Proprietary Nursing Homes

a report on interviews with 35 nursing home operators in Detroit, Michigan

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The problem

ONE OF THE MAJOR AREAS OF CONCERN in the health field today is the care of Americans over age 65. As increasingly larger numbers of persons survive through the middle years of life to reach older ages, this aspect of health care is receiving widespread attention in the health and medical fields and by the public in general. Though there is much interest in the subject of the care of older persons, the amount of factual information available is limited. The subject is comparatively unexplored and many of its problems are unique in the health field.

Perhaps the chief problem among persons over age 65 is long-term disabling and debilitating illness. While chronic illness and disability occur in all age groups, those at the older ages are the most susceptible. Such long-term illness often requires long-term care and it is in this context that the growth of a special health facility in the United States—the nursing home—has occurred. Though known by various names, convalescent home, rest home, etc., a nursing home provides room and board, personal services and skilled nursing care. Thus the nursing home is distinguished by definition from the boarding home where nursing care is not provided. Although public and voluntary groups operate many nursing homes, by far the greatest number of beds are in the proprietary homes. The 466 proprietary nursing homes and voluntary homes account for 10,987 beds in the state of Michigan,* 91 per cent of which are proprietary.

The nursing home is designed to care for those patients no longer needing hospital care but not able to receive proper nursing at home. Little is known about the type of patients in nursing homes nationally, but under

*Albert E. Heustis, M.D., *Health Proposals for 1957* (Michigan Department of Health, October 19, 1959), p. 4.

the Hospital Survey and Construction Act of 1949 the states have begun surveying the extent of such facilities and the future needs.

The proprietary nursing home is an attempt by private enterprise to supply a service not fully met by other means in the community. Despite its important role in caring for the aged, the proprietary nursing home today is generally not well regarded either by others in the health field or by the public. Part of this may be due to the mutual mistrust inherent in situations where profit-making and nonprofit organizations share the same sphere of operation. Nevertheless much of the proprietary nursing homes' low status must be ascribed to past reports of poor personal and medical care found in some of these homes.

The growing need for long-term care for persons over age 65 makes it imperative that proprietary nursing homes be carefully examined. The attitudes of the operators of these homes must be understood by any public or voluntary health and welfare agency seeking to plan programs. Only by knowing more about the proprietary nursing home can an overall program, more rewarding to the patient and to the community, be implemented.

In addition, an idea of what problems these operators have encountered in dealing with the aged patient may provide the basis for more promising programs of care and rehabilitation. This study is only one attempt among many to delineate the problems of aged persons in modern society. Its objective was to increase understanding and thereby enable the total community to better serve a particularly important group, the aged.

This study analyzes the feelings of the proprietary nursing home operator about his role in the health field, the function of the proprietary nursing home in the community, and the problems involved in caring for the aged patient. Although the findings presented here are based on a study of a limited number of proprietary nursing home operators in one metropolitan area, they are probably representative of the attitudes held by many such operators nationally. It is hoped that this report will add new insight into this little understood facility in the health community.

Methodology

This study was conducted primarily by means of an interview survey of a random sample of licensed proprietary nursing home owners in

Detroit. However, background data were obtained from informal interviews with persons active in the health field in Detroit and from direct observation, by the author, of the operation of typical homes.

The process of compiling the list of proprietary nursing homes to be sampled presented many problems. First, the term "nursing home" had to be defined. Second, an accurate listing of all the proprietary nursing homes in the city of Detroit had to be obtained. Third, once such a list was prepared a random sample had to be drawn.

For the purpose of this study a proprietary nursing home was defined as "a profit-making enterprise, supplying room and board, personal services, and skilled nursing care." Homes providing only domiciliary care were not included under this definition.

A list of such homes was obtained at the Detroit Department of Health. The difficulties involved in dealing with files and contents were solved quickly with the splendid cooperation of the members of the department. Seventy homes appeared on the list, representing 52 separate ownerships. It was decided that 35 different owners would represent an adequate sample provided the group was selected randomly. Consequently, each of the 52 owners was given a number. Using the random number table, a sample of 35 was taken. As each name was selected it was recorded and replaced in the group.

It was anticipated that some owners were probably not active in the operation of the nursing home beyond an initial investment and therefore would be of little help. In these cases, and where the owner or owners were not acquainted with the actual administration of a nursing home, the administrator or business manager would be interviewed. Throughout the body of this report the "active" owners together with those interviewed instead of the "inactive" owners are referred to simply as the "operators" of the homes. Some data on the 35 originally sampled *licensed owners,* regardless of their administrative participation, is given in the Appendix.

To insure frankness on the part of the respondents, their cooperation in the study was needed. At the monthly meeting of the Southeastern Michigan Association of Nursing Homes held on March 18, 1957, a sample questionnaire was read to the members and their endorsement

requested. The approval of the general membership was put into the minutes of that meeting. During the interview period this approval did much to smooth the arrangements with the operators.

The actual interviewing took varying lengths of time. The longest interview lasted two hours, the shortest only 35 minutes. The average length of time given to all 35 interviews was 45 minutes. The interviews began in mid-April and were completed at the end of May, 1957.

Before the interview schedule was prepared, extensive use was made of library materials, although literature in the past on the subject of proprietary nursing homes has been scarce. Recent emphasis upon geriatrics and the problems it brings to society has spurred more comprehensive reporting on this subject.

In addition, meetings were arranged with various representatives in the health and welfare fields who were interested in, and in various ways were working with, the nursing homes in Detroit. These interviews provided a broad picture of the current situation. In order to uncover more specific material, contact was made with a proprietary nursing home operator who suggested that the author observe the daily routines of her institution. This was done for two days and observations were recorded on the nursing home routine, staff problems, and the patient needs and services. An understanding of the nursing home and its problems were much more vivid after this observation period.

Letters to the 35 persons on the sample list were mailed out a few days before the interview was planned. Mrs. Ralph Guiney, Planning Director for the Aging of United Community Services, was most helpful in this respect. Actual arrangements for the interviews were made by telephone a few days after the letters were mailed. There were no unusual problems in making interview arrangements. More than one telephone call was necessary in many cases before contact was made with the person appearing on the sample. Actual appointments were missed in only three cases. Follow-up appointments with these people were immediately successful in two cases. In the third case, the third appointment was the successful one.

Characteristics of operators and homes

The operator. The proprietary nursing home operator doesn't share a common academic background with his contemporaries as do members

of many professional groups. He may come from one of several professional groups, or be a non-professional. He (or she) may be a physician, a registered nurse, practical nurse, or businessman, or someone who does not belong in any general classification.

In view of this variety, it is essential to have a comprehensive picture of the sample of operators interviewed in regard to their professional and educational attainment, marital status, sex, and racial group. Thus there is a focal point from which responses of each group may be examined. Since certain professional groups denote specific academic attainment, physicians and registered nurses were not questioned about educational background in this study. The sampled practical nurses and laymen (businessmen and others without training in medicine and health) were asked about the number of years of education they had completed.

Registered nurse and layman were the most frequently reported backgrounds among the proprietary nursing home operators in this study. The former group comprised 15 and the latter, 12, of the 35 interviewees (see Table 1). The remainder were practical nurses and physicians. If the registered nurses are considered professionally trained, there is an almost even division among the operators as far as training is concerned. As many laymen and practical nurses operate nursing homes as do physicians and registered nurses. This breakdown into "professional" and "lay" operators is reflected throughout this study by the divergent responses given by these two groups to many of the interview questions.

