Nursing Home GOALS

The First National Conference on Nursing Homes and Homes for the Aged, called by the Public Health Service, was held February 25–28, 1958, in Washington, D. C. Some 150 persons, representing individual homes, social service organizations, State health and welfare departments, and 32 national associations met to discuss measures for improving services to the chronically ill and aged. The goals set by the participants, their recommendations on how these goals can be reached, and three of the addresses at the conference are summarized on the following pages. The full proceedings are being published by the Public Health Service.

Achieving the Goals

The Federal role in achieving the goals of this conference is necessarily an auxiliary one, affording certain aids and opportunities that are valuable only to the extent that they are used, creatively and imaginatively, by the States and communities. A review of current activities of the Public Health Service and other units of the Department of Health, Education, and Welfare as they relate to these goals may spark your thinking on ways you can use existing aids to greater advantage and suggest to you recommendations for additional activity which we could legitimately undertake.

Goal 1. Several national studies, completed, in progress, or planned, should help to advance this goal. One of them, already published, is especially pertinent: Nursing Homes, Their Patients and Their Care. Knowing the characteristics of the people in these homes is an important first step toward determining the services and facilities they require.

This summary is based on a paper presented by David E. Price, M.D., chief, Bureau of State Services, Public Health Service.

Other studies now under way, such as the U. S. National Health Survey which began in July 1957, and the sample survey of Old Age and Survivors Insurance beneficiaries which will be conducted this year, can be expected to give us additional data that will be helpful.

Goal 2. Perhaps the most notable contribution the Federal Government has made in this area is the so-called standard-setting amendment to certain public assistance titles of the Social Security Act. Prior to this legislation, there was no way substandard homes could be forced to provide at least the essentials of decent living for older people. Now, all States have regulatory authority over most types of homes even though all States do not have it for all types of homes. Licensing authorities in both the State welfare departments and the State health departments have recognized that the most important contribution they can make to the improvement of services is not through the use of police power, but through the assistance they can offer home operators.

Goal 3. The Federal Government has been active in many facets of the knotty financial problems involved in improving the services and facilities of nursing homes.

The Hill-Burton program provides a strong financial incentive to States and communities to create much needed facilities. Since 1955, about $21 million in matching funds have been provided annually for construction of facilities primarily serving patients with long-term illnesses. Four hundred projects, adding 3,900 chronic disease beds, 4,500 nursing home beds, and other facilities, were aided by these special funds.

Public assistance financing has also been liberalized. Legislation in 1956 not only increased the Federal share in assistance payments but also provided a separate formula and additional funds for medical care.

Here again, however, there are wide variations in the value an area receives for its Federal aid dollar. For example, with the constantly increasing number of older people in the population, general hospitals, planned, staffed, and organized to provide costly care for patients with acute illness, find that more and more of their beds are occupied by long-term patients.

Conference Goals

1. To determine the essential elements of service in the different classifications of homes.

2. To delineate more clearly ways in which accrediting, standard-setting, and regulatory agencies may assist in improving the quality of care in nursing homes and homes for the aged.

3. To encourage a more realistic attitude in financing the cost of facilities and services provided by nursing homes and homes for the aged.

4. To explore the need for and methods of providing public, professional, patient, and family education.

5. To explore ways and means of providing consultative services and assistance to administrators and staffs of nursing homes and homes for the aged.

6. To set guidelines for future action.

Many of these same patients could be cared for at far less cost in nursing homes where medical care is available.

Similarly, public assistance payments for medical care are often much higher than they would need to be if the community were willing to invest more in public health programs that prevent the development of chronic diseases, retard their progress, and minimize their effects. Multiple screening projects for the early detection of chronic conditions would reduce the need for institutional care. Rehabilitation programs, planned cooperatively by health and welfare agencies, hospitals, homes, and physicians, would help to reduce the time period when costly medical and nursing care is required.

Goal 4. In the field of professional education, we can already count solid gains: the Public Health Service traineeship programs for nurses and public health personnel into which some $5 million is being invested this fiscal year and the authorization for a program of grants to States for extending the number of trained public assistance personnel, to mention only two of the most recent ones.

Another educational approach is through publications. For example, there is now available an illustrated booklet showing in detail the exercises that will help stroke patients. This will make it possible for the general practitioner, his patient, and the patient's family to work out a regimen of exercises. The new diet booklets prepared for heart disease patients on sodium-restricted diets, sponsored by the Public Health Service and a number of voluntary and professional agencies, are designed for the same type of use. Other examples are the manuals How to be a Nursing Aide in a Nursing Home, produced cooperatively with the American Nursing Home Association, and The Older Person in the Home, and, of course, the periodical *Aging* which is issued by the Department's Special Staff on Aging.

Goal 5. The Public Health Service last year received from Congress an additional $3 million in general health grants to assist States to develop programs in chronic disease and other health areas not covered by the traditional type of public health activity. A gratifying number of States elected to use their share of this fund to strengthen their consultative services to nursing homes. Altogether, 75 percent of this fund has gone into chronic disease and health of the aging programs.

Other units of the Department have also taken measures to strengthen their service component. The Bureau of Old-Age and Survivors Insurance, for example, has recently established a welfare branch to help its field staff give better service to OASI beneficiaries who consult them about nursing homes and other personal problems. Recent public assistance legislation encourages welfare agencies to extend their social services to older persons, a significant step because social problems are quite as important as medical problems. The well-balanced nursing home program makes provision for dealing with both.

Goal 6. I hope this partial review of Federal programs will prove of some value to you in achieving your final goal of setting guidelines for future action. For any Federal effort to be meaningful, it must be backed by local action. Every type of Federal aid, to be of real value, must evolve from firm roots in local soil; otherwise you may have paper progress, token action, but you will not really change the lives and outlook of the rapidly growing millions of the very old.

This First National Conference on Nursing Homes and Homes for the Aged will indeed become historic if it marks the beginning of a concerted drive to give our chronically ill and aged the kind of care that each of us would hope to have when it comes our time to enter into that final stage of life.

The Heart of the Matter

In a certain nursing home lives a little old lady, aged 90 years, a former school teacher. She is happy, active, comfortable, busy with crossword puzzles, books, and newspapers. She takes a daily walk around the block with the aid of her aluminum walker and watches the world go by from her cheerful front-room window.

A year ago, she was alone in the world, living in a house that had been her home for nearly 50 years. When a severe stroke crippled her, she was living in squalor, helpless in an unheated room. The postman missed her usual greeting one day, and getting no response to his knock, he summoned the police. After a few weeks in the hospital, she was removed to a nursing home.

