970 at the four nursing homes included in the review showed that, generally, physicians had not charged fees for signing death certificates. GAO's examination revealed, however, that on three occasions physicians apparently had been paid under these programs for signing the death certificates.

GAO's examination of the records of 322 Medicaid and Medicare patients who died during fiscal year 1970 identified 39 instances in which payments had been made under the Medicaid program for nursing-home care for periods after the deaths of the patients. No such payments were detected for Medicare services.

GAO found, however, that 36 of the 39 overpayments had been detected by State employees and that adjustments had been made to correct the payments prior to GAO's bringing them to the attention of State officials. While examining into the question of payments for nursing-home care for periods after the deaths of the patients, GAO found that in some cases payments had been made to nursing homes for care on the same days under both the Medicaid and Medicare programs.

Although the procedures followed by the State have enabled it to detect and correct most of the payments made for nursing-home care for periods after the deaths of the patients, additional procedures are required to help avoid payments for nursing-home care on the same days under both the Medicaid and Medicare programs.

Regarding the claimed practice of nursing-home operators' purchasing food at prices lower than the amounts billed Medicare or Medicaid, GAO found no irregularities. GAO's examination of the homes' accounting records and supporting invoices for food purchased during the month of June 1970 revealed that the food prices used in computing the daily rate for nursing-home care were not higher than the prices paid for the food. GAO noted, however, that Medicaid audits required by the State were not being made at three of the four nursing homes visited.

RECOMMENDATIONS OR SUGGESTIONS

GAO believes that weaknesses noted during its limited examination in Maryland may exist in other States as well. The probability that such weaknesses exist in other States is supported by prior work done by GAO and by the Department of Health, Education, and Welfare Audit Agency.

To help improve controls over payments to physicians and nursing homes for care of Medicare and Medicaid patients, the Social Security Administration and/or the Social and Rehabilitation Service need to assist the paying agents under the Medicare and Medicaid programs in:

Making a study of the feasibility of establishing procedures to ensure that payments are not made to physicians for signing death certificates, which is an unallowable cost, and

Establishing controls to ensure that duplicate payments for the same services are not made under the programs.

Also, the Social and Rehabilitation Service needs to improve its monitoring of the States' administration of the Medicaid program, to ensure that required audits of nursing-home costs are made.

Appendix B

ADDITIONAL MATERIAL SUBMITTED BY MITCHELL GOULD, EXECUTIVE DIRECTOR, GOULD CONVALESARIUM, BALTIMORE, MD.