Upon comparing the professional background of the operators with that of the owners, as given in the Appendix, two factors of interest emerge. First, although seven physicians own nursing homes, only two

Table 1

Professional Background of Nursing Home Operators Interviewed

Physician	2
Registered Nurse	15
Practical Nurse	6
Layman	12
Total	35

are operators, i.e. active in the administration of their homes. Secondly, with two exceptions, the laymen owning homes are all operators.

Considering the type of medical or professionally-oriented training that would be advantageous in nursing home operation, it is surprising that the number of operators with little or no such training is quite large. This had led many of those with medical or related training to believe that unqualified persons are active in the nursing home field. Regulations require that adequate staffing be provided for the particular type of patient cared for in each home, but the presence of a layman untrained in medicine or nursing care or as an administrator raises criticism among some of the doctors and registered nurses.

The sex of the operators along with their marital status is presented in Table 2. Females predominate in the operation of the nursing homes. This is true both for professional and lay operators. The reasons are understandable. Nursing has largely been a profession of females, and the nursing homes present no exception to this. Many of the operators are older nurses who opened a nursing home as a means of income after tiring of working in hospitals, private duty nursing, and so on. A large majority of the professional and lay operators were married at the time of the interview.

An interesting aspect of this study was the relatively large number of Negro operators found (see Table 3). This was especially marked among the professional operators (physicians and R.N.s combined)—10 of the 17 professionals are Negroes. In marked contrast to this, among the lay operators 15 of the 18 are White. The proportion of Negro operators in the sample may have been strongly influenced by the location of this study in Detroit, for this city has a large Negro community.

The education of operators was of special concern when these individuals were practical nurses or laymen. These data are presented in Table 4. The academic and training experience of the doctors and registered nurses was, of course, assumed.

A large number of college graduates among the laymen might indicate the presence of trained administrators and managers but this is not the case in nursing homes. Only one respondent had completed college; his degree was in business administration. The educational backgrounds

Table 2

Professional Background of Operators by Sex and Marital Status

	M	F	Single	Married	Div.	Wid.
Professional (Physician & R.N.)	2	15	2	14	0	1
Lay (P.N. & Layman)	7	11	3	12	1	2
Total	9	26	5	26	1	3

Table 3

Professional Background of Operators by Race

	White	Negro
Physician	1	1
Registered Nurse	6	9
Practical Nurse	5	1
Layman	10	2
Total	22	13

Table 4

Education of Practical Nurses and Laymen Interviewed

	P.N.s & laymen combined	P.N.s	Laymen
Completed college	1	0	1
Some college	4	0	4
Completed high school	9	5	4
Some high school	4	1	3
Elementary school only	0	0	0
Total	18	6	12

of the laymen indicate little uniform training that would qualify them as administrators or managers of a health facility.

The homes. In the 35 nursing homes selected for study, there were 1,131 beds. At the time of this study, 1,080 of these beds were occupied. The homes ranged in size from 10 to 89 beds (see Table 5); the average number of authorized beds for each of the 35 homes was 32.3. The distribution shows the greatest concentration of homes in the 21 to 30-bed range. This indicates the small business nature of the proprietary nursing homes in the city of Detroit. The small number of beds is also related to the size of the physical plant being used as the nursing home as well as other factors.

On the average there were few vacant beds in the nursing homes sampled. Eighteen had no vacant beds, five had only one vacancy, and four had two vacant beds each. Only one home had as many as ten vacancies at the time of the study and it was one of the largest homes, with 89 authorized beds.

When the addresses of the 35 nursing homes were plotted on a map, the largest number clustered along East Grand Boulevard, once an upper income area, where many old spacious homes have been converted into apartments, rooming houses, and nursing homes. The large houses were easily converted into nursing homes for far less money than it would take to construct new buildings. All but one building of the 35 in the sample were second-use buildings. In this respect the Detroit nursing homes are probably similar to those in other parts of the country.

The 35 homes in this study employed 558 full-time staff members, an average of about 16 per home. As would be expected by the nature of these homes, the overwhelming majority (425 out of 558) were classified as nurses or aides (see Table 6). The remainder of the staff was composed of various custodial and administrative personnel and, in addition, there were 4 full-time physicians employed by these homes.

The homes are operated on a shift basis since 24-hour nursing care is involved. The actual number of staff in a nursing home depends upon many things: the size, kind of program, type of patient, and any number of variables. There is no accepted way of determining the number of staff necessary for each patient under nursing home care, but it has been generally stated that there should be two employees to one patient

Table 5

Distribution of Nursing Homes by Number of Authorized Beds

Authorized beds	No. of homes
4* to 10	3
11 to 20	5
21 to 30	11
31 to 40	7
41 to 50	5
51 to 60	3
Over 60	1
Total	35

*Under law (Act No. 139 of the Public Acts of 1956) only homes with four or more beds are subject to licensing.

Table 6

Job Classification and Number of Full-Time Staff

Classification	Number
Physicians	4
Registered Nurses	54
Practical Nurses	107
Aides	264
All others*	129
Total	558

*Others include cooks, laundrymen, janitors, clerical help and administrators without medical training.

receiving infirmary care.* It would appear that at the time of this study the suggested standard was not being met by some homes.

Problems of staff. The staffing of any health facility seems to be a great problem today, and the probability that nursing homes have a more difficult time than other facilities was anticipated. The operators interviewed were asked if they believed they had experienced more, less, or about the same trouble in hiring qualified personnel than other health facilities, such as hospitals, public nursing homes, church or fraternal nursing homes.

Sixty-nine per cent of the respondents said that they believed they had experienced more difficulty in staffing a proprietary nursing home than is common to staffing other health facilities. Thirty-one per cent believed they had experienced the same amount of difficulty; none said they had experienced less. The reasons given for these difficulties are shown in Table 7. Unless otherwise noted, the figures appearing under frequency indicate all of the responses made to the questions asked. (In many instances in this study, "frequency" columns total over 35 since some respondents gave more than one answer.)

*"Standards of Care for Older People in Institutions," *Section I Suggested Standards for the Aged and Nursing Homes*, (New York: The National Committee on the Aging of the National Social Welfare Assembly, 1953), p. 55.

Table 7

Problems in Hiring Qualified Staff Mentioned by Operators

Response	Frequency*
Cannot compete with others in wages, fringe benefits, etc.	14
Nursing homes lack excitement and activity found in hospitals	8
Nurses do not like caring for the chronically ill	7
Lack of personnel trained in geriatrics	5
The work is much harder	3
Must take older nurses no longer able to work in hospitals	2
Young nurses want varied experience not found in nursing homes	2

*Figures do not total 35 because some operators of nursing homes gave multiple responses.

The most frequent response indicated an economic basis for the difficulty. The sample group generally believed proprietary nursing homes could not pay the wages and fringe benefits common in other health facilities. Probably, the "other" health facility referred to was the hospital, and not public or church-sponsored nursing homes.

Also mentioned was that nursing homes were less exciting than hospitals and that nurses did not like caring for the chronically ill. The reality of such problems is indicated in the following comments by some of the operators:

> *"A lot of nurses do not like to care for older people; they get on your nerves."*
>
> *"Young people do not have the patience and understanding to care for older patients."*
>
> *"Young nurses want experience. They can't get it here. They want companionship and excitement; we just have to settle for the 'has been' who can't keep up in the hospitals."*
>
> *"Caring for the chronically ill is not as dramatic (as caring for the acutely ill). They like to see action in medicine; this isn't true with the aged patient."*

These responses point to important differences in nursing the chronically ill and the acutely ill. The problems they suggest will occur more and more frequently as the aged become an increasingly larger segment of the population.

