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THE ROLE OF A MEDICAL COORDINATOR
IN EXTENDED AND LONG TERM CARE FACILITIES
IN BRITISH COLUMBIA - A DELPHI STUDY

by

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ABSTRACT

A role description for a medical coordinator in extended and long term care facilities in British Columbia has been defined using a Delphi method. Also obtained during the study was a long term care philosophy. Three groups - nurses, administrators, and physicians took part in three rounds of the Delphi study. Thirty-five respondents were interviewed in the first round. During this interview the researcher obtained from the respondents the statements that they considered should be included in this role and philosophy description.

During the second round the respondents rated the responses of the first round and in the third round those of the second round were revised after seeing the mean scores of the whole group and the three separate groups.

The description of the role of a medical coordinator developed describes the role as it applies to: resident care; private physicians; planning, development and evaluation of care; staffing of a facility; education; administration; and the training, experience, skills and attitude of a medical coordinator.

When the description created was compared with that for the medical director in a long term care facility in the United States it was found that this study had described additional dimensions of the role, in particular the multidisciplinary approach and the physician's knowledge, train-

ing, experience, skills and attitude.

The results of the study show where there was agreement and where there were differences of opinion between the three professional groups.

A long term care philosophy which was considered very important for a medical coordinator to promote, has been defined during the study. It focuses on the resident reaching his full potential, the creation of a special environment, as well as acceptance of disability, dying and death.

Recommendations from the study are made for facilities which might be considering employing a medical coordinator, for planners deciding whether to provide funds for medical coordinators, for geriatric medical education and for the acceptance of a long term care philosophy in all parts of the health care system where there are long term care clients.

To my wife Penny,
and children Mark and Sarah.

TABLE OF CONTENTS

ABSTRACT	(i)
DEDICATION	(iii)
TABLE OF CONTENTS	(iv)
LIST OF TABLES	(viii)
LIST OF FIGURES	(ix)
ACKNOWLEDGEMENT	(x)
 I INTRODUCTION	 1
The study	2
Long term care facilities	3
Extended care facilities	5
The management of facilities	5
Defining a role	7
The study question	8
Definition of terms used in this study	8
Organization of the thesis	11
 II LITERATURE REVIEW	 12
The medical director in a long term care facility	12
The development of geriatric medicine	13
Great Britain	13
University teaching of geriatric medicine	14
The United States	14
Institutionalization	15
Recent developments in geriatric medicine in the U.S.	16
Aging and medical education in the U.S.	17
Training programs in the U.S.	18
Manpower requirements in the U.S.	19
Canada	20
Training programs in Canada	22
Definition of geriatric medicine in Canada	23

Psychogeriatrics in Canada	24
Institutionalization and physicians in Canada	24
The attitude of physicians towards older patients	25
Complexity of problems	29
Physician satisfaction	29
Dementia	29
Problems seen	30
Diminished functional status	30
The philosophy of long term care	31
Objectives for long term care	36
Attitude of care givers	38
Nursing models	39
Rehabilitation	40
Caring	42
The change in philosophy for the resident	44
A role description	44
A role description and a job descrip- tion	45
Consensus on role expectations	45
The Delphi method	46
Description of method	47
Effectiveness	48
Problems of a committee	49
Problems with a Delphi method	50
Benefits of a Delphi method	51
III METHODOLOGY	54
Ethical review	54
The sample	54
The Delphi process	56
The first round	56
The second round	60
The third round	62
Response rate	62

IV	RESULTS	66
	Differences between groups	67
	Differences between nurses and physicians	67
	Differences between nurses and administrators	69
	Differences between administrators and physicians	70
	Effect of the Delphi method on consensus	70
	Defining the consensus	71
	Summary of a medical coordinators role	73
	Resident care	73
	Private physicians	73
	Staff of a facility	73
	Education	73
	Management	74
	Training and experience	74
	Skills and attitude	74
	A long term care philosophy	76
V	DISCUSSION	77
	Reliability and validity	80
	Bias	81
	The development of the role	81
	Limitations	81
	Comparisons	82
VI	RECOMMENDATIONS	84
	Opportunities for further research	85
	BIBLIOGRAPHY	87
	APPENDICES	94
	I Description of a coordinator of an extended care unit (from guide for operation of extended care programs - B.C. Hospital Programs 1980 - Appendix I)	94

II	The role of a medical coordinator (from guide for operation of extended care programs - B.C. Hospital Programs 1980 - Appendix VII-2)	96
III	Guidelines for a medical director in a long term care facility (American Medical Association 1977)	97
IV	Submission to the University of British Columbia Screening Committee for research and other studies involving human subjects: Behavioural Sciences.	100
V	Introductory letter to senior administrators	105
VI	Delphi round I - Introductory letter	106
VII	Delphi round I - Questionnaire	107
VIII	Delphi round II - Introductory letters	109
IX	Delphi round II - Questionnaire	111
X	Delphi round III - Introductory letter	116
XI	Delphi round III - Questionnaire	117
XII	Delphi round III - Results	127

