Toward a Brighter Future

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WHATEVER TYPE of national health insurance finally comes out of Congress, it will place a strong emphasis on extended care facilities and similar alternatives to hospital care, primarily for the purpose of reducing costs.

This emphasis is going to place the nursing homes and homes for the aged squarely in the middle of the health and medical care delivery system. It is going to involve the homes' administrators and the members of my profession, the physicians, in a partnership. Perhaps some administrators do not conceive of their institutions as part of the health care delivery system. But the pressure to become part of the health care system is going to come, not only from government, but from the residents of homes and their families. I base that remark partly on personal experience and partly on general observations.

I serve on the board of a retirement home in North Carolina. At the outset, we never perceived of the home as any kind of nursing home or extended care facility. But it has been our experience that, unless we made specific provisions for medical care, we simply could not attract persons into the home. Looking back, I think we should have expected this. After all, concern for one's health does not diminish with age—if anything, it intensifies. This intensified concern is supported by the fact that, within 4 years of admission, 35 to 40 percent of the residents will require some medical care, and some portion of these persons will be bedridden.

Our response to this reality has been to set aside part of our facility for nursing home care. It anticipates needs before they occur, and it reassures potential residents that their medical needs will be met.

It also reassures their families, and that is not an unimportant consideration. For as more and more families turn to homes for

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for Nursing Homes

the aged and nursing homes as a home for their elderly—and that is very clearly the trend—there is going to be increased public scrutiny of these institutions. Most assuredly, the quality of medical care will be an important factor in the public judgment.

A New Partnership

As I have said, this public concern places home administrators and physicians in a partnership, and I want to discuss this relationship on several levels, including the objectives, methods of cooperation and financing, and education of the public. I think it behooves the administrators of homes for the aged and nursing homes to work out, in cooperation with physicians, a clear definition of the role of the homes in the medical care delivery system. The scope and limitations must be defined lest you in the nursing homes find, as we in the medical profession have found, that you become the victims of unreasonable expectations.

In preparing for this speech, I talked with officials of the Joint Commission for the Accreditation of Hospitals (JCAH). I learned from them that only about 10 percent—1,800 of some 20,000 homes—are now accredited. The JCAH officials informed me that lack of adequate medical supervision is the primary problem that they find in their inspections. Unfortunately, one of the major reasons for this lack is either the unavailability of a physician or lack of interest among those physicians who are available.

I recognize these lacks as a problem, and one for which my profession bears the major responsibility to correct. Maybe the final answer lies in the development of a new specialty. But that answer lies down the road a bit. In the meantime, there are some steps we in the AMA are taking to provide some immediate relief. We are undertaking both a general educational effort with our members and a specific program to develop expertise for service by physicians as medical directors.

In 1971, the House of Delegates of the American Medical Association adopted a series of 10 concepts for guidance to physicians in their care and attitudes toward elderly patients. I will not list the 10, but they are instructive for the insight they give on our professional approach to this particular portion of the population. The guidelines, which can be obtained from the AMA Committee on Aging, appear in Re-

port G of the Council on Medical Service (A–71).

Working from the base established by these 10 concepts, we are now engaged in the second phase of our educational effort. This phase is much more direct. Under a contract with the Department of Health, Education, and Welfare (HEW), the AMA Committee on Aging has launched a series of 10 seminars across the country for home administrators and medical directors. There will be one seminar held in each of the 10 regions of HEW. Each will offer 14 to 16 hours of instruction over a 2-day period. (The first seminar was held November 9–10 in White Plains, N.Y.; the series is expected to conclude in April 1973.)

The short range objective is to prepare physicians to serve as medical directors and to upgrade the skills and knowledge of those who now serve in such posts. The long range goal is to use the seminars to establish permanent State and local work groups that would have continuing responsibility for upgrading medical services in the homes. It is hoped that this activity will result in an increased supply of physicians willing and capable of serving nursing homes and homes for the aged as medical directors.

In the interim, I recommend that administrators and directors of nursing homes develop a working relationship with the local medical society. Make its members aware of the problems and needs of the homes in their area and ask for assistance in resolving them. I do not believe that any of our societies would turn a deaf ear. I would urge an open mind and a flexible attitude in working out a plan to insure adequate medical care and supervision.

Medical Director's Role

Once a home has found a medical director, what should be expected and required of him? As defined by the AMA, the medical director should have four major areas of responsibility.

1. To help define the scope and characteristics of the services provided at each level of care
2. To share in developing standards of care for each discipline, such as nursing and rehabilitation
3. To help insure quality controls
4. To assume specific responsibility for overall management and delivery of patient care services—by agreement with the administrator. I would underline that phrase "by agreement with the administrator."

To meet these objectives and to insure a relatively high quality of care will not, in most instances, require a full-time medical director. This can be accomplished if the medical director will adopt a series of guidelines developed for the seminars by the staff of the Committee on Aging.

The first guideline is to develop written policies governing care and to insure that they are executed. These policies should provide for meeting the total underlying and psychological needs of the patient.