The patient in the proprietary nursing home

Characteristics of the patients. At the time of the study, 1,080 patients were in the 35 proprietary nursing homes included in the sample. The age of 65 was chosen arbitrarily as the usual mark indicating the beginning of old age. Using this criterion, 953 of 1,080 patients or 88 per cent were geriatric patients. There was much comment by the operators, however, that persons 65 years of age were youngsters compared with the number of patients in their 70's and 80's.

The proportion of patients over 65 (among these 35 nursing homes) ranged from half to all of the patients in each home. Most of the homes,

however, had between 80 and 90 per cent over 65. In nine homes all of the patients were over 65, six homes had all but one patient over 65, and four of the homes had only two patients under 65 years of age.

The length of time a patient spends in any health facility is of primary importance, and this is particularly true of nursing homes. The operators furnished the information on patient stay shown in Table 8. The median length of stay of the patients in the nursing homes studied was 1.9 years. In other words, half of the patients had been in the homes for less than this period, half for longer. However, this figure is deceptively low, for one quarter of all the patients had been in a given nursing home for over 3 years or 15 per cent over 5 years. A few operators told of cases where a patient had spent over ten years in nursing homes.

There were many different reasons why these patients were placed in nursing homes (see Table 9). The most frequently given was that their family was unable to care for them at home. The causes behind this response are numerous; however, they are well known in the field and have been reported many times. This study was designed to point out reasons not usually given for the placing of a person in a nursing home.

Seven of the respondents indicated that the family did not want the person around the home at all. In these seven cases, the operators believed the physical and mental condition of the patient did not really

Table 8

Length of Patient-Stay in Nursing Home as of April-May 1957

Time	Number	Per cent*
Under 1 year	348	32
Over 1 year less than 2	212	20
Over 2 years less than 3	220	20
Over 3 years less than 5	140	13
Over 5 years	160	15
Total	1,080	100

*Percentages rounded to nearest whole number.

justify placement in a nursing home. The operators believed the family was just getting the person out of the way.

Ten of the operators said that many of the patients used to live alone and were no longer able to take care of themselves. It is to be expected that the number of such persons in nursing homes would be high. If they represent persons without families, or out of contact with their families, they are likely to go into nursing homes more quickly than older persons living with their families.

The reasons given by the operators for the patients being placed in a nursing home are mirrored by the problems that arise in caring for the patients in the nursing home itself. The sampled operators were asked about the nature of these problems and their responses are shown in Table 10.

Some mentioned physical ailments as being the most difficult problem. Many said mental conditions caused difficulty. All those responses which indicated a definite physical condition were grouped under *physical deterioration.* Since mental deterioration could be physical and/or psychological, all references to mental conditions were grouped under *mental deterioration.*

The nursing home patient has many hours to pass. In order to find

Table 9

Reasons for Aged Being in Nursing Homes Given by Operators

Response	Frequency
Family unable to care for them at home	29
Unable to continue living by themselves	10
Family does not want to care for them at home	7
Aged prefer living in nursing home	2
Friends recommend nursing home to aged	1

Table 10

Problems in Caring for the Aged Patient Given by the Operators

Response	Frequency
Mental deterioration	23
Physical deterioration	11
Lack of interest in anything	9
Poor living and eating habits	8
Adjustment to their illness	5
Bitterness at their families for putting them into home	5
Peculiar habits	5
The resignation to dying	4

Table 11

Daytime Activities Mentioned by Operators as Enjoyed Most by Patients

Activity	Frequency
Television	29
Radio	21
Reading	15
Sewing and needlework	13
Visiting with patients and outsiders	9
Games, cards, checkers, etc.	5
Sitting in the yard	3
Not much of anything	2

out just what activities patients prefer, the operators were asked what the patients enjoyed doing most.

It is interesting to note the overwhelming frequency of activities requiring little or no physical effort (see Table 11). Watching television, listening to the radio, and reading were the most popular ways patients passed the time of day. Some of the typical comments presented point out the belief by many operators that the patients are just not interested in doing anything:

> *"Some do not want anything, or any activity. They are just not interested."*
>
> *"It is hard to reach them. We have tried everything without much success. They usually forget what we have taught them about games, etc."*
>
> *"For the most part, they just like to sit. Some will watch TV or listen to the radio, but the biggest group of them prefer to just sit and watch."*
>
> *"The only things they are interested in is eating, sleeping and going to the bathroom."*

Some of the operators pointed out that their efforts concerning needlework classes, leather working, or other types of recreation with some therapeutic value, were usually unsuccessful, although one operator reported that she had started a program to have patients make dolls for the Children's Hospital in Detroit. She said this program was very successful, but this kind of response was not typical, and the majority of the operators believed that daytime activities must be limited to activities requiring little physical effort on the part of the patient. Some even pointed out that many of their patients were incapable of doing anything because of physical or mental conditions.

Rehabilitation. There is always hope for the patient to improve sufficiently to be discharged. Among older patients suffering from chronic and disabling illnesses this may be only a slim hope, but still it exists. The operators interviewed in this study seemed to agree, however, that once an aged patient was admitted because of senility, incontinency, or other symptoms usually related to the aging process, little hope of returning to their families or own homes could be offered.

For example, the operators as a group felt there was little possibility of rehabilitating a significant number of incontinent patients (see Table 12). Thirteen of the 35 interviewed responded that none could be rehabilitated. An additional 10 operators believed the total number of such patients rehabilitated would be 5 per cent or less.

However, the professional operators had a somewhat more optimistic view, with only 4 out of the 17 in this group predicting that none of these patients could be rehabilitated. Within the professional group itself the two physicians were more optimistic than the registered nurses. Similarly, among the lay operators, those who were practical nurses generally expressed a stronger belief that these patients could be rehabilitated than the remainder of this group.

In light of the apparent association between optimism about the prospects for rehabilitation and degree of "professionalism" among these operators, it is instructive to compare the generally pessimistic findings presented in Table 12 with those of another study. At various county institutions in Alleghany County (Pennsylvania) bed-pan training was given to a group of ordinary women in various stages of deterioration,

Table 12

Operator's Prediction of Proportion of Totally Incontinent Patients That can be Rehabilitated to be Totally Continent, by Professional Status of Operator

Per cent able to be rehabilitated	All operators	Professional (Physicians & R.N.s)	Lay (P.N.s & laymen)
None	13	4	9
5% or under	10	7	3
25% or under	3	1	2
50% or under	5	3	2
Over 50%	1	0	1
Depends on patient	3	2	1
Total	35	17	18

"stroke" victims, and others with every conceivable deformity.* In the first four months, the extra linen needed daily for each patient dropped from 11 pieces to two. Of course, estimates of successful rehabilitation will vary considerably from study to study. Nevertheless the Alleghany study, as well as many others, has shown marked improvement of incontinent patients after a period of guided care and training.

Several additional questions relating to rehabilitation were included in the interview schedule. Unfortunately, the preparation of some of these questions was found to be faulty once the interviewing was well underway, and only the data relating to totally incontinent patients were usable.