There, with skilled care under a physician's supervision, she was restored to her present state of self-care, better health, comfort, and good spirits. Her pension and funds from the sale of her house assure her good care in the nursing home as long as she lives. Her remaining years will be far happier there than in any other setting.

She (with some 300,000 others in nursing homes and homes for the aged) is the focal point of your deliberations. Never lose sight of her, or her counterpart in some home known to you.

It is not easy to keep focused on the human factor. We deal with scores of impersonal

---

This summary is based on remarks by Leroy E. Burney, M.D., Surgeon General of the Public Health Service.

factors. Physicians may tend to think of diseases and diagnoses, administrators of programs and procedures, nurses of medications and supervisory problems, social workers of caseloads and therapeutic interviews.

But if we think exclusively of our own little specialties, we do so at the peril of the people we serve. For although each of us makes a necessary contribution, no one has all the knowledge, the skills, and the resources to place and maintain this elderly, retired school teacher in her present happy state.

Nor can we think exclusively of our particular zones of responsibility, whether it is national, State, or local. What is done or not done in each zone, in the national agency, the State, the community, and the nursing home affects in some degree all other zones. And this in turn affects for better or worse the people in nursing homes and homes for the aged. We who have any kind or degree of responsibility for the well-being of aged people cannot afford to let a colleague's efforts go unmarked with respect, his successes without rejoicing, nor his failures without prompt help.

Kaleidoscope of Health Services

There is no ideal pattern for nursing homes and homes for the aged in the kaleidoscope of health services for older people. The health services that older people require, like the bits of colored glass in a kaleidoscope, can be arranged in an endless variety of harmonious, effective patterns to suit the circumstances of any individual, any family, any community, or any State. The nursing home is just one piece, and its place in the pattern depends on the availability and quality of other health services for the aged.

This is a vast kaleidoscope, and we must keep our eyes on single bits of this pattern which concern this conference. We must seek a common vantage point from which we can describe the place of the homes and their quality in practical terms as realistic goals for every institution, community, State, and national organization.

Facilities and services that permit better care of older people are at the center of the larger problems of aging. This lack keeps tens of thousands of older patients in general hospitals when they no longer need full hospital services. The lack of enough high-quality nursing homes and homes for the aged, or their equivalent, places persistent, exorbitant demands upon many communities for additional general hospital beds and drives up the costs of hospital care. The lack of high-quality institutions to serve the aging population thus denies good hospital care to thousands.

According to the first estimates of the U. S. National Health Survey, about 1,800,000 men and women over 65 years are unable to carry on their normal family and vocational activities because of chronic conditions. I do not imply that all of these should be in nursing homes or homes for the aged. But among them are many whose families cannot afford skilled care at home, many who are eking out a lonely, marginal existence, and many whose illness contributes to dependency because an employed member of the family must give up a job to care for an invalid. We have reason to be disturbed about the dollar price of our neglect of health services for the aged; it touches everyone's pocketbook.

Personal Concern

More important, we care about people. The past 20 years have dynamically changed the whole fabric of our society. But another sort of change, hard to define and springing in part from these dynamic processes, is becoming widespread. It might be called the depersonalization of society. Industrial automation and its counterparts in family life have removed large segments of the population from direct participation in basic communal activities. Decisions affecting the entire population are made by a relatively few people far from the local community. As cities absorb neighboring rural areas, distances from residential areas to the center of community decision increase. The migration to the suburbs is depriving the central city of much of the personal concern of its leadership. Not only in metropolitan areas but in the burgeoning smaller cities community

functions tend to become concentrated in the hands of a few.

This aspect of depersonalization should be a continuous warning light to the health and welfare professions. In making community decisions leaders in these fields should be severely

Nursing Home FACTS

TYPES OF HOMES

Proprietary. Operated under private, commercial ownership.

Public. Operated under State or local governmental auspices.

Voluntary. Operated under private, nonprofit auspices, such as church and other groups.

Skilled nursing. Provides as its primary function skilled nursing care, including procedures which require technical nursing skill beyond that of the ordinary untrained person.

Personal care (with skilled nursing). Provides some skilled nursing care, but only as an adjunct to its primary type of services.

Personal care. Provides such personal services as help in walking, getting in and out of bed, bathing, dressing, and feeding and supervision of self-administered medications.

Shelter. Provides room, board, and minimum services of a domiciliary nature such as laundry, personal courtesies, and occasional help with tasks such as shopping and correspondence.

THEIR NUMBERS

There are an estimated 25,000 nursing homes and homes for the aged in the United States.

They contain 450,000 beds, 180,000 in skilled nursing homes, and 80,000 in homes that provide some skilled care.

Ninety-one percent of the nursing homes are privately owned; three percent are publicly owned. The publicly owned homes have 15 percent of the beds, an average of 69 each; privately owned homes average 18 beds each.

Nursing homes are licensed by every State and Territory except Puerto Rico and the Virgin Islands; only Puerto Rico, the Virgin Islands, and South Carolina do not license homes for the aged. State agencies responsible for licensure programs are:

Type of agency	*Nursing homes*	*Homes for the aged*
State and Territorial health departments	42	34
State welfare departments	6	14
Other State agencies	3	2
None	2	3
Total	53	53

The demand for nursing homes is growing. At present 15 million Americans are more than 65 years of age, and by 1975, there will be 19 million. The control of infection, higher standards of living, and improved medical and hospital care are contributing to the longevity and growth of the population of oldsters.

THEIR RESIDENTS

Nursing home residents have an average age of 80 years; two-thirds of them are more than 75 years old. Two-thirds of them are women. Two-thirds have some circulatory disorder. Less than half can walk alone. About one-third are incontinent. More than half have periods when they are disoriented.

Their care costs an average of $150 monthly. Public funds pay for the care of 50 percent of nursing home residents, and public assistance payments range from $55 to $155 per month.

These definitions and data were obtained from Public Health Monograph No. 46, Nursing Homes, Their Patients and Their Care, by Jerry Solon, Dean W. Roberts, Dean E. Krueger, and Anna Mae Baney, 1957.

self-critical lest we fall into the delusion that we are the community.

A major contribution of this conference can be to lift the deadening hand of depersonalization from planning and programs for the aging throughout our country. In doing so we would release the most powerful force that mankind has developed, the force of human affection and personal concern.