LIST OF TABLES

	<u>Page</u>
1. Total study sample, questionnaires sent and number and percentage of respondents interviewed from each of the three groups - administrators, nurses and physicians - round I.	64
2. Questionnaires mailed and numbers and percentages received from respondents - round II and round III.	65

LIST OF FIGURES

	<u>Page</u>
1. Comparison of acute care model and long term care model - from Weiler (1974).	33
2. Comparison of scientific and humanistic medicine for selected health care elements - from Halstead and Halstead (1978).	35
3. Headings used in the round I interviews.	57
4. Headings for the round II questionnaire.	59
5. Likert five point ranking scale used in rounds II and III questionnaires.	60

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I. INTRODUCTION

With the predicted increase in the proportion of the population aged over sixty-five years (Canada's elderly - Statistics Canada 1979), health care planners are interested in the development of care for this age group. Physician input to the overall care of the elderly in extended and long term care facilities is the focus of this thesis.

Most residents of extended and long term care facilities in British Columbia (B.C.) have their own private physicians. When a facility has many residents there may be a large number of different physicians visiting patients. The boards who are responsible for the overall care of the residents in a facility may have no particular physician to whom they or the administrators can refer for advice or otherwise involve in decision making for the institution. The director of nursing may also wish to discuss with a designated physician problems relating to overall resident care.

The Medical Services Commission which is the branch of the Ministry of Health principally responsible for payment of physicians in B.C., has recognized this role for the physician and has provided some funding for medical coordinators in both extended and personal/intermediate care facilities. Other divisions of the Ministry of Health which may also provide funding for medical coordinators either directly or indirectly are Hospital Programs and the Long Term Care Program. The B.C. Medical Association has recently recommended

that all long term care facilities have medical coordinators (Fahrni, 1980)

B.C. Hospital Programs Division of the Ministry of Health has defined guidelines for the duties of a coordinator of an extended care unit (Appendix I). This person may have training in any one of several health disciplines - administration, medicine, nursing, occupational therapy, physiotherapy, psychology or social work.

Guidelines are also given for the role of a medical coordinator in an extended care unit (Appendix II) and the statements are made that

"The duties of the medical coordinator should be set out in writing. There should be a clear definition of this supervisory physician's position relative to other medical staff and the extent of his or her authority."

A medical coordinator, if he is to fill his role effectively, needs to be aware of the expectations of the role that are perceived by physicians, administrators and directors of nursing. This study will examine these expectations.

THE STUDY

The aim of this thesis is to examine the possible role of a medical coordinator in extended and long term care facilities in British Columbia, first by reviewing the experience with medical directors in long term care facilities in

the United States and then the development of geriatric medicine in three countries. Following this two areas of concern - the attitude of physicians towards older patients and the concept of a long term care philosophy are reviewed. The results of this study in which administrators, directors of nursing and physicians were asked to define the role of a medical coordinator are then reported. The Delphi method was chosen for the study. It is an alternative to an interactional group or committee process for making decisions or for generating ideas upon which decisions may be made in the future. The Delphi method was chosen because

- . The issues involved in the question to be answered were uncertain.
- . It would be imposing unduly on the respondents to ask them to meet for a day in one location.
- . The method may enable the participants to be more creative than other group methods.
- . The method would enable interprofessional communication to occur.

LONG TERM CARE FACILITIES

There are listed 515 long term care centres or facilities in B.C. (Directory of long term care centres in Canada 1980). These facilities vary in size from those with five residents to those with 450 residents. Each type accommodates residents who have differing degrees of disability. Included are homes for the mentally retarded, mental health

boarding homes, and personal, intermediate and extended care facilities. The personal and intermediate care facilities are chiefly for older persons and most are within the Long Term Care Program which is administered by Community Health Programs Division of the B.C. government's Ministry of Health. In September, 1980 there are 15,700 persons in community (or long term care) facilities in B.C. (Verbal report - Dr. S. Bland). The classification into five levels of care - personal, intermediate I, intermediate II, intermediate III and extended care is made by this program.

The Long Term Care Program was introduced in B.C. on January 1st 1978 to provide government subsidised care for those in need of long term care and to provide maximum home support to try and maintain more persons in need of long term care at home. It is a comprehensive progression of services designed to provide a continuum of care for those who cannot live without help because of health-related problems that do not warrant care in an acute care hospital. Service may be provided in the home, in a community care facility licensed for this activity, or in an extended care hospital. (A citizen's guide to long term care in B.C., 1979).