The nursing home operators interviewed in Detroit frequently mentioned that by the time most of the patients are put into a nursing home, they are too aged or ill to rehabilitate. They wanted it understood that when an aged person is put into their home it is because he is too old and too sick for his family or friends to continue caring for him. Many operators said that rehabilitation programs may be worthwhile in boarding homes, or with older folks in their own homes, but that nursing homes housed a population too far gone for any real rehabilitation program.

There were a few, however, who voiced an opposite opinion. These few were convinced that much more could be done in rehabilitating the aged patient, even the totally incontinent patient. Both of the doctors interviewed indicated that too few nursing home operators are well enough versed in the medicines and therapies that may be used to increase the numbers rehabilitated. One doctor believed that a few of the operators were so poorly qualified for their task that they thought a rehabilitation program represented an attempt to return the patient to a full and normal life and were not aware that helping a patient move a finger that had been paralyzed was also rehabilitation. He said that rehabilitation in any of its stages was practiced very little in most nursing homes. A registered nurse believed that much effort and intensive care must go into a rehabilitation program, but that even if the only accomplishment was to help the patient feed himself, it was effort well spent. Thus, the poor experience in rehabilitation reported in the Detroit proprietary nursing homes may be a result of lack of knowledge on the part of most

*Murray B. Ferderber, M.D., and Gerard P. Hammill, M.D., "An Effective Comprehensive Program for Geriatric Patients," *Journal of the American Medical Association*, January 29, 1955.

operators. Another factor may be the cost of rehabilitation programs.

In an attempt to determine what problems the operators felt were involved in setting up rehabilitation programs in proprietary nursing homes, those interviewed were asked to list their special problems. Their responses are shown in Table 13. The meaning of the phrase "rehabilitation program" was not explained unless the respondents requested further explanation. They were then told that it meant every type of rehabilitation in all stages of recovery.

That patients lacked interest was a frequent response, as some of the accompanying comments show:

"The old folks don't want to do the things involved in a rehabilitation program."

"The patients are individuals, just like everyone else. They aren't interested in doing these things, they get mad when we try to get them to do it. We used to take them outdoors on good days so they could get some exercise, but we made too many enemies that way and stopped it."

"Old people just can't understand the exercises. If we do it for them, it's all right. But, if they have to do it, they forget to do it the minute we are out of sight."

Table 13

Special Problems in Rehabilitation Programming as Viewed by the Operators

Response	Frequency
No special problems	13
Lack of interest of most patients	11
Rehabilitation useless with type of patient we have	9
Our limited income	8
Lack of cooperation by community groups	3
Lack of cooperation by families	2
Lack of knowledge of what to do	2
Lack of space in nursing homes	2
Overcoming fears of patients	1

Rehabilitation of the aged patient is a task requiring great patience and a lot of hard work. The experience of finding the patients disinterested in exercises is not new to anyone with experience in rehabilitation. It is natural for most patients to dislike exercises, but rehabilitation programs are built upon keeping the patients active by continuously combating their lack of interest.

Those who said that rehabilitation was useless because of the type of patient they had usually made statements like the following:

"The type of patient we get lacks mental powers and coordination. A rehabilitation program depends upon age and diagnosis. We get that group that makes any type of rehabilitation useless."

"A lot of the people we get are illiterate. Being able to read makes a big difference. These can't read, and are just not interested in learning things."

"By the time we get them they are in bad shape. They don't have the mental ability to grasp things. They are mentally shot."

The frequent reference of the nursing home operators to the special group of patients they receive does have a basis in fact. However, the conception of successful rehabilitation held by many of the sampled operators may well limit their actual success as much as the condition of their patients.

Operators' conceptions of themselves and their homes

Certain character traits are associated with some professional groups. We have all heard of the born salesman, the dignified banker, or the shrewd lawyer. These may be stereotypes, but they are symbols of personal characteristics that have become associated in the public mind with certain professions. In order to find out what qualities might be part of the image of the proprietary nursing home operators, the 35 sampled operators were asked to list the personal qualities a nursing home operator should have. The most frequently mentioned qualities were "sympathy and kindness" and "a love for older people," both of which were mentioned by 15 of the operators (see Table 14). While these qualities are important, they did not reveal, as much as some of the other responses, the difficulties of nursing home operation.

The belief that an operator should understand what older people are like was mentioned 14 times. These respondents felt that there are

certain characteristic problems of the aged patient which must be understood by an operator. The following comments are typical of this group of operators:

> *"If the aged person wasn't a problem to his family, he wouldn't be in a nursing home in the first place."*
> *"Many are old and mean, but you (a nursing home operator) must understand that they have deep-seated reasons for being that way."*

The need for patience was mentioned by 12 respondents. Nursing of an aged patient demands time, and impatience, it was felt, would be a poor trait for anyone caring for this type of patient.

There was strong indication of the need for professional training with 10 operators mentioning this quality. Statements that the operators should be "nurses," "registered nurses only," or "professionally trained

Table 14

Personal Qualities Mentioned by Sampled Operators That Nursing Home Operators Should Possess

Response	Frequency
Sympathy and kindness	15
A love for older people	15
An understanding of older people	14
Patience	12
A professional background	10
A stable temperament	6
Tolerance	3
Stamina	3
Obligation to serve community	2
Know training limitations	1
Honesty and integrity	1
Tact	1
Efficiency	1
No racial bias	1

nurses," were very common. Some of the respondents believed that professionally trained nurses possess character traits that all operators should possess. The professional—non-professional differences among the nursing home operators were evident in these responses. The belief by many professionals that a nursing home operator should have some medical or related training appears throughout.

In an attempt to characterize more specifically the different views of the professional and lay operator, those interviewed were asked if they believed that any special schooling or training was necessary in order to operate a nursing home. However, it became apparent that some interpreted this question as meaning training over and above what they already had. Others believed that the "special schooling or training" meant the training customarily received by nurses. Probably because of this, only about one-fourth of the operators (9 out of 35) answered that they thought special training was needed (see Table 15). Furthermore, there was almost no difference between the professional and lay operators in the proportion answering this question affirmatively. The operators' comments accompanying their replies to this question were more revealing.

Of the nine who believed special schooling or training was necessary, six believed it should be part of the registered nurses' or practical nurses' curriculum, one thought that on-the-job training in a county institution would be a good idea; another thought the state should run a school for new operators and give an examination at the end of the training period. The other respondent believed a school for geriatric nursing should be started.

Table 15

Operators' Attitude Toward Special Schooling or Training

Response	All operators	Professional (Physicians & R.N.s)	Lay (P.N.s & laymen)
Necessary	9	5	4
Not necessary	25	12	13
Don't know	1	0	1
Total	35	17	18

Although those saying no special schooling or training was necessary were not asked their reasons for this view, many volunteered information. Five said that special schooling wasn't necessary but that registered nurses' training was. Four believed special schooling would be helpful. One said you are born with the knack, and one said it just takes common sense.

Although many of the registered nurses believed that special training over and above their present training wasn't needed, they did believe at least that much training should be necessary for all. In general the registered nurses look upon practical nurses and laymen as unqualified to operate nursing homes, although the administration of the nursing home can be a thing quite different from the nursing care that is offered by the home. All persons operating nursing homes in Detroit must meet certain requirements of the health department regarding size and quality of staff. As long as nursing homes meet the basic requirements of nursing care, the actual operation of the home can be in the hands of a doctor, nurse or layman.