To do this, we need to touch base with the realities of the problems we hope to solve; to draw upon the experience of the frontline workers in our midst.

I come back to the little old lady in the nursing home. By keeping her in the center of our thinking, we find that the patient is often the first obstacle. Don't think she wears a halo. A person so resistant to change is not easy to help.

Many older people seem to withdraw progressively from the world around them. Their perception of themselves and others and their responses seem to grow less acute. When illness comes, the benefits of medical, psychological, and social treatment are more difficult to achieve. The family may also be an obstacle to better care and better health of an older person.

The community, however, is the greatest obstacle to better care and better health of the aging in these homes. By its collective attitudes and its resistance to change, the community places these institutions in the same withdrawn situation that characterizes so many of their residents. The community has allowed the remarkable scientific and technical advances of this century to bypass nursing homes and homes for the aged.

Deeply rooted in the community consciousness is the age-old dread of institutions. In the 19th century the hospital, as well as the nursing home, the county farm, or the old folks home, was a place for the sick poor to go to, and die. Advances in medicine, psychiatry, sociology, architecture, equipment, and personal services have revolutionized the community general hospital and made it a place where all classes go, and live. These advances are applicable to the nursing home and the home for aged, as many existing institutions have demonstrated.

Our main task is to find ways that will make all nursing homes and homes for the aged places for all classes to go and live.

State and Local Progress

Despite overwhelming handicaps, the State and local official agencies that license nursing homes and homes for the aged are making great progress. But there is much more progress to be made. Moreover the official agencies alone cannot improve the operation and the quality of patient care in these institutions.

Primary responsibility for the licensure of nursing homes and homes for the aged rests with the State health department in most States. Moreover the health departments are usually consulted in the States where some other department handles licensure. Within the State health departments, however, administrative patterns for licensure vary. But the majority of the departments have the same overall program director for both licensure and Hill-Burton programs. Usually the licensure unit itself is a small section within a division of the health department. It calls on other parts of the State health department for such services as public health nursing, nutrition, environmental health and safety, and chronic disease.

The licensure of hospitals and the licensure of nursing homes and homes for the aged are handled by separate units in most States, although an increasing number of States are combining their functions in one division.

State agencies are delegating more and more functions to local agencies when the local unit can handle them. States with strong local health departments find that decentralization is effective and that activities relating to the homes can be integrated into regular public health programs.

Other States hold that decentralization to the regional level is best, and some carry on all activities from the State level. Others are still

---

This summary is based on a paper presented by Bruce Underwood, M.D., consultant in nursing homes, Chronic Disease Program, Public Health Service.

experimenting and trying out various plans. Some understaffed local health departments do not have time to give to programs for the homes. However, it is my impression that whenever local health departments have a major role in these programs, progress is greater. The picture is similar in the States where welfare departments have the licensure function.

There is wide variation in the types of personnel who actually do the inspections and consultations and carry on the programs. The background of these people may be primarily environmental health, architecture, engineering, medicine, nursing, or a combination thereof. Few State licensure agencies have adequate staffs. Consultation services available from or through the agencies are usually meager.

Inspection procedures also vary. In one State, 7 to 9 inspectors from separate agencies must visit the nursing home before a license is issued. In most, one person inspects for the official licensure agency and another for the official fire safety agency. The inspecting agencies usually work well together and with interested voluntary and professional groups, but in a few States there is little cooperation.

Educational Approach

Perhaps the most important trend among the official agencies is the use of the educational approach rather than the big stick of law enforcement. In one county with long experience in licensing, the official inspectors or consultants have good relationships with the homes. Persons who want to open homes are helped if they can meet the standards, discouraged if they cannot. Homes are approached with these questions: How can we help you? What can we do for you? What are your problems? How can they be met?

This county once had a number of homes that didn't comply with the standards. At informal hearings with the administrators of these homes, laws and standards were not emphasized. Rather patients' needs were stressed, a list of necessary items were agreed upon, and a timetable and priorities were established for the most urgent needs. In this way, the homes, agencies, professions, voluntary agencies, and the nursing home administrators came to understand, support, and cooperate with each other. Together they received the all-important backing of public opinion and public understanding as well as the support of appropriation agencies.

This educational approach is being used increasingly all over the Nation. Where it prevails, the State nursing home associations usually want higher standards, stricter enforcement, and more consultative assistance than the official agency can give. In some areas cooperation is so close that official personnel are difficult to distinguish from those of the voluntary agency. Statewide and regional seminars and institutes are jointly planned and conducted.

Signs of the Future

Nursing home laws and regulations are being revised and standards are being raised all over the Nation. The Public Health Service is assisting official agencies by providing consultation of various kinds and making available instructive handbooks. Various laws and regulations on nursing homes and homes for the aged are being compiled. Also under way is the development of definitions and principles for the States to use as a guide for their nursing home laws and regulations.

Some new, exciting developments are indications of the future. In Peoria, Ill., under a project of the Illinois Public Aid Commission, workers have been trained and are visiting nursing homes to teach aides physical and occupational therapy and rehabilitation techniques.

The outlook of the staff in the homes is changing. One of the attendants in one of these nursing homes was asked, "What do you think of this program?" She answered, "It makes me feel good down in my heart." The administrator of that home said, "Our home will never be the same. People are being rehabilitated and returned to self-help at home or in a foster home at the rate of five or six a month."

Efforts are being made in at least one State to set up accreditation programs for nursing homes in addition to licensure. Others are studying operating costs and personnel time. Some States are experimenting with increased payments to nursing homes to employ physical

therapists and occupational therapists to return people to self-help whenever possible. They are finding this program to be more economical in the long run, to say nothing of the humane factors involved. There are many other new developments and activities taking place in our Nation.

The philosophy behind these omens of the future has been expressed by Dr. Albert L. Chapman, Division of Special Health Services, Public Health Service, in these words, "The hallmark of civilization is a voluntary commitment of time and money to make sure that oldsters, youngsters, and the infirm are not denied whatever benefits and privileges a humane society can endow them with."

Conference Recommendations

General Policy Questions

1. Nursing homes and homes for the aged are and should continue to be admininstered under public, voluntary, and proprietary auspices. All have a part to play in providing facilities of good quality. In any particular instance, the most desirable sponsor of a facility from the community's point of view is that one which will provide the best quality of care economically.

2. To clarify the functions of nursing homes and homes for the aged, the following fourfold classification of services is recommended. Each successive category encompasses the preceding category and goes beyond to the extent indicated. Homes, whatever their names and auspices, may be characterized according to the level of services provided in these terms of classification.