ITEM 1. SUMMARY, BY PATIENT, OF ONSET OF ILLNESS, NOTIFICATION OF PHYSICIAN AND INITIATION OF TREATMENT BY PHYSICIAN

Patient	Age	Doctor	Initial symptom	Date notified	Response
Mueller, Simon	85	H. J. Koetter	Aug. 12	Aug. 12	Aug. 12 phone.
Burrill, Claude	87	Harbold	July 27	July 27	July 27 visit.
Creamer, Helen	77	Bradley	do	do	July 27 phone.
Ankenbauer, Eliz	79	H. Goodman	do	do	Do.
Moxley, Albertina	70	W. Wong	do	do	July 27 visit.
Dobson, Byrd	86	R. J. Hills	do	do	July 27 phone.
Willis, Closter	83	Bradley	July 29	July 29	July 29 visit.
Hunter, Mabel	93	J. E. White	July 28	July 28	July 28 visit.
Garrity, Raymond	80	Harbold	July 29	July 29	July 29 visit.
Scherer, Maude	83	Baumgardner	July 30	July 30	July 30 phone.
Souder, Cora	84	Bradley	(1)	(1)	(1)
McArthur, Helen	66	Harbold	Aug. 1	Aug. 1	Aug. 1 visit.
Austin, Helen	76	Jandorf	Aug. 2	Aug. 2	Aug. 2 visit.
Young, Mollie	70	Harbold	Aug. 3	Aug. 3	Aug. 3 phone.
Sautter, Edward	88	L. B. Stevens	Aug. 4	Aug. 4	Aug. 4 phone.
Chenoweth, Leo	80	White	July 28	July 28	July 28 phone.
Grabill, Grace	93	Goldstone	Aug. 3	Aug. 3	Aug. 3 phone.
Brown, Donna	80	Stevens	July 28	July 28	July 28 phone.
Nicholas, Emma	76	MacMinn	July 29	July 29	July 29 phone.
Devon, Mae	76	Harbold	July 30	July 30	July 30 visit.
Cocke, Stanley	83	Bradley	July 27	July 27	July 27 visit.
Vhenoweth, Emma	80	White	do	do	Do.
Vandusen, Chester	75	Bradley	do	do	Do.
Boeckl, Anna	86	do	do	do	Do.
Warehime, Nellie	76	Harbold	do	do	Do.
Rhodes, William	84	do	July 29	July 29	July 29 phone.
Schaake, Mary	86	Klimes	Aug. 4	Aug. 4	Aug. 4 visit.
Schultheis, Henry	85	Karfgin	July 27	July 27	July 27 phone.
Bechtold, Ida	80	Lyden	do	do	Do.
Newnan, Emma	78	Stevens	do	do	Do.
Heil, Mary	75	Jandorf	July 29	July 29	July 29 phone.
Gatzke, Bertha	80	Bradley	July 27	July 27	July 27 phone.
Bagley, Mary	87	do	do	do	Do.
Uhlan, George	75	Kasik	July 28		
Moran, Rose	78	Bradley	do	do	July 28 phone.
Dunphy, Madeline	64	Harbold	(1)	(1)	(1).
Smith, Edna	81	Artigiani	July 28	July 28	July 28 visit.
Heintzelman, Paul	75	Klimes	(1)	(1)	(1).
Morawe, Johanna	88	Haase	July 29	July 29	July 29 visit.
White, Grace	84	Jandorf	July 27	July 27	July 27 phone.
Thorp, Reider	75	Bradley	(1)	(1)	(1)
Miller, Harry	88	Mintzer	July 27	July 27	July 27 visit.
Marcus, Mary	77	Harbold	July 28	July 28	July 28 phone.
Brinkman, Florence	87	Lyden	July 27	July 27	July 27 phone.
Heisterhagen, Louis	83	Wong	July 28	July 28	July 28 visit.
Smith, William	75	Bradley	July 29	July 29	July 29 phone.
Barnett, Barbara	75	Sadaranda	do	do	Do.
Simpson, Robert	87	Toms	do	do	Do.
Harrison, Charles	73	Harbold	July 30	July 30	July 30 visit.
Way, Claude	67	do	do	do	Do.
Wildbarger, Maude	78	Mintzer	July 30	do	Do.
Pridham, Nellie	100	Anderson	July 31	July 31	July 31 phone.
Torre, Anna	80	Alessi	(1)	(1)	(1).
Martin, Hilda	73	Harbold	July 26	July 26	July 26 phone.

See footnote at end of table.

ITEM 1. SUMMARY BY PATIENT, OF ONSET OF ILLNESS, NOTIFICATION OF PHYSICIAN AND INITIATION OF TREATMENT BY PHYSICIAN—Continued