The choice of a job, position, or profession is dependent on many factors not always fully understood by those making the choice. Environment, education, and social contacts all have had impact on the individual's lifetime, and when the choice of a career is made, these come into play. However, the reasons given by an individual for choosing a certain job are usually used in determining the motivations and values involved in his choice. The reasons given by the 35 sampled operators are shown in Table 16.

Table 16

Operators' Reasons for Working in a Proprietary Nursing Home

Reason	Frequency		
	All operators	Professional (Physicians and R.N.s)	Lay (P.N.s & laymen)
Prefer geriatrics	13	12	1
Friend or relative in business	9	2	7
Wanted own business	8	1	7
Personal experience with chronic illness or nursing homes	5	3	2
Way to make a living or good investment	4	1	3
Always interested in medicine	2	0	2
Wanted change from hospital	2	1	1

In looking at these reasons, the responses are not unusual considering the diversity of backgrounds. There is a decided shift in emphasis that reflects the difference between the professional's adherence to his group ideals and the non-professional's personal values.

In the lay group it is interesting to note the high number who indicated that the choice came about through being related or acquainted with someone in the business. There seemed to be a chance factor in these cases that should be noted. The comments that follow point this up very clearly:

"I inherited the nursing home from my mother-in-law and I took a chance on running it."

"I married into it. My husband's mother started the business, and when she died, I started into it."

"A friend of mine wanted to go on a vacation, and he asked me to run the home while he was away. I didn't know anything about nursing homes, but I did very well. I bought him out when he got back. I love this type of work."

The degree of satisfaction among the operators regarding their

Table 17

Response to the Question: "If You Were to Make the Choice Again, Would You Still Choose This Sort of Work?"

Response	Number
Yes	30
Don't know	1
Depends upon job offer	1
No	3
Total	35

choice is quite high (see Table 17) if we accept the belief that dissatisfaction would cause them to make a different choice if they had it to do over again.

Advantages and disadvantages of proprietary nursing homes

Since proprietary nursing homes are profit-making facilities, and compete with many government and church homes providing the same type of nursing care, the operators were asked what advantages or disadvantages they had compared to their government and church competitors. Their responses appear in Table 18.

The advantage most frequently mentioned by the operators, "less institutional and more homelike," is valid if small size and type of residence are the criteria. Compared to most public and church sponsored homes, the proprietary nursing homes studied in Detroit were much smaller. The institutional character does seem to depend in part upon size.

The next two responses in order of frequency point out very basic philosophical beliefs generally held by those depending upon economic competition for a livelihood. Those associated with a profit-making concern often believe that greater efficiency results from competition and that pride of ownership plays an important role in better housekeeping.

The disadvantages are not listed since only a few responded to this part of the question. Three said that the staff people were underpaid;

Table 18

Advantages of Proprietary Over Other Types of Nursing Homes as Mentioned by Sampled Operators

Response	Frequency
Less institutional and more homelike	15
More efficient because we are in competitive business	5
An owner has pride in doing a good job	5
Aged do not resent entering private nursing home	4
Better relationship between nursing home, family, and home	3
Responsibility can be placed in one person — the owner	3
Staffs are larger than in public institutions	3

two said that proprietary homes pay taxes whereas the non-profit do not, and two claimed that they had to meet stricter rules and regulations than the others.

Licensing program

The responsibility for the licensing of the Detroit nursing homes was recently assigned to the Michigan Department of Health. The 35 operators were asked if they felt that the licensing program in the city of Detroit was adequate. The reactions of the operators to this program appear in Table 19.

There was a remarkable degree of agreement on the excellence of the licensing program in the city of Detroit. Respondents commented on how well it was administered. A few commented on what they believed to be poor licensing standards in rural areas outside of Detroit, but believed the program very good in their city.

One of the four negative responses made mention of the fact that the law did not cover homes with three or less beds. The respondent believed all homes, regardless of the number of beds, should be licensed and supervised. The other three believed that there was too much emphasis upon physical facilities. One believed more patients should be permitted in the space he had. Another believed the rules were *"just plain asinine."*

Among those believing the current licensing program adequate some commented that this was not true before the Department of Health

Table 19

Operators' Opinion of Adequacy of Licensing Program

Response	All operators	Professional (Physicians & R.N.s)	Lay (P.N.s & laymen
Adequate	30	16	14
Not adequate	4	1	3
Don't know	1	0	1
Total	35	17	18

took over. When the licensing was a welfare duty, some said it was not handled as well as it is now.

The one respondent who said *"don't know"* went on to explain: *"There are some bad homes. There must be something lacking if they get bad ones. My aides tell me what happens in some and I wouldn't put my mother in those homes. But, the city inspectors aren't always able to catch things."*

Status in the health community

Many reports have been made of the poor standards of safety, sanitation, and nursing care in nursing homes, irrespective of type of ownership. The National Committee on the Aging of the National Social Welfare Assembly reported on some aspects of nursing home standards in the following manner:

Physical Safety and Comfort

Safety hazards often exist. A study in one community showed that 80 per cent of the nursing homes had safety hazards. These include steep, dark stairways, slippery floors, small rugs, lack of handrails in long corridors, obstacles to movement, and an absence of personnel on duty at night.

Management and Personnel

Many state agencies report evidence that owners of some commercial homes are concerned solely with financial profit, and exploit sick and helpless people in the interest of making money.

Restraints

Shocking evidence of inhumane treatment is known to exist in homes located in all parts of the country. In some homes patients strapped to their beds have been found by state inspectors, public health nurses or welfare workers from the local public agency. Complaints sent to local and state health departments reporting that patients were given drugs to induce almost continuous sleep were investigated and found to be true. Many complaints are made of harsh treatment to patients who are incontinent. Some homes are known to refuse fluids to these older people, or to give them medication to cause dehydration.

Health and Medical Care

Poor health and medical care exist in many homes under every type of auspice. Many homes provide no medical supervision and no assurance of hospital care when needed. Some accept patients for whom they are not licensed to care, such as persons with severe mental conditions or tuberculosis. Often the sick and well are kept together in long wards . . . Relatively few homes provide preventive and rehabilitation services.*

Such reports are very common, and have produced a stereotyped picture of all nursing homes and of the proprietary nursing home in particular.

This study was not concerned with assessing the validity of reports similar to those above. It attempted, instead, to gauge the effect of these reports on the people who operate nursing homes, and to get their responses regarding the reasons for such reports. In order to obtain their opinion on this subject, the operators were asked if people in other medical service fields had a fair opinion of proprietary nursing homes. Over two-thirds of the respondents believed that the opinions held by others were unfair (see Table 20). A somewhat larger proportion of the professional operators than of the lay thought that opinions of others about proprietary homes were fair.

*Ibid., p. 15.

Table 20

Attitude of Others in Health Field Toward Proprietary Nursing Homes as Judged by Sampled Operators

Response	All operators	Professional (Physicians & R.N.s)	Lay (P.N.s & laymen)
Do not have fair opinion	25	11	14
Have fair opinion	8	5	3
Don't know	2	1	1
Total	35	17	18

The 25 operators indicating that others had unfair opinions were asked what these were. Their responses appear in Table 21.
Many of these responses will sound familiar since they form the substance of most of the criticism of nursing homes. The respondent was then asked for the reasons such unfair opinions were held. These reasons are given in Table 22.