Services

The descriptions only convey the essential differences among the categories. This should not detract from the necessary focus in each of the categories on the social, emotional, and spiritual needs of the residents as part of providing opportunity for a satisfactory total pattern of living.

Residential services. Encompasses housing, food sevices, and limited services of a domiciliary nature such as laundry, personal courtesies, occasional help with correspondence or shopping, and an occasional helping hand short of routine provisions of "personal care."

Personal care. Includes such personal services as help in walking and getting in and out of bed, assistance with general bathing, help with dressing or feeding, preparation of special diet, supervision over medications which can be self-administered, and other types of personal assistance of this order.

Nursing care. Includes services in caring for the sick which require technical nursing skills.

Comprehensive services. Extends the types of care outlined above to emphasize, in addition, social and group-work services, auxiliary medical services and rehabilitation (including psychiatry, physical medicine, and occupational therapy). This multiplicity of services provides full opportunity for a rich, well-rounded living experience in its social and psychological aspects as well as medical and nursing aspects short of hospital care.

Facilities

Corresponding to this classification of services, the following terms are recommended as designations for understanding the type of home, whatever its given name. These types are the residential facility, personal care facility, nursing care facility, and the comprehensive services facility.

It should be recognized that any type of facility need not confine its services to its residents. It may also be open to persons living outside the facility who come in for a portion of the day to use its services.

3. Comprehensive planning at the local level should be done in developing new facilities, utilizing existing planning agencies where such exist, or creating a medium for this purpose. Community planning for new facilities should take into consideration the availability of services to assist in care of patients in their own homes.

4. For those persons who can and wish to be cared for in their own or family homes, this "natural" home usually provides the most desirable environment. To help maintain this environment, the community should make available enabling resources such as visiting nurse services, homemaker services, day centers, foster homes, meal-delivery services ("meals-on-wheels"), and so forth. For those persons in this category who are in financial need, the community should provide adequate financial assistance.

5. Government, through its public welfare programs, is in a position to influence the quality of nursing home care. By its frequently inadequate payments for public assistance recipients in nursing homes, government denies to many patients adequate care while it perpetuates the operation of homes at a substandard level. Government should provide payments for public assistance recipients in nursing homes in amounts sufficient to assure provision of adequate care.

6. The development of planned cooperative arrangements between hospitals and homes for the aged and nursing homes should be widely and energetically promoted. Such

plans should include arrangements for ready transfer of patients into the hospital and back again as their needs dictate, with full exchange of medical and related information. Arrangements may also be made for bringing the benefit of the hospital's resources to the patient while he is in the home, through use of the hospital's laboratory, radiological, and other direct services, and through consultative services to the patients and the staff by the medical, dental, nursing, dietary, physical therapy, social, and other staffs of the hospital.

7. There is a trend toward establishment of nursing homes under the jurisdiction of hospitals. This is one among many other arrangements for achieving closer relationships between nursing homes and hospitals. This trend should be encouraged, particularly for the benefit of certain types of patients for whom close and continuing medical supervision is most essential.

8. Older people who are ill have changing needs, ranging from full hospital care to assistance in personal care. For those who are not in need of hospital services, the remaining range of services may be provided within a single facility or in several different types of facilities. It is the community's responsibility to assure the availability of these services and to make possible the ready movement of patients among facilities according to their needs.

9. Voluntary classification and accreditation of nursing homes and homes for the aged have the potential for upgrading standards of care beyond minimum acceptable requirements of licensing programs. It is important that appropriate mechanisms for such an accrediting and classification process be developed.

10. The beginning efforts toward correcting the lack of training of health personnel in the problems of care of chronically ill and aged persons are commended. Extension of undergraduate and graduate education programs in this direction is strongly urged for all professions contributing to care. Nursing homes and homes for the aged should be utilized in such educational programs as appropriate clinical teaching facilities.

11. There is a great need for research and investigation into the many complex problems associated with nursing homes and homes for the aged. Emphasis should be given to expanded programs of study and experimentation directed toward improvement of administration, to provision of health, social, and related services, and to financing of these services and facilities.

Selected Professional Services

1. In order to insure proper placement of the nursing home patient in the facility best suited to his needs, it is recommended that a system of classifying patients be developed which considers diagnosis, type and degree of disability, potentialities for rehabilitation, and medical, nursing as well as other professional service requirements. A beginning has been made in several localities toward developing such a classification, but it is felt that further research is required to refine, improve, and test such a classification system.

2. Every home should have some organized plan for medical supervision in keeping with its size and needs. It is recommended that every nursing home operator select at least one physician to act as principal medical adviser to advise on medical administrative problems, review the home's plan for medical care, and handle emergencies if the patient's personal physician is not available.

3. The adequacy and effectiveness of medical supervision depend in part upon the relationship that exists between the home operator and the local physicians. Recognizing the need for continued improvement of this relationship, it is recommended that the American Medical Association Committee on Aging continue its efforts to bring about the formation of State and local committees on aging to advise administrators of nursing homes and homes for the aged concerning their programing of medical care.

4. For maximum benefit to patients in nursing homes and homes for the aged, it is recommended that:

- Each patient have his own personal physician and be under continuous medical supervision.
- Every patient have a medical and social evaluation prior to or at the time of admission to establish a specific plan for care and that this evaluation be made a part of the patient's record in the home.
- Every home have an organized plan for the medical care of its patients.
- The frequency of physician visits rests with the personal physician and should be based on the needs of the particular patient.

5. It is recommended that general hospitals and nursing homes cooperate in the development of integrated programs for care of long-term patients.

6. It is recommended that there be further exploration of the development of nursing home facilities as integral units of general hospitals.

7. Colleges of nursing should be encouraged to develop regional conferences on nursing administration in nursing homes and homes for the aged in the various States in cooperation with nursing home associations and State health and welfare departments similar to the pilot project conducted in Pennsylvania, December 9–13, 1957.

8. Nursing services in skilled nursing homes should be under the supervision of a registered professional nurse.

9. Personal care home groups should, as a minimum requirement, have their nursing care supervised by a trained, licensed practical nurse.

10. It is recommended that curriculums in nursing education be enriched to include clinical practice in chronic illness and administrative practice in chronic illness facilities.

11. Since personnel policies have a direct effect on recruitment and retention of qualified personnel, it is recommended that clear, written

personnel policies be developed by nursing homes and homes for the aged, including job descriptions, plans for orientation of new staff and provision for inservice education. It is suggested that the American Nursing Home Association give consideration to the development of suggested personnel policies for nursing homes.