EXTENDED CARE FACILITIES

The extended care hospitals or facilities in British Columbia are funded through B.C. Hospital Programs. Some of the extended care beds are attached to acute care hospitals and some are in free standing facilities. There are seventy six hospitals or facilities with extended care beds in the province.

The Ministry of Health's Annual Report (1978) showed an existing 5261 extended care beds with 680 under construction for a total of 5941. The provision of care for those disabled to the degree that they are not able to transfer independantly, walk ten to fifteen feet unaided, use a wheel chair unaided and who do not need acute, rehabilitative or psychiatric or a lesser level of long term care, (i.e. those requiring extended care) became an insured benefit in B.C. on December 1st, 1965.

THE MANAGEMENT OF FACILITIES

Each facility develops its own way of ensuring overall care for its residents. Guidelines and regulations have been developed by the Ministry of Health for personal and intermediate care facilities (The community care facilities licensing act - Adult care regulations 1977) and for extended care (Hospitals for extended care - Guide for operation of extended care programs (1980) and the Hospital Act (1977))

The guide for the operation of Extended Care Programs describes the role of a medical coordinator (see Appendix II) and the Hospital Act, which applies to public hospitals, private hospitals and rehabilitation and chronic hospitals in B.C., outlines the requirement that hospitals have an organized medical staff. The adult care regulations (1977) of the community care facilities licensing act, however, makes no recommendation or requirement for the organization of medical staff for a personal or intermediate care home. These regulations do mention that a resident shall not be transferred to an acute care hospital without consulting a physician, that the name of each resident's physician be recorded and the physician be informed if any adverse drug reaction is noted.

Facilities that are governed by the community care facilities licensing act are both non-profit (Administered by a board under the Societies Act) and proprietary. There are approximately fifty percent of each in the province of B.C. at this time.

In the smaller facilities there is usually an owner-manager, in the medium sized facilities a nurse-administrator and in the large facilities a management team comprised of administrator, director of nursing, possibly a physician, and other professionals who are the decision makers and who assume responsibility for the overall care of residents. The administrators, directors of nursing and physicians in this study were all connected with such large

facilities. (Eight extended care and eight intermediate/personal care facilities). The results of the study will be of interest to the operators of smaller facilities but because only persons from larger facilities took part in the study the findings may not be applicable to the smaller facilities.

DEFINING A ROLE

Ingman, Lawson and Carboni (1978) showed that in the United States (U.S.) the administrators and directors of nursing care of long term care facilities have differing views on what should comprise the work of a medical coordinator.

The importance of defining a role was noted by Smith (1957) who confirmed the hypothesis that unclear role expectations interfere with effectiveness of problem solving and decrease members' satisfaction. These produce psychological effects on the individual which are discernable in such reactions as personal frustration and strain between workers.

The role-defining process should be designed to enable an organization to perceive its participants as accurately as possible. (Kahn 1964)

One might expect that a role defined by those who are closely linked to it will more closely reflect those activities which are feasible for the person filling the role to carry out. The process of defining a role will produce content issues which may not be seen as important by the person

in the role but which will be important to the acceptance of the role by those with whom the role is linked. Because the responsibilities of administrators and directors of nursing care are closely linked to those of a medical coordinator they were chosen to be involved in defining the possible role.

A new personality entering a role may alter the role expectations as the behaviour potentials, attitudes and expectations of each individual will be different. If roles are expected to be standardized then the person who fills the role will be an incumbent rather than a personality. The interpretation of any proposed guidelines for the role of medical coordinator therefore should stress the fact that a role description should not be rigid.

THE STUDY QUESTION

The question to be explored in this study is: "What is the role for a medical coordinator in extended and long term care facilities in British Columbia?" The study involves larger facilities and may not be applicable to smaller facilities with less than 100 residents.

DEFINITION OF TERMS USED IN THIS STUDY

Administrator -

A person who is responsible for the management of an extended care of long term care facility.

Dementia -

Denotes supposedly irreversible loss of mental function in adults. If the loss of function is reversible, even partly, it would be more correct to use the term "confusional state". However the geriatrician is always on the lookout for reversible "dementia". Terms used synonymously with dementia are "brain failure" and "organic brain syndrome."

Director of Nursing -

A graduate nurse who is responsible for the nursing care and overall care of residents of extended and long term care facilities.

The Elderly -

Usually used to apply to anyone over the age of 65 years. However, in this study the elderly of interest are those in extended and long term care facilities.

Geriatric Medicine -

The care of the elderly; the diagnosis, prevention, treatment and management of their multiple disorders, disabilities, diseases and problems (see chapter II for expanded definitions).

Gerontology -

The study of the aging process by means of biological, biochemical, genetic, psychological, social and other sciences.

Intermediate Care -

Personal care under professional supervision.