Judging from Tables 21 and 22, one thing is quite clear: Proprietary nursing home operators are quite conscious of the poor opinions of their organizations held by the public and the health community. The reasons given for the unfair opinions were varied. Some of the comments relating to lack of understanding of the nature of the aged patient and the cost involved in caring for the aged patient follow:

"Nursing home care to the aged patient requires twenty-four hour attention and that is expensive."

"People do not realize the amount of services our patients require. They have never been in a nursing home."

"People expect us to do as much on $5 to $7 a day as a hospital does on $30 a day. We just can't afford to do as much as we would like to do."

The group believed that most people are unaware of just how much care the chronically ill patient requires. Many operators believed

Table 21

Nature of Unfair Opinions About Proprietary Nursing Homes Mentioned by Operators

Response	Frequency
Patients neglected and mistreated	18
Homes are dirty and unkempt	10
Home owners are interested in money only	5
Homes do not try to rehabilitate patients	3
Homes are firetraps	1
Other facilities could do better job	1
Homes are dumping grounds for old folks	1

that more care could be given the patients, but that the increased cost to the families would be prohibitive. There was general agreement among those accepting assistance patients that the rate allowed was woefully inadequate.

The responses attributing the unfair opinions to publicity are interesting in that quite a few operators agreed that in the past conditions were very bad, but believed that current reports of substandard care are greatly exaggerated.

In view of the six respondents attributing current unfair opinions to conditions that were true in the past and those admitting past conditions were bad but attributing current opinion to the publicity a few homes receive, it seems that many present operators agree that the history of nursing homes has been bad.

Most operators also seem agreed that present conditions are improved but that due to the unfamiliarity of others with both the type and cost of care an aged patient requires, and the type of facility a nursing

Table 22

Reasons for Unfair Opinions About Proprietary Nursing Homes

Response	Frequency
Do not understand nature of the aged patient and cost of care	9
Associate few publicized poor homes with all nursing homes	8
In the past the standards in nursing homes were poor	6
Have never visited nursing homes	5
Non-professionals in business give us a bad name	4
Odors from terminal cancer and incontinent patients aren't understood	2
No distinction made between nursing home and boarding homes	1
Patients without a clear mind tell false stories	1
Public Assistance rates are too low to give better care	1
Making profits thought wrong by some	1
There is a lot of truth to it	1
There is a certain amount of shame attached to putting aged in homes	1

home is, common misconceptions arise. The awareness of generally poor opinion of nursing homes by those working in the business has affected their relationship with others in the health community.

An important health facility, providing service for a substantial number in our aged population, is neither accepted nor trusted by related public or private health and welfare agencies. The distance between the groups must be narrowed, but in view of the low status long ascribed to proprietary nursing homes, it will demand more understanding than either group has been willing to exhibit thus far.

Those blaming the non-professional operators for the bad reports again point out the undercurrent of feeling apparent throughout this study. These responses were typical:

"Some of the homes are run by people not in the nursing profession. They don't know how to do it. They haven't been trained."

"Some homes are opened by non-professionals just for money, and their patients aren't getting the proper food and treatment."

Table 23

Operators' Opinions on How Prestige Could be Increased

Response	Frequency
A public relations campaign	14
Invite public into homes at any time	9
Do a good job in your own home	8
Raise standards for operators and homes	5
Public education program on geriatrics and problems of aged	5
Get more professionals into field	4
Raise public assistance rate so better care can be given	2
Enough being done already	1
It is impossible	1
Don't know	1

It is evident that there is strong feeling among some of the doctors and the registered nurses that the operators have no professional training, and that some operators who have recently entered the field represent a group of speculative businessmen.

In view of the low status of nursing homes acknowledged by them, operators were asked in what ways their prestige could be increased. Table 23 reports these responses. Over half of the responses indicate a belief that some form of improved publicity or public education was needed. However another large group of replies involved improved standards or practices in running the homes.

The most frequent response to this question shows there is strong support for a public relations campaign. An attempt was made to make them more specific about what constitutes public relations, but this was unsuccessful. The invitation to the public to enter the homes, however, indicate confidence on the part of many that they are doing a good job, and do not fear criticism.

Once again the feeling among this group, that certain homes and operators now in business shouldn't be, is reflected in the belief that standards for both operators and homes should be raised. Also, four respondents believed more professionals should be in the field.

In view of the importance that nursing homes are assuming today, the operators were asked if they believed the future would see an increase or decrease in the number of proprietary nursing homes. The respondents were further queried for the reasons behind their future outlook.

Table 24

Operators' View on Future Number of Homes

Response	All operators	Professional (Physicians & R.N.s)	Lay (P.N.s & laymen)
Increase	25	15	10
Decrease	10	2	8
Total	35	17	18

About 70 per cent of all the operators look for an increase in the number of nursing homes in the future (see Table 24). The most frequently given reason was that the aged population is increasing (see Table 25). However, among the lay operators only a little over half of them thought the number of proprietary homes would increase. While within the lay group, all but one of the six practical nurses interviewed felt that the number of homes would decrease.

The following comments by the practical nurses indicate why their feelings run counter to the generally optimistic outlook:

"The rules and regulations are way out of line. People who do not know nursing homes draw up the plans, and this will force us out of business."

"Many coming in will go broke. Following the regulations, you can't make money."

Table 25

Reasons for Increase in Homes

Response	Frequency
Aged population is increasing	15
People think there is money in this business	9
No other place for the aged in society today	7
Public becoming aware of the care given in nursing homes	4
People cannot afford the other methods for caring for the aged	4

Table 26

Reasons for Decrease in Homes

Response	Frequency
New rules and regulations too expensive for many homes to meet	6
Those coming in after money will go broke	1
Government competition will force us out of business	1
Expanding much too rapidly at present	1
State will eventually take over all nursing homes	1

"They (nursing homes) are expanding too rapidly, too many inexperienced people are in after the money."

"Just can't keep up with the rules, will have to decrease."

"The old homes on the boulevard (East Grand Boulevard in Detroit) will go out of business because of regulations. And it's pretty hard to open up new homes now."

The general feeling here is that the new rules and regulations make it difficult to operate a nursing home (see Table 26). Perhaps more pressure is felt by the relatively little-trained practical nurse operating a nursing home than by the businessman who hires well-trained registered nurses. The almost unanimous agreement by this group that the number of nursing homes will decrease is a good indication of the effect of the steady rise of standards on some owners of nursing homes. The end of the relatively little-trained practical nurse as a force in proprietary nursing

Table 27

Operators' Opinions of the Problems Facing Proprietary Nursing Homes Today

Item	Frequency
Public assistance rates too low	16
Finding qualified personnel for staffing homes	13
Unqualified people running substandard homes	5
Unnecessary government regulation	5
Poor public relations	4
Adjusting to the new rules and regulations	4
Eligibility for public assistance investigation too slow	3
Operating costs are increasing	3
Government competition	2
Lack of uniform standards for new and older nursing homes	2
Lack of cooperation by public and private agencies with nursing homes	2
Racial problem	2
Need for consolidation of small nursing homes for purchasing	1
State taking us over in 20 years	1
Use of nursing homes as dumping grounds for troublesome agency cases	1

home operation seems very likely if the experience of these operators studied in Detroit is typical.

The problems facing any group in society reveal much about that group and their values. The problems of proprietary nursing home operation that were mentioned by those interviewed are presented in Table 27.