12. It is recommended that appropriate groups undertake research projects in nursing homes and homes for the aged to develop criteria for classifying patients according to nursing needs, the levels of nursing personnel required to meet these needs, and the educational programs desirable for each type of personnel needed to provide these services.

13. State licensing agencies should include professional health consultation services for nursing homes and homes for the aged.

14. It is recommended that a study be made to determine the requirements of nursing homes and homes for the aged with relation to supply, availability, storage, dispensing, and supervision of administration of medications. This study should consider providing medications for acute, chronic, and maintenance needs with due regard for all legal and medical requirements.

15. Medication and its administration should be based on the plan of medical care for the patient and the level of nursing services available.

16. Comprehensive dental care has not been readily available to many residents of nursing homes, especially to those in smaller institutions. In most instances, dental treatment has been limited to emergency care for the relief of pain.

Therefore, to stimulate interest in oral health and to improve the quality and quantity of dental care in nursing homes, the following actions are recommended:

- Dental evaluation of patient on admission to be included in the patient record.
- A principal dentist and/or an advisory committee to nursing homes and homes for the aged should be appointed from the appropriate dental society.
- The dental staff of the community hospital or hospitals should organize a liaison committee with the administrators of nursing homes and homes for the aged for dental consultations and service.
- The dental division of the public health agencies should establish a consultant service to nursing homes and homes for the aged.
- The curriculum in dental schools should include instruction in problems of caring for the chronically ill and the aging.
- Research should be conducted to establish dental needs, necessary portable equipment, and appropriate treatment procedures.
- There should be representation of the dental profession on planning committees for nursing homes and homes for the aged.

17. It is recommended that refresher courses and inservice training on dietary service be provided to personnel responsible for inspection of nursing homes and homes for the aged.

18. It is recommended that to meet more adequately the individual needs of patients in nursing homes and homes for the aged, established community agencies jointly undertake a plan whereby specialized professional services in the community are made available to patients in these facilities. Such services might be made available by voluntary or public agencies or both. Services should include occupational, recreational, and physical therapy, and social, nutritional, X-ray, laboratory, pharmaceutical, and dental services. Specific patterns for providing these services will depend on the local situation.

19. It is recommended that central referral and counseling services for the chronically ill and the aged be developed on a community or regional basis with provision for outposts in surrounding local areas. These services should be provided by skilled professional personnel.

20. Public assistance agencies with support and cooperation of professional and other interested groups should make the utmost effort, as part of their responsibility for providing care for indigent persons, to obtain public funds adequate to provide the recommended services.

These services should be furnished to all patients on the basis of their needs, without regard to the source of financial support or the type of ownership of the institution.

21. One objective of the nursing home is to promote optimal physical and emotional health and to restore and return to his community every individual who has a potential for such restoration. Therefore, it is recommended that:

- Efforts be made to develop within the nursing staff techniques and skills in counseling and in restorative services and to utilize these so that the patient will not remain bedridden unnecessarily.
- Nursing homes adopt a program of restorative care that can be accomplished through a combination of direct services by the staff or by personnel services provided by other community agencies and consultation services. Personnel used for such services should be individuals with recognized professional qualifications who function under specific medical directions.
- The therapist should be a graduate of a school approved by the American Medical Association's Council of Medical Education and Hospitals, and State licensed or registered, if required by the State.
- Those patients with severe disability and rehabilitation potential beyond the capacity of the nursing home should, when possible, be referred to a rehabilitation facility.

Nutrition and Food Service

1. The nutritional needs of persons in nursing homes and homes for the aged should be met in accordance with the National Research Council's current Recommended Dietary Allowances adjusted for the population concerned.

It is recognized that these allowances may be met by many food combinations designed to meet the

cost and cultural demands of the patients and residents in the homes.

2. The food service in nursing homes and homes for the aged should meet the nutritional needs of the patients and residents through foods. Nutrient concentrates should be given only on the prescription of a physician.

3. Any processed foods served in nursing homes and homes for the aged should be processed by safe and approved methods.

4. The licensing agency should provide ways and means of making it possible for nursing home administrators to put into practice a food service which will meet the Recommended Dietary Allowances. This will involve information on selection and use of kinds and amounts of foods at varying cost levels and use of qualified personnel and/or authoritative materials. Some sources of personnel and materials are official and nonofficial health and welfare agencies at national, State, and local levels; colleges and universities with home economics departments; hospital dietitians and dietetic associations; and Federal, State, and local departments of agriculture and extension services.

5. At least 3 meals per day should be provided with not more than a 14-hour span between a substantial evening meal and breakfast.

6. Food should be prepared in ways that conserve the nutritive value, and it should be suitably cooked for the digestive capacity of the groups served. The food should be served in a manner that will be acceptable to the patients and residents.

7. Table service for the individual or group should be available to all those who can and will eat at a table. Table service should be provided in a manner that will best serve the interests of the patients.

8. Because of the therapeutic value of getting the patient up for meals wherever possible this practice should be followed, whether or not it would affect the classification of the patient or the rate charged.

9. The entire licensing staff of the regulatory agency should be familiar with the criteria for evaluating the food service and the specific assistance for food service which may be provided to the operator of the home.

10. The licensing agency should assume responsibility for education and training in all phases of food service for all personnel in nursing homes and homes for the aged. Such education and training should include individual and group conferences, on-the-job training, and formal training. Qualified personnel from the following sources could be used: health and welfare agencies, home economics departments of colleges and universities, hospital dietary departments, and departments of vocational education. New and prospective employees in nursing homes and homes for the aged should be included in such programs.

11. Formal training of professional workers concerned with care of patients and residents of nursing homes and homes for the aged should emphasize geriatrics and especially geriatric nutrition. Furthermore, this recommendation should be relayed to the appropriate organizations and groups responsible for its implementation.

12. Regulations should require that there be made available for review the menus as served, a record of kinds and amounts of food used for a given period of time, and the number of people served during this period.

13. A national project should be conducted to develop a cost accounting system specifically for nursing homes and homes for the aged.

14. Further studies of the nutritional requirements of the aged person in nursing homes and homes for the aged should be encouraged; this recommendation should be referred to properly equipped research laboratories.

Social and Related Services

1. It is recommended that as a basis for sound medical, social, and personal planning for the older individual, there be the recognition that he be enabled through coordinated community efforts and services to remain in his own home as long as this is consistent with his health and welfare.