The medical director should coordinate medical care, maintain effective liaison with attending physicians, and implement methods to keep the quality of care under constant surveillance.

In cooperation with the home's professional staff, he should develop a definition of the therapeutic goals for the patient and should assure a planned regimen of medical care for each patient —including medication, restorative services, and diet.

Finally, he should insure that each patient is receiving adequate services and that a patient will be transferred to an alternative method of care when a transfer is appropriate.

Those duties are what an administrator should expect of the medical director and what should be required of him. Insistence on adherence to these guidelines will insure the quality of care residents deserve and will eliminate or prevent a lot of problems.

Health Care and Medical Care

I have talked about medical care in the belief that that is the matter of most immediate concern to administrators in the managements of their homes. Now I want to change the perspective to health care. I have two reasons for doing so. First, we at the AMA are becoming more and more conscious of the need to draw a clear distinction between health care and medical care and to educate the American people as to the difference.

In general terms, health is largely in a person's own hands. We as physicians normally enter the picture only when there is a health malfunction. Many of those malfunctions are avoidable if only the individual will take proper care of himself. There is one other distinction—health care is relatively inexpensive; proper medical care, particularly long-term care, is not.

As extended care homes get more deeply involved in the medical care system, the economic pressures on them are going to intensify. Administrators will be seeking ways to control and reduce costs. A sound medical program employing utilization review is one way. Avoiding unnecessary medical care is another. And this can be done without in any way shortchanging the residents.

Destroying a Stereotype

We are all familiar with the stereotype that most younger persons have about the elderly. They conceive of them as being chronically ill, forgetful, and emotionally unstable. That stereotype has some validity—many older people are exactly like that. But what is not valid is the assumed cause of that condition. The cause is not age, but the conditions we impose on older persons. As Dr. Frederick C. Swartz, the chairman of the AMA Committee on Aging, testified before Congress in July 1969 (*1*):

> Forgetfulness and mental retardation result largely from lack of attention, failure to concentrate and loss of motivation. This can largely be prevented if we will continue to encourage people of all ages to maintain the habits of study learned in school. We can prevent mental deterioration by helping older people to continue in employment. Some serious reading and thinking should be a part of each man's daily life. The muscles are strengthened and the wits sharpened only by proper physical exercise and mental activity.

These daily activities, along with proper nutrition and control of harmful habits, are what I mean when I speak of health care. Proper health care will serve the interests of patients and will save money in the long run by reducing the need for medical care.

Let me now turn to the other task I have put forth for our partnership to accomplish—public education. All our other tasks are minor compared to this one, both in terms of need and in terms of successful accomplishment.

Health education is the most difficult task we at the AMA face. We try very hard to get the public to take care of itself. We have had only limited success.

Changing the public's mind about anything is a formidable task. Yet we must try if we are to bring about a true revolution in this nation's attitude toward aging and the elderly. We must make a supreme effort to destroy the stereotype of the aged and the myths on which it is based. The scientific facts are exactly the opposite to the popular conception of old age. We at the AMA discovered this almost by accident.

About 16 years ago the AMA began to get deeply interested in the problems of the elderly. At that time, the AMA established what it called the Geriatric Committee. The name of that committee is significant. Since geriatrics was defined as the study of the diseases of the aging, it all seemed to be rather simple. All the committee had to do was to discover what diseases were the result of the aging process and undertake their study and eventual conquest.

But the committee and other researchers were unable to find a single disease entity that depended directly on the passage of time. What they did find was that diseases usually associated with older persons also occurred in the young and vice versa. One result of that discovery was to change the name of the committee from the Geriatric Committee to the Committee on Aging. Far more important, it also changed the perspective of the committee, the AMA, and ultimately, I hope, the perspective of the medical profession as to the nature of the medical problems that affect the aged.

That no disease entity or any single physical or mental condition is endemic to a particular age clearly has vast implications for the medical profession. It is the basis from which all who care for the elderly must begin. It is this basic fact that we must get across to the American public so that we, as a nation, can begin to develop a realistic, rational philosophy of aging. That need is fundamental to all else we may wish to do.

The need is urgent because the over 65 age group is the fastest growing segment of the U.S. population. According to the 1970 census, 10 percent of the population is now over 65. They represent one of the largest blocs of votes in the country, and no politician is even going to try to resist the temptation that this bloc presents. Change is coming; the only question is the nature of the change—whether it will be merely the usual band-aid approach of government programs or whether it will be a truly revolutionary change that touches the spirit and the mind of the nation. The answer to that question is largely up to us. And the place to begin is by asking the most basic question of all.

What is aging?

The AMA Committee on Aging faced that question and answered it this way: "Aging is really living, growing, and developing so that the final days and contributions should be far different in the future than they seem to be today."

To make that statement come true, to make it the national concept of aging, is the most important duty of all nursing home administrators.

REFERENCE

(*1*) U.S. Senate, Special Committee on Aging. Hearings before the Subcommittee on Health of the Elderly, July 17–19, 1969, 91st Cong., p. 624.