The high response concerning public assistance payments would be more meaningful if the questionnaire had determined what number of patients in each home were public assistance cases. This was not part of the study. But from observation, it can be said that nearly all homes with empty beds and without any prospect of filling them with private cases would accept public assistance patients. A few said they would not accept public assistance cases because it was impossible to care for them with the amount paid. On the other hand, some homes provided care solely for public assistance patients.

The concern over finding qualified personnel for the nursing homes is common in all parts of the health community. Nursing home needs differ from the needs of other health facilities in that training in geriatrics is considered highly important and desirable.

Summary and conclusions

The purpose of this study was to obtain information about proprietary nursing homes and operators in the city of Detroit and to help those concerned with the problems of the aged in better understanding this segment of the health community. More data could have been obtained. Better structuring of certain questions might have produced more extensive information. Better interviewing techniques might have strengthened the reliability of some responses. All these are common afterthoughts of any study; it is hoped, however, that the data here may be useful and provide starting points for further research.

Certain questions were raised at the beginning of the study, and the results of this research have answered these to a considerable extent. It is not the purpose of this summary to review the contents of all tables and data presented, but to summarize the data as they relate to the ten questions presented as the basis for the study.

For years the size of our aged population has been increasing gradually. As this group grows, the number susceptible to chronic dis-

eases associated with age and in need of care and supervision similarly increases. The nursing home is a facility that helps to meet this need, serving as an intermediary between family homes and hospitals.

In communities not fully aware of the problems of the aged, and consequently not too active in the regulation of proprietary nursing homes, the early growth of such homes was marked by frequent mismanagement of patients. When some state governments began to take more interest in this problem, they found an established business with a history of operation.

The data uncovered in this study help to bring about understanding of many of the serious problems facing proprietary nursing homes and those working with and regulating them.

The physical structures now housing the aged patient in Detroit were not originally designed to be nursing homes. They are mostly older houses that, because of size, location, and price, could easily and profitably be converted. The large number of patients in these converted houses make any drastic change in building requirements improbable in the near future. New proprietary nursing homes will face rising building standards, but standards for older homes will rise only gradually. The reality underlying the tolerance by the regulatory authority of older second-use buildings and their many inadequate and outdated furnishings is quite simple. Beds are needed. Though the buildings are not the newest, and their furnishings not the latest, proprietary nursing homes are contributing an important number of beds to the total required to meet today's needs.

Although many of the problems of staffing a proprietary nursing home are not very different from those encountered by any medical service facility, they do present added complications. These homes are serving a specific group—the aged. Nurses, and for that matter all other nursing personnel, are scarce today. Geriatric nurses, in a sense, are specialists within the nursing field, and much more difficult to recruit. The data in this study point out some of the reasons for the difficulties in staffing a nursing home, including a low-wage standard.

The type of nursing care found in nursing homes does not appeal to most trained personnel. More than one operator interviewed for this study said that the aged patient is just not pleasant to take care of.

Perhaps more basic is that the outlook for the chronically ill, aged patient does not offer a nurse much possibility of uncomplicated and emotionally satisfying "cures." The nurse in a nursing home sees almost all of her patients eventually die, and unless she has great interest in geriatric nursing, she may find this too depressing.

Another important factor in anyone's work is the working environment. Many operators commented on the great contrast between hospitals and nursing homes. One called it the contrast between youth and age. The excitement of a hospital is a very real thing; the people working there feel a certain sense of being part of an active and dramatic community service. Employees are in constant contact, not only with others of their own training, but with a wide variety of professionals and non-professionals. This contrasts with the typical proprietary nursing home where the average number of staff working during the day is six or seven persons. Unless these individuals are specifically trained in geriatric nursing, or prefer such nursing, it is not hard to understand the statement one operator made: *"We must take older nurses no longer able to work in hospitals."*

The skills required for nursing the aged patient did not appear to warrant special schooling or training in the opinion of most operators. It was felt that a little on-the-job training would be sufficient unless a person were just not capable of adjusting to such nursing. In view of the increased interest in all phases of geriatrics, the low response favoring special schooling or training is unexpected. The large number of laymen represented in the study sample may explain this, however, since they were not involved in actual nursing duties.

The staffs of the nursing homes did not list any persons in the field of rehabilitation, and probably could not support such personnel; however, three homes did participate in an experiment. An occupational therapist was hired for one year, with each home paying one-third of the salary. The occupational therapist set up programs in all three homes and, when at the end of the year the results were examined, they proved to be very poor. In the words of one operator, *"Our staff finished the work some of the patients began."* This was the only instance where a professionally trained therapist was mentioned, and the combination of poor results and cost ended such work.

If the size of the nursing homes makes cost a prohibitive factor in the employment of such personnel, some special arrangement should

be made. Unless the nurses and aides can fill this need, the aged patient is denied the opportunity of receiving a highly significant aspect of geriatric care.

The staff of a nursing home seldom includes a doctor on a full-time basis. The usual arrangement is to have one or two physicians who are on call at all times. However, many patients or families retain their own physicians who make periodic visits. This means that most often the responsibility for running the home is in the hands of a registered nurse, or sometimes, a practical nurse. The skill and reliability of the nurse in charge becomes very important under such circumstances.

The size of the average proprietary nursing home does cause some problems, but in the opinion of many operators, its small size is an asset as far as the patient is concerned. The reference to the homelike atmosphere of the small nursing home was contrasted with the large public and non-profit institutions. The proprietary nursing home was also given an advantage over the governmental and non-profit homes because of reasons attributed to its competitive nature.

The types of institutions usually operated by government are well known. They are large imposing buildings, and for the most part have not presented the brightest picture to the aged persons staying in them. The homes run by non-profit churches and fraternal groups vary in size, but the tendency here has been toward a large number of beds. On the other hand, a majority of proprietary nursing homes are small, with twenty-five or thirty beds, but this is often a result of the amount of capital investment available, and the type of building used. There are some large proprietary homes that do seem to reach institutional size.

In the "Spotlight on Chronic Illness" series, an issue was devoted to the planning and equipping of the nursing home. The requirements of the physical plant were given as:

> Nursing homes above all should approximate the homelike atmosphere as closely as possible. A somber institutional character must be avoided.
>
> One means of approach to a homelike quality is to keep the nursing home as small as is consistent with economical

> maintenance of essential services and quality of care. Homes with capacities of 25 to 50 beds are considered to be of the most practical size. This range has advantages from the administrative standpoint in that smaller units are easier to operate to give individualized service. Also, provision of small nursing homes in rural communities serves to restrict the size of the area from which patients are drawn which will make visiting convenient and help the integration of the patient in community activities. Some larger homes will probably be required in areas of concentrated population.*

The proprietary nursing homes in the city of Detroit do meet the recommended size, but homelike quality does not depend upon size alone.

The competitive nature of proprietary nursing homes reflects their profit-making basis, of course. As a group, they showed some concern over the increased activities of government and non-profit groups. Under the Hill-Burton Act of 1949, a survey of the nursing home needs was started. Where the existence of a bed shortage is established, the local and state governments can apply for financial aid to help construct buildings to help remedy the situation. The sponsorship of such homes may be public, or non-profit, but the proprietary nursing homes were specifically excluded in this legislation. This has caused many owners and operators of proprietary nursing homes to feel that eventually their services will no longer be needed.

The Michigan Department of Health has taken over the licensing and regulating of proprietary nursing homes as a result of Act No. 139. The administration of that program is well received by a large majority of nursing homes. Some comment should be made, however, on the problems that the department now faces.