2. It is recommended that ways be developed to provide information about services and resources to guide the aged and their families to the appropriate service or resource which may best meet their needs. These informational resources could be central referral services, brochures, booklets, and/or other media.

3. It is recommended that in the interest of mobilizing and making available all community resources for the evaluation of the older individual and his needs, emphasis should be placed on the importance of the development and coordination of consultative services at Federal, State, regional, or local levels.

4. It is recommended that the team approach be used in evaluating the individual's health, social, and other related needs, including the involvement of the older individual and his family in order to do the best possible planning to meet his needs and those of his family.

5. It is recommended that in all applications for institutional placement, the total assessment of the older person's needs and the resources available to meet those needs, be required prior to actual placement in any institutional setting.

6. We recommend acceptance of the basic premise that persons living in institutions have a right to live as fully as possible within the limits of their abilities and within the limits imposed by the group setting. To achieve this end, full utilization of all social and related services of the community is essential.

7. We recommend continuous consultation on social and related services by both regulatory and other public and voluntary agencies to all institutional facilities for older people.

8. We recommend that professional schools include in their curriculums content material emphasizing the social and emotional needs of older people. Professional schools, colleges, universities, and other com-

munity agencies should be encouraged to offer institutes and other inservice training programs with similar content for institutional personnel and others working with older people.

9. We recommend that in every community there be a responsible group, such as the regulatory agency, council of social agencies, or other special group whose function it is to evaluate and interpret to the public the human values as well as the costs of social and related services. Evaluation and interpretation are necessary if sufficient funds are to be secured and the best possible utilization of these funds is to be assured.

10. We recommend that studies be made by qualified individuals or agencies (voluntary or public) to develop minimum standards for the amount and types of social and related services required by the older person in a crisis and for his long-term requirements. These standards should be related to the size and type of community in which the older person lives.

Environmental Health and Safety

1. Whereas it is the consensus that fire protection in nursing homes for the aged is of paramount importance,

Therefore, it is recommended that the States adopt, as minimum requirements for life safety in these establishments, the current National Fire Protection Association Standards pertaining to nursing, convalescent, and old age homes, and that each State establish a deadline date for the adoption of these standards.

2. Whereas the importance and the use of automatic fire sprinkler systems in all nursing and rest homes and other structures housing the aged and infirm is recognized, and

Whereas it is especially important that such installations be made in rural locations not served by water mains, and

Whereas it is recognized that the installation of sprinkler systems and other safety to life measures present a problem of increasing operating costs, and

Whereas the majority of the patients housed in nursing homes are supported by the community and other public sources,

Therefore, it is recommended that the communities and their legal representatives recognize their responsibility to the aged and infirm to provide funds that will permit the installation of such equipment as necessary safety elements in the adequate housing of such patients.

3. Whereas there is not available a compilation of all State and local laws, rules, regulations, and methods of enforcement in regard to nursing homes, and

Whereas such information would be of great value as a basis for discussions of standards and for assisting State and local groups in the development of standards,

Therefore, it is recommended that the work of the Public Health Service now being carried out in the compilation of such data be continued and extended to include laws detailing fire prevention and control, and that such a compilation be published and made available to interested groups.

4. Whereas innumerable active and prospective nursing home operators are acquiring or attempting to modify unsuitable facilities,

Therefore, it is recommended that all available means of publicity be utilized by all interested persons or organizations to acquaint the general public with the free consultation services offered by the individual State licensing agencies, and that a compilation of all such consultation services by any governmental or other agency be published for distribution by the U. S. Department of Health, Education, and Welfare.

5. Whereas the dissemination of information among the participants of this nursing home conference has proved most valuable in creating sympathetic understanding of common problems, which gives promise of practical approaches to the solution of some of these complex and difficult problems, and

Whereas this kind of transmission of information and development of understanding is most urgently needed at local levels where the facilities are being operated and where the laws are being applied,

Therefore, it is recommended that the Public Health Service continue and extend the sponsoring and development of regional conferences at the local level throughout the country, to which are invited personnel representing local groups similar to those participating in this conference and including agencies and organizations having an interest in the regulation of or services to nursing homes, as well as those agencies and organizations providing financial support for individuals cared for.

6. Whereas employees' fire safety training programs are required of hospitals for accreditation, and

Whereas the fire hazards in nursing homes and homes for the aged are generally similar to those existing in hospitals, and

Whereas the universal adoption of fire sprinkler systems is still in the future,

Therefore, it is recommended that this conference advocate that nursing homes and homes for the aged institute employee fire safety training programs.

7. Whereas accident prevention programs and specific procedures designed to avoid accidents in nursing homes and homes for the aged are restricted by a present lack of substantive information,

Therefore, it is recommended that the Public Health Service make known this general situation and advise qualified investigators that morbidity and mortality studies of nursing home accidents will be considered for National Institutes of Health research grants and, further, that State health departments, municipal health departments, medical schools, and schools of public health be specifically contacted in this regard.

8. Whereas several State associations of nursing home owners now operate desirable and effective pro-

grams of self-inspection of members' facilities, and

Whereas in facilities where unsatisfactory conditions are found to exist the several State associations do take appropriate action to have such conditions corrected and when this fails deny or revoke association membership, and

Whereas this program of self-inspection is most beneficial to the welfare of the patients as well as the financial success of the individual nursing home,

Therefore, State nursing home associations are commended for their programs of self-inspection and are urged to continue and strengthen their procedures for corrective action in the case of members who continue to willfully and flagrantly fail to carry out the objectives of good nursing care of the nursing home association.

9. Whereas it is the total care given to the nursing home patients which is of paramount importance to the nursing home operator, the general public, and the State and local agencies responsible for the inspection and licensure of nursing homes and nursing home operators, and

Whereas the development of a mutual understanding between the official agencies and the members of the nursing home industry for the ultimate attainment of an acceptable level of care in nursing homes and a better understanding of the problems involved in this rapidly increasing community responsibility, and

Whereas this goal would be attained more readily if the staff members and the directors of the official agencies responsible for the inspection and licensure of nursing homes were given an opportunity to approach their problems on a more definite and uniform basis, a better relationship could be established with the operators and agencies responsible for providing patient care,

Therefore, it is recommended that the Public Health Service undertake to establish regional meetings to train such public agency personnel, and to secure some financial aid for personnel selected to attend such training meetings.