Patient	Age	Doctor	Initial symptom	Date notified	Response
Bartram, Bessie	81	Baum	July 27	July 27	July 27 phone.
Scheib, Elizabeth	83	Harbold	July 28	July 28	July 28 phone.
Wright, Blanche	85	Bradley	July 27	July 27	July 27 visit.
Schepf, Ida	91	Harbold	do	do	Do.
Schmidt, Catherine	74	do	do	July 28	July 28 phone.
Devlin, William	75	do	do	July 27	July 27 phone.
Hussey, William	78	Wong	July 28	July 28	July 28 visit.
Spoerke, George	83	Mintzer	July 27	July 27	July 27 phone.
Diehl, Frieda	85	Haase	do	do	Do.
Crist, Robert	70	Harbold	do	do	Do.
Walters, Mary	79	do	do	do	Do.
Carroll, Helen	77	do	do	do	Do.
Wheltle, Irene	71	Russo	do	do	Do.
Moscariello, Raffaelo	73	Artigiani	do	do	Do.
Fernsner, Lula	78	Harbold	July 28	July 28	July 28 phone.
Pietrowiak, Frances	86	do	July 27	July 27	July 27 phone.
Renoff, Mary	85	Koetter	do	do	August 3 visit.
MaJane, Angela	68	Bradley	do	do	July 28 phone.
Frei, Johanna	84	Harbold	July 27	do	July 28.
Young, William	94	Bradley	do	July 29	July 29 visit.
Gardner, Louise	89	Stevens	(1)	(1)	(1).
Matusek, Mary	82	Mintzer	July 28	July 28	July 28 phone.
Pavon, John	81	Bradley	do	do	Do.
Bayrle, Johanna	76	Gaskel	do	do	Do.
Hartlieb, Genevieve	73	Harbold	do	do	Do.
McCormick, John	76	do	do	do	Do.
Monius, Margaret	87	do	do	do	Do.
Ogden, Adeline	80	do	do	do	Do.
Hart, Lillian	80	Benson	Aug. 2	Aug. 2	August 2 phone.
Wood, George	63	Harbold	July 28	July 28	July 28.
Baker, Everett	73	Artigiani	(1)	(1)	(1).
Fowler, Elizabeth	79	Harbold	July 27	July 27	July 27 phone.
Sawicki, Rose	68	Sawyer	July 29	July 29	July 29 visit.
Parsons, Wesley	84	Bradley	do	do	Do.
Schafer, Wilhelmina	75	Swiss	Aug. 2	Aug. 2	Aug. 2 phone.
Barnhart, Marie	70	Harbold	July 29	July 29	July 30 visit.
Miller, John	83	do	(1)	(1)	(1).
Ulrich, Elizabeth	88	Klimes	(1)	(1)	(1).

[1] None.

ITEM 2. PHYSICIANS TREATING PATIENTS WITH SALMONELLA SYMPTOMS AT THE CONVALESARIUM

Name of doctor	*Number of patients*	*Name of doctor*	*Number of patients*
E. J. Alessi	1	L. F. Klimes	3
W. A. Anderson	1	S. B. Klijanowicz	1
P. Artigiani	3	H. J. Koetter	2
M. Baum	1	R. J. Lyden	2
Benson	1	C. C. MacMinn	1
A. B. Bradley	16	D. W. Mintzer	4
J. H. Gaskel	1	A. Nahum	1
H. Goldstone	1	S. Russo	1
H. Goodman	1	V. Sadaranda	1
D. H. Haase	2	L. E. Saylor	1
H. V. Harbold	33	G. J. Sawyer	1
D. J. Hills	1	L. B. Stevens	4
R. J. Hills	1	A. G. Swiss	1
R. D. Jandorf	4	S. Toms	1
W. Karfgin	1	J. E. White	3
Kasik	1	W. K. Wong	3

ITEM 3. CLINICAL ASPECTS, OUTBREAK OF SALMONELLA ENTERITIS, GOULD CONVALESARIUM, JULY 1970, BY WILLIAM B. GREENOUGH, CHIEF, INFECTIOUS DISEASES DIVISION, THE JOHNS HOPKINS UNIVERSITY SCHOOL OF MEDICINE

BACKGROUND

The nature of infection by salmonella is well outlined in the recent publication by The Baltimore City Health Department*. Death can result from several causes and the very young, very old or chronically ill are particularly at risk to fatal outcome. If the organism enters the blood stream, the blood vessels, heart and any other vital organs can be infected. Such infections are characterized by high fevers and local signs referable to the particular organ or organs involved. More commonly infections are limited to the gut and the main problem is fluid loss due to diarrhea. Fever, chills and abdominal cramps often accompany such gastroenteritis. The causes of death in the case of primarily intestinal infection are all related to decreased blood volume leading to lowered blood pressure and poor perfusion of vital organs such as the brain, heart and kidneys or deranged electrolyte concentrations secondary to losses of potassium and bicarbonate.