First, a period of gradual adjustment in standards must occur. The department is faced with the recognition of bed needs, and cannot raise standards unrealistically or too fast, or a shortage of beds may result. Second, the setting of standards requires a number of persons to insure that such standards are met. The difficulties of inspection are legend in any area, but in the field of health, the problems attending inspection are many. Third, the actual licensing of the nursing home owner to

*"Planning and Equipping the Nursing Home," *The Modern Hospital*, Vol. 86 (March 1956), p. 72.

operate a facility requires that he hire staff to meet certain patient needs, the size of staff depending on types of patients, the care required and related factors. There is great turnover, particularly among aides, and periodic visits by members of the city health department finds frequent staff changes in each home.

Such problems cannot be solved quickly. The general agreement by the operators concerning adequacy of the licensing program seems to indicate that current standards have not been too tough on nursing homes; however, there will be much discontent as future changes in physical plant requirements are made.

The status of the proprietary nursing home is quite low in the health community. Owners and operators are quite aware of this, and have generally avoided any active role in community health planning. What are the factors that have contributed to the low status of nursing homes? The chief reason is a poor past history. Although the nursing home is quite different from a boarding home, few people seem aware of it. There seems to be a consensus that all homes for the aged, regardless of classification, are places where individuals must go when they become too poor or infirm to be active in society.

This viewpoint is changing, however, particularly among those active in community health and welfare services. But, the problem of drawing the proprietary nursing homes into cooperative community planning is difficult. The lack of understanding the operators believed prevalent among others in the health community is, in fact, very great. Also, a defensive attitude among many operators has often kept them from making any real effort to work with other groups concerned with the problems of the aged. There is some evidence that this defensive attitude might be justified as a result of the opinions and actions of some community groups and leaders.

Interest in this study was initially aroused by the very strong hints of something "sinister" to be found in private nursing homes. In conversations with people representing many segments of the community there were either obvious references to the "terrible" nursing homes, or hints of the bad conditions to be found there. If such feeling is widespread among community leaders, it is not difficult to see why communication between proprietary nursing homes and other health efforts is so often

strained. When twenty-five of thirty-five persons interviewed believe that others in the medical service fields maintain unfair opinions of the types shown in Tables 21 and 22, it is easy to understand the reluctance of the operators to assume community responsibility.

It is hard to believe that the standards of treatment and care in Detroit are low enough to warrant the "unfair" opinions held, even though standards for the care of the aged are in need of great improvement. But improvement should be a continuing process in all aspects of medical care and service. Lack of improvement is usually an indication of lack of interest of society in general, and not of a particular group mistreating another. The inadequacies of proprietary nursing homes are signs of a disinterested society.

The data in this study on individuals owning or operating proprietary nursing homes reveal several important patterns; however, comments in this summary must be limited to those believed most important, as follows:

The presence of many laymen in the nursing home business may be an indication of the profits it seems to promise. There is a very definite need for beds which is well illustrated by the few vacancies found in the homes during the study. As long as there is a need for beds, and it is not met in some way, the prospect of speculators entering the nursing home business is good. What the margin of profit may be is not known; however, many comments made during interviews would indicate that it is much smaller than many believe.

The large number of laymen-operators caused much concern among the medically trained owners and operators. The general feeling was that knowledge of what constituted good medical and personal care varies greatly depending upon the owners' education and experience. Many nurses firmly believed that the layman's ignorance of medicines and drugs actually deprived many patients of the benefits of new medicines and treatments. They also believed that minimum care, rather than good care, might be given by profit-conscious laymen, whereas the trained nurse does not put profit before the patients' welfare.

The extent and quality of medical and personal care depends upon the honesty and integrity of the owners, as well as level of education. If

laymen employ qualified personnel, however, there should be no difference in the operation of their nursing homes from those owned by doctors or skilled nurses.

There is little doubt that the owners and operators interviewed in this survey were not generally providing the finest care possible. The reasons are numerous. Cost is the most important, for those depending largely upon public assistance payments are able to provide only minimum care. Some homes, due to their small incomes, caring for mostly private cases, are naturally limited by what charges the market will bear.

A serious problem that the licensing authority must face is a careful screening of those persons applying for licensing. Then, once an individual is licensed to operate a nursing home, consultative services and inspection become the two primary tools to assure that patients receive adequate care and that all standards are met.

The data concerning patient needs and services are most revealing on the subject of rehabilitation. Despite all that has been accomplished in this area of geriatrics, the proprietary nursing home operators hold little hope for the rehabilitation of most of their patients. Much more research is needed before the processes of aging are completely understood. On the basis of all present knowledge it is apparent that few proprietary nursing homes have attempted rehabilitation programs. The extent of rehabilitation practiced in any given nursing home varies with the knowledge and skill of the people working there, and it seems that many who are so employed lack the necessary qualifications.

There must be a point at which human beings are no longer able to be rehabilitated; the body is only capable of a certain length of life. But with modern medical care continuously increasing the life expectancy of humans, and sustaining faint glimmers of life for long periods of time, the life span often can be extended without true rehabilitation. It is possible that many individuals in nursing homes today are the beginning of a much larger group that in the future will have to live out longer lives under constant care. This seems very pertinent as science keeps lengthening life. Certainly it is important in determining the nature and standards of nursing homes and what function they may be expected to serve in the community.

The future of the proprietary nursing home depends upon many things. Most important is the future course of government. Society is now very conscious of the aged, because those over 65 are becoming an increasingly larger proportion of our population. Legislation to aid in housing and caring for aged persons has been passed on both the federal and local levels. If the role of government continues to grow in these areas, it will naturally have greater impact on the proprietary nursing home and on its future.

Seventy-one per cent of the operators interviewed in this study believed the number of proprietary nursing homes will increase in the years ahead and that these homes will be capable of meeting increased needs as they arise. This group is concerned about greater government regulation, but does not believe that private businessmen running nursing homes will suffer too much from government competition in the immediate future. The demand for beds will be too great. A few operators did believe that changes in the proprietary nursing homes must occur if they are to continue operating. The field must rid itself of substandard homes and unqualified operators and begin working toward raising standards. This group is aware of its responsibility as a growing part of the health community and realizes that society is too conscious of the problems of the aged to ignore the role of private efforts in meeting some of them.

In general, proprietary nursing home operators are quite conscious of the increased interest in their activities by the general community, as well as the public, and voluntary health and welfare agencies. As a group, they present special problems that are not often fully understood. It is hoped that this study may further that understanding by supplying data of a type not usually available. ■

APPENDIX

Table 1

Professional Background of Owners

Physician	7
Registered Nurse	10
Practical Nurse	4
Layman	13
Other*	1
Total	35

*Ownership listed as a corporation.

Table 2

Year Present Owner First Licensed in City of Detroit

	1945 or earlier	1946-1949	1950-1954	1955 to present
Physician	—	1	4	2
Registered Nurse	—	3	7	—
Practical Nurse	1	—	1	2
Layman	1	1	7	5
Total	2	5	19	9

Table 3

Professional Background of Owners by Sex

	Male	Female
Physician	7	—
Registered Nurse	—	10
Practical Nurse	—	4
Layman	5	8
Total	12	22

Table 4

Professional Background of Owners by Race

	White	Negro
Physician	4	3
Registered Nurse	5	5
Practical Nurse	3	1
Layman	9	4
Total*	21	13

*Corporate Ownership not shown.

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