10. Whereas nursing homes and homes for the aged have a real and vital concern with the process of aging, and

Whereas there is proposed a White House conference on aging,

Therefore, it is recommended to the U. S. Department of Health, Education, and Welfare, and to such other agencies as may participate in structuring a White House conference on aging, that the assistance of representatives of nursing homes and homes for the aged be actively sought in developing plans for the conference.

11. Whereas the thermal, acoustical, and illumination characteristics of environment have a direct bearing on the health and safety of the aged in both private and institutional homes, and

Whereas there exists today no recognized qualitative or quantitative criteria for the design of the optimum environment for the aged, in terms of thermal, acoustical, and illumination factors,

Therefore, it is recommended that the Public Health Service foster the development of study and research programs leading to a better understanding of these important environmental factors and to the development of criteria which may serve as a basis for sound environmental design.

12. Whereas the proper care of the aged is a major and growing problem facing the United States today,

Therefore, it is recommended that the American Medical Association, American Hospital Association, American Nurses' Association, American Dietetic Association, American Nursing Home Association, and other groups interested in the total problem coordinate their efforts in order to bring about maximum benefits to our aging population.

Regulatory Agency Problems

1. This conference should endorse the action of the Association of State and Territorial Health Officers, November 2–8, 1957, which has formally requested the Public Health Service to collaborate with other groups having interest in the field of medical care facilities to establish classifications and definitions of such facilities.

2. The Public Health Service should be asked to develop a model law, rules, and regulations for nursing homes and homes for the aged.

3. The model law, rules, and regulations should provide that:

- each patient have his personal physician, a physician be available at all times for emergencies, and medical advice be available to the administrator;
- physical examinations be required within 48 hours of admission date and periodic examinations be made thereafter;
- the regulatory agency will specify the required records on a current basis, including identifying and socioeconomic information, records of physical examinations, and other continuing medical records.

4. The model licensure law should include provision for an advisory committee to the regulatory agency composed of representative professional and interested groups, official and voluntary in the State concerned.

5. In drafting the model law, attention should be given to the human factors, for example, personal interest, dignity, and privacy in patient care.

6. The law, rules, and regulations should include initial and continuing evaluation of physical, mental, financial, educational, and moral qualifications of applicants for licensure to operate or manage nursing homes and homes for the aged.

7. It is recommended that in nursing homes sufficient personnel be on duty and awake at all times.

8. It is recommended that the Public Health Service undertake a study of the requirements for the staffing of nursing homes and homes for the aged.

9. It is recommended that the agency best qualified to provide the following functions should be the responsible regulatory agency: set standards for safety, environmental

health, and patient care; carry out and coordinate inspections; give consultation and planning services; and furnish teaching.

10. It is recommended that a single agency have primary regulatory responsibility for all medical care facilities and homes for the aged.

11. It is recommended that there should be provision for the exchange of information between regulatory and other agencies which would enable all concerned to carry out their responsibilities.

12. It is recommended that State regulatory agencies arrange interagency meetings for workers within a State.

13. It is recommended that adequate funds be made available for research and demonstration projects by State and local agencies with monies furnished by Public Health Service, the States, or other agencies.

14. It is recommended that the appropriate body or bodies should: study staffing needs, qualitatively and quantitatively, of State regulatory agencies including full-time and borrowed services; survey the resources available for education and training of personnel; and prepare a plan to supply education and training not currently offered.

15. It is recommended that the appropriate body or bodies should: study training needs, qualitatively and quantitatively, for administrators of nursing homes and homes for the aged; survey the sources available for education and training of personnel; and prepare a plan to supply education and training not currently offered.

16. It is recommended that the Public Health Service be requested to collaborate with State agencies and other interested groups to collect statistical data at least annually, regarding nursing homes and homes for the aged.

17. It is recommended that there be regional meetings similar to the National Conference on Nursing Homes and Homes for the Aged.

18. It is recommended that regional meetings be held by the Public Health Service, working with State agency personnel giving direct service of all kinds in the area of patient care.

19. It is recommended that the Public Health Service and the State agencies prepare additional guidance materials for dissemination to administrators of nursing homes and homes for the aged.

20. It is recommended that the Public Health Service collect pertinent material developed by State regulatory agencies and all other agencies and disseminate such information.

Financing of Facilities and Services

1. There is need for Federal legislation to further encourage financing for the construction and renovation of nursing homes and homes for the aged, including a set of recommended construction standards for use by the financing agencies when such construction or renovation meets clearly demonstrated local needs. The need for such legislation is so urgent as to require prompt consideration by the appropriate executive and legislative sections of the Federal Government.

In view of the action already taken in certain States in providing funds for housing for older people, it is recommended that consideration be given to allocation of State funds on either a grant or loan basis for the construction of homes for the aged and nursing homes.

Since county and municipal tax funds have traditionally been a primary source of financing institutions for dependent local residents, the possibility of this source for additional financing should also be considered.

2. Since realistic payments cannot be intelligently negotiated without a sound basis of cost, it is recommended that modern accepted accounting methods be adopted in nursing homes and homes for the aged.

Local agencies should be encouraged to determine costs, based on modern accepted accounting methods, related to the kinds and quality of services that can be provided. Public assistance payments should be established to provide a minimum commensurate with these established costs.

3. It is recommended that the Public Health Service collect and publish good cost data that are presently available concerning the operation of nursing homes and homes for the aged, separated by geographic area, and further subdivided to show various levels of service.

4. It is recommended that health insurers of all types should give earnest study and consideration to the further extension of health insurance to cover care in nursing homes and other institutions performing the functions of nursing homes. The prerequisites for such action should be establishment of the medical nature of the care and specific recommendation of the service by a physician either following hospitalization or otherwise. Consideration should also be given to continuation of existing health insurance policies, regardless of age or health condition of the insured. Welfare departments should continue the payment of health insurance premiums on behalf of people who have health insurance coverage at the time they are accepted for public assistance.

5. It is recommended that States be urged to take full advantage of Federal matching funds for medical care to defray cost of care of public assistance recipients in nursing homes and related institutions providing nursing care.

Administration of Homes

1. Every nursing home and home for the aged should have an administrator who is continuously responsible for the proper operation of the home. His functions should include planning of objectives and services; organizing staff and facilities; directing, supervising, and co-

ordinating services; reporting to the board, the public, and the clients; and budgeting.

2. All nursing homes and homes for the aged, whether nonprofit, proprietary, or public, should have a governing board or advisory committee. In some communities it may be more practical for several homes to utilize one committee.