In the current outbreak the disease was primarily an enteritis. Whether blood stream invasion occurred and contributed to some of the deaths cannot be judged without blood cultures. This data was not available to me and could be derived only from the charts of hospitalized patients.

SOURCES OF INFORMATION

1) Visit to Gould Convalesarium: Talks with Mr. Gould and members of nursing staff.
2) Review of 55 charts of patients involved in the outbreak at the Gould Convalesarium.
3) Review of one hospital record.
4) Review of one autopsy report.
5) Center for Disease Control Morbidity and Mortality Weekly Report Volume 19, Number 32, 314 (August 15, 1970).

NATURE OF THE POPULATION AND EPIDEMIC

The average age of the patients who became ill was 78 years. All of them had serious underlying illness. The most common variety was vascular with evidence of damage to brain and heart. During the 10 days from July 26 until August 3, 1970, 104 of 145 patients (72%) and 19 of 66 employees (29%) were known to have developed diarrhea. Salmonella enteritis was cultured from the stools of 25 patients and 17 employees. Twenty-five patients died with diarrheal symptoms (case fatality ratio—25%). There were no deaths among employees. There was no difference in the case fatality rate between those patients treated in the nursing home as compared to those transferred to hospitals (Table 1).

CLINICAL CHARACTERISTICS OF ILLNESS

Review of 55 charts of the most severely affected patients has indicated that although there were five deaths within 72 hours of the onset of diarrhea, the average time of death was 8.0 days after onset of diarrhea. Most of the patients dying more than one week after onset of illness had little or no diarrhea at the time of death. The average time after onset of diarrhea when patients were transferred to hospitals was 6.6 days and as noted above the mortality rate of the hospitalized patients was 6/28 or 22% which was identical with the 19/79 or 24% mortality seen in patients remaining in the nursing home. Of those patients with data available for blood pressure during the 24 hours before hospitalization only 2 out of 10 patients had sustained decreases of more than 20 mm of mercury over their normal systolic blood pressures.

The population whose charts were reviewed in detail are described in Table 2. The characteristics of the illness are summarized in Table 3. All patients had diarrhea and the majority also had fever with the diarrhea. A decrease

* Baltimore Health News, vol. *XLVII*, 121–124, Aug.-Sept. 1970.

in systolic blood pressure of more than 20 mm of mercury occurred in 17 out of 32 patients at some time during their illness where there were sufficient recordings to determine the incidence of hypotension. Hypothermia of less than 97.5° F rectal temperature occurred in 5 out of 44 instances.

TREATMENT

In general, patients were treated by increasing their intake of oral fluids. In 2 out of 53 instances intravenous replacement with electrolyte solutions was carried out. In 2 further patients clysis with isotonic saline was given (Table 4). A large number of patients (28) were sent to hospitals when their condition seemed to indicate treatment beyond the capacity of the nursing home. In most cases referral to the hospitals was accomplished before a serious drop in blood pressure had occurred, 2 out of 10 where data was available.

Most patients had very severe underlying vascular disease which had resulted in obvious brain or heart damage. Such patients were highly susceptible to any decrease in blood flow to vital organs. It is clear from the autopsy report of Mr. Robert Simpson, Johns Hopkins autopsy No. 37433 that dehydration, hypotension and resulting diminished perfusion of vital organs resulted ultimately in his death.

DISCUSSION

An overwhelming epidemic of diarrhea due to salmonella enteritis resulted in 25 deaths within a short period of time in The Gould Convalesarium. Although in the 5 cases who died within 72 hours and an undetermined number of other cases may have died because of loss of body fluids, it is striking that the majority of cases which died survived an average of 8 days. Thus the bulk of deaths cannot be attributed to simple dehydration and shock because of fluid loss. Furthermore, it is of interest that the mortality rate in those patients who were hospitalized was not significantly different from those remaining in the nursing home. This again suggests that complications related to the underlying diseases were more at fault then was simple dehydration. In otherwise healthy people with severe fluid loss due to diarrhea, replacement of the deficit, intravenously or by mouth, if shock is not present prevents all deaths. Hence, if fluid replacement was the main problem none of the hospitalized patients should have succumbed. This of course assumes that the hospitals gave the needed intravenous fluids which was true in the charts of the two hospitalized patients I have reviewed.