3. Ways and means should be found for encouraging the conduct of active education programs for board and advisory committee members on their functions and responsibilities.

4. Every nursing home or home for the aged should have a medical adviser or medical advisory group. It should be the responsibility of the administrator to initiate the action for establishment of such advisory service, preferably utilizing a local general hospital. If there is no general hospital within easy access, liaison should be worked out with the medical profession through the county or State medical society.

5. A person who becomes an administrator of a nursing home or a home for the aged should be licensed to do so by a properly designated regulatory agency. Such a person should possess a personal motivation to provide or obtain suitable patient care, possess the customarily required moral qualities, and have the following minimum qualifications to merit a license:

- Graduation from an accredited high school or equivalent training.
- Successful completion of a prescribed course of training presented by a recognized educational agency. The content of the course may be planned in cooperation with pertinent professional organizations and approved by the regulatory agency. In any jurisdiction enacting legislation along this line it is expected that suitable training facilities be organized to make feasible the procurement of such training.
- A minimum of 6 months' professionally supervised experience in a recognized medical care facility which would provide background and experience in institutional management, human relations, and ethical practices.
- For one currently functioning as an administrator of a nursing home and/or home for the aged it is further recommended that upon the establishment of a licensure program a grace period of not more than 3 years be extended as a reasonable period of time for such a person to acquire the additional training necessary to qualify for licensure. A specified number of years of appropriate experience could be accepted by the regulatory agency in lieu of this requirement.
- It is recommended that persons currently functioning as administrators of nursing homes or homes for the aged be immediately screened by a testing process designed to disqualify for such a position those who cannot demonstrate adequate ability to read and understand the regulations and literature pertinent to the operation of such institutions.

6. Every nursing home and home for the aged should have a homelike, cheerful, friendly, and hopeful atmosphere that will contribute to the promotion and preservation of the personal integrity of each individual. The home should make available and utilize those services necessary for the emotional, physical, social, and spiritual enrichment of the patient.

This would require properly trained personnel to provide: personal care including food, shelter, and personal hygiene; medical and nursing care, and rehabilitation and optimum health; social, emotional, and spiritual well-being.

Personnel should be selected on a full-time or a part-time volunteer basis to meet these needs. It is recognized that the size, location, and type of home would determine the variables in the staffing pattern of one home compared with another.

The administrator should have a knowledge of the necessary skills and education, as well as the legal requirements for the successful performance of the services to be rendered.

In the selection and engagement of personnel, the administrator should give consideration to the individual applicant's physical, mental, and emotional qualifications for work with the resident "to help the patient to do as much as he can as well as he can as long as he can." He should try to instill in all of his staff a sense of dignity and worth as members of the team of the nursing home or home for the aged.

Personnel practices, methods, and procedures should be explained to staff members in the most effective way possible so that they will be apprised of their functions in the operation of the home. General policies under which the home operates should be written and available to all employees at all times.

7. The administrator of a nursing home and home for the aged should be responsible for determining the qualifications and suitability of each prospective employee for the job he is to perform.

8. Prospective employees should have a preplacement health examination.

9. Every administrator should provide opportunity for the growth and development of staff, professional and nonprofessional, through training either within or outside of the home. Such inservice training may be provided separately or in cooperation with each other by: nursing home associations, State welfare and health agencies, universities, professional organizations, hospitals and related institutions, and other voluntary agencies.

10. There should be uniformity of business and accounting practices in order to establish a basis for charges to patients and agencies purchasing patient care and for better planning and programing.

Smoking-Mortality Rate Among Veterans

A Public Health Service study among 198,926 United States veterans shows a significantly higher death rate among regular tobacco smokers than among nonsmokers. The first report on the continuing statistical survey was made July 8, 1958, by Dr. Harold F. Dorn, chief statistician for the National Institutes of Health, to the Seventh International Cancer Congress in London. Dr. Dorn is also chief of the Biometrics Branch in the Division of Research Services of the Institutes.

The survey generally supports findings of earlier studies which demonstrated a statistical relationship between death rates and smoking.

Death rates among the group of veterans who were United States Government Life Insurance policyholders were summarized for the period July 1954 to December 1956. The deaths were then related statistically to the smoking habits of the veterans. Clinical and laboratory research were not included in the study.

The initial report covers 7,382 deaths during the 2½-year period. Of these, 6,203 occurred in smokers and 1,179 in nonsmokers. The data was from persons who served in the Armed Forces between 1917 and 1940 and ranged in age from 30 to 90 years. The majority were between 50 and 70 years of age.

The report included the following points:

- The death rate from all causes of persons who used tobacco was 16 per 1,000, compared with 13.1 per 1,000 for persons who never smoked. Adjusted for differences in age distribution between the two groups, the death rate was 32 percent higher for smokers than for nonsmokers.
- Persons who regularly smoked only cigarettes had the highest death rate of all groups of smokers—58 percent greater than the death rate for nonsmokers.
- The lung-cancer rate for regular smokers of cigarettes only was about 10 times the death rate for nonsmokers.
- The death rate among regular cigarette smokers was closely related to the amount smoked. For example, the death rates of persons who smoked more than 40 cigarettes a day were much higher than those of persons who smoked fewer than 10 cigarettes a day.
- The death rate of persons who regularly smoked cigars or pipes, or both, was not significantly higher than that of nonsmokers. Only the heaviest users of cigar and pipe tobacco had an appreciably higher death rate from all causes than nonsmokers.
- Nearly two-thirds of the 6,203 deaths of tobacco users studied were attributed to diseases of the heart, blood vessels, and kidneys. The death rate from coronary heart disease was found to be 63 percent higher for regular cigarette-only smokers than for nonsmokers.
- Regular cigarette smokers who had stopped smoking cigarettes before the study began in 1954 had a lower mortality rate than those who continued to smoke. However, the rate was 30 percent higher than that of nonsmokers.
- Regular cigarette smokers also had higher death rates from certain respiratory diseases, such as bronchitis, pleurisy, and emphysema, from ulcers of the stomach and duodenum, and from cirrhosis of the liver.
- The death rate from coronary heart disease among regular users of cigarettes only is 63 percent higher than the rate for nonsmokers.

In addition to the use of tobacco, the continuing study will also explore possible statistical relationships between death rates and such environmental factors as occupations, work environments, and characteristics of the home communities.

Dr. Dorn's paper is entitled "Tobacco Consumption and Mortality from Cancer and Other Diseases." The study was made possible by the cooperation of the Veterans Administration.