On the other hand, if all the patients who experienced voluminous diarrhea had an accurate appraisal of their degree of dehydration by measurement of plasma protein or specific gravity and had prompt intravenous replacement been given, it is possible that some of the complications of renal failure and cardiovascular failure might have been averted. It would not be possible to carry out such therapy in the setting of a nursing home unless a special team of physicians had been called in at the earliest indication of epidemic diarrhea. It is not likely that even with more prompt hospitalization of all cases that there would have been very much gained. The damage done by hypotension in such a population of patients is irreversible at a very early stage. Furthermore, in patients, many of whom already had heart failure, the rapid administration of intravenous electrolyte solutions is fraught with the great risks of pulmonary adema and death if used injudiciously and without proper control.

RECOMMENDATIONS FOR THE FUTURE

I believe the only really effective way to reduce mortality in an explosive outbreak of diarrheal illness such as that which occurred at The Gould Convalesarium is to know ahead of time who to call on for emergency assistance. In Baltimore there are two groups of physicians expert in the management of severe dehydrating diarrhea who could be called on to render the needed measurements and guide treatment as soon as an outbreak occurs. These are the group of The Infectious Diseases Division of The University of Maryland Medical School under Dr. Richard Hornick and the group of the Infectious Diseases Division of The Johns Hopkins University School of Medicine which is under my direction. Short of getting prompt help I think there could be little improvement over the performance of the staff of the Gould Convalesarium who actually managed a very large epidemic in an admirable fashion in light of the limited staff available.

Summary

(1) An explosive epidemic of dehydrating diarrhea did occur and can be documented from the records.

(2) When blood pressures were found to be low, patients were transferred to hospitals.

(3) Many patients were critically ill before the onset of diarrhea and although fluid loss hastened death it cannot be incriminated as the sole cause of death.

(4) People without vascular disease survived this strain of salmonella enteritis readily. The mortality mainly reflects the severity of the vascular disease in the older patients.

(5) Earlier recognition of the extent of fluid losses and more prompt hospitalization and intravenous therapy would have been helpful but would not have saved all the patients involved because of the reasons cited in 4.

(6) Laboratory measurements by which early detection and proper control of intravenous fluid therapy are the province of a hospital and should not be expected in nursing homes.

(7) In future outbreaks of this severity prompt assistance with measurements of dehydration and guidance in replacement therapy would be the most effective means to reduce mortality and morbidity. Both the University of Maryland and The Johns Hopkins University have groups of physicians possessing a large experience and high degree of current skill in managing diarrheal illness. These resources may be called in future outbreaks.

TABLE 1. CHARACTERISTICS OF PATIENTS HOSPITALIZED VERSUS THOSE NOT HOSPITALIZED

	Hospitalized	Not hospitalized
Total patients	28	76
Deaths	6	19
Case fatality rate (percent)	22	25
Mean time from onset to death	No data	8.0
Deaths in 72 hours	0	5

TABLE 2.—*Population reviewed*

Charts provided for review	55
Hospitalized from this group, outcome of these not known, 2 charts	
from hospitalizations were seen	28
Not hospitalized	27
Survived	5
Died	22
Death within 14 days of onset	21
Late death[1]	1
Death without diarrhea[1]	2
Death within 7 days of onset	16

[1] Excluded.

TABLE 3.—*Clinical data*

Diarrhea	53/53
Fever >100 degree F. (no data 10)	36/43
Drop in blood pressure >20 mm. Hg. over lowest value	17/32
Temperature <97.5 degree rectal	5/44

TABLE 4.—*Treatment*

Intravenous Ringer's lactate or saline	2/53
Clysis saline	2/53

ITEM 4, LETTER FROM DR. WILLIAM B. GREENOUGH, CHIEF, INFECTIOUS DISEASES DIVISION, TO MR. HENRY H. HOPKINS, BALTIMORE, MD.

THE JOHNS HOPKINS UNIVERSITY,
SCHOOL OF MEDICINE,
November 20, 1970.

DEAR HENRY: I have reviewed the report of Oct. 27, 1970 by the panel investigating the salmonella outbreak at the Gould Convalesarium. The key statements to my mind are on pages 2 and 5 where it is stated "This panel's report, which should not be mistaken for the exhaustive study that is demanded, is offered at this time because of a . . ." and "the panel must state at the outset, however, that it firmly believes that specific failures evident in the current tragedy are but symptomatic of the serious problems of nursing homes in general. All of the evidence suggests that the Gould home was and is a better-than-average nursing home." Hence all critical comments would apply to the whole industry and do not fault the Gould home specifically except as a member of the group. This is noted again with regard to the comments in violation of food handling (2nd paragraph p. 9). I really have no specific comments on the general aspects of nursing homes in Baltimore, as I have no special information on this subject.

With respect to item 6 on page 18 of the report "Did delays in reporting influence mortality?" I must categorically reject the idea that "earlier awareness would have altered outcome" (p. 20) as being too vague to be meaningful. As I point out in my report the very young and the very old are at a much higher risk of death due to Salmonella enteritis or any other severe dehydrating diarrheal illness. The data from this epidemic makes this clear. None of the healthy employees died, while 1 in 4 of the aged and ill patients succumbed. I further pointed out that unless a team of physicians and nurses skilled in intravenous fluid replacement had been called to the scene within hours of the start of the epidemic and appropriate measures for estimation and replacement of fluid loss instituted there would have been no effect on the mortality. This is underlined by the fact that after notification there was not a significant change in the kind of care rendered as judged from the medical records i.e. no new measurements of dehydration or increased use of fluid replacement therapy of the required nature. Arrival on the scene by health authorities did not result in the contacting of physicians skilled in the treatment of epidemic diarrhea nor did it result in the measurement of gut fluid losses or institution of measurement of dehydration by plasma protein or specific gravity. None of the patients received either the oral electrolyte therapy, well established in the treatment of cholera, nor was the intravenous therapy increased. The mortality of patients transferred later to hospitals was identical to those remaining at the Gould Home, hence this form of treatment was not very helpful. The comment that mortality was higher early in the epidemic is not surprising as it is a characteristic of epidemic dehydrating diarrheal diseases. My review of the charts indicated that the same therapy was given early as later on.

Once again I would recommend that in future situations of this sort, unless reporting results in mobilizing effective therapy in the form of rapid transfer of all, even mildly affected patients, to centers where fluid replacement can be monitored or unless physicians and nurses skilled in the measurement and therapy of syndromes with major fluid losses are mobilized promptly there will be no difference in the mortality rate of the next occurrence. With the frequency of occurrence of epidemic diarrheal disease and the growing threat of importation of cholera I believe that health authorities should make plans for mobilizing the appropriate personnel and facilities which could be called on in a matter of hours when the need occurred.

Finally, it is apparent that the hospital records of patients from the Gould epidemic were not reviewed. These were not made available to me. They, of course, contain essential data for any complete appraisal of the reasons for the high mortality rate of this particular outbreak. Without careful review of this material all statements about mortality in the hospitalized group are conjectural.

I appreciate having had the opportunity to evaluate the available information on this epidemic, but would have been far more effective if called on early in the outbreak to assist in guiding therapy. The reporting of the outbreak in this case did not result in this sort of consultation, hence the Gould Convalesarium can hardly be faulted since reporting did not generate an appropriate change in treatment.

Sincerely yours,

WILLIAM B. GREENOUGH III, M.D.,
Chief, Infectious Diseases Division.

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