(Community care licensing act - Adult care regulations 1977)

Long Term Care -

Denotes continuous care over a long period of time of a person of any age and can include a range of services from minimal social and physical assistance in the home to twenty-four hour skilled nursing in an institution. In B.C. the institutions are called extended care hospitals and intermediate or personal care homes.

Medical Coordinator -

A physician who performs some type of coordination of care and should be considered also to be synonymous with medical director, medical supervisor and medical advisor since although different institutions may use such titles the physicians filling these positions will be performing some coordinating, directing, supervising and advising functions.

Personal Care -

Means assistance with the performance of the personal functions and activities necessary for daily living that a person is unable to perform efficiently for himself.

(Community care facilities licensing act - Adult care regulations 1977)

Psychogeriatrics -

The diagnosis, prevention, treatment and management of psychiatric, psychological and behavioural disorders in the elderly.

ORGANIZATION OF THE THESIS

The following chapter reviews the literature on several subjects related to the role of a medical coordinator in long term care --experience in the United States, the development of geriatric medicine in three countries, attitudes of physicians, and possible reasons for these attitudes. The concept of a long term care philosophy is reviewed followed by some information on role theory and the Delphi method.

Chapter three describes the methodology, the ethical review and the three rounds of the Delphi method.

Chapter four gives the results of the study. The differences in opinions between the three professional groups is shown, and then a role of a medical coordinator in extended and long term care facilities in B.C. is described from the consensus of opinion obtained in the study. The description of a long term care philosophy is similarly constructed from the consensus of the study respondents.

In chapter five the findings are discussed and in the final chapter there are recommendations to persons interested in the role of a medical coordinator as well as for geriatric medical education and for further research.

II. LITERATURE REVIEW

THE MEDICAL DIRECTOR IN A LONG TERM CARE FACILITY

In the United States on January 1st 1976, long term care facilities providing skilled nursing care were faced with a new Medicare and Medicaid requirement for medical direction. This led the American Medical Association (AMA) to publish a series of articles written by physicians, nurses, administrators and lawyers, on the role of the medical director (Olin 1977).

The origin of a medical director was traced to Maryland in the 1960's when nursing home care was surveyed. A committee concluded that

- . Medical care given by the principal physician was much better than that given by the private practitioner and
- . That care and morale was better in those homes that had an interested principal physician who took time to advise the administration on medical matters and to help the nursing services.

It was stated that the prime responsibility of the medical director was to assure high quality care for each patient in the facility.

It was recognized however that the primary responsibility for the quality of care rested with the governing body through the administrator.

The AMA has established guidelines for the medical director in the long term care facility (Appendix III). These stress the desirability of an organized medical staff, of having the director appointed by this staff, and the importance of the physician confirming his role in consultation with the administrator and the director of nursing. It was recommended that the medical director be compensated for his services.

THE DEVELOPMENT OF GERIATRIC MEDICINE

The medical coordinator will be expected to have expertise in geriatric medicine. The following is a review of the development of this discipline in three countries: Great Britain, the United States and Canada. In addition, by country, there are cited recent articles on subjects closely related to geriatric medicine - teaching, manpower, psychogeriatrics and institutionalisation.

Great Britain

The present trend toward paying more attention to the geriatric patient began with the work of Marjorie Warren who published two papers, (1943, 1946) in which she described her ideas and results of her treatment. These origins are acknowledged by Howell (1975). Dr. Warren had been given the responsibility of the medical care of a large number of British old people in an institution who were often "demented, incontinent old folk, restless and disturbing others by their behaviour". She began by examining each patient

and establishing a diagnosis. Thorough medical treatment was instituted and arrangements for discharge were made for those that did not require hospital attention and facilities. She achieved a discharge rate of twenty-five percent. Apart from her medical work and activation programs she "made a spirited attack on the gloomy surroundings which had depressed the patients under her care". The walls had previously been painted shades of chocolate and dark green; she changed these to cream, had better lighting installed and as well implemented other measures to create "large airy spaces".

University Teaching Of Geriatric Medicine

When Britain's National Health Service was started in 1948 geriatrics was recognized as an area of special need, but it was not until 1962 that the first chair of geriatric medicine was established in Glasgow University. MacDonell (1976 (b)) reported that in Britain there were nine established chairs of geriatric medicine and that the British Geriatric Society had a membership of 700 physicians engaged in clinical geriatric practice. Geriatrics was recognized in Britain as a separate specialty for physicians.

The United States

In the United States, Nascher (1916) is credited as the first person to use the term "geriatrics". It is instructive to read what was written sixty-four years ago.

Nascher wrote "Mental stimulation is the most important measure in the hygiene of the aged". Most geriatricians would agree with this statement today although they might use the word "health" instead of "hygiene".

Institutionalization

The benefits and problems of institutionalization in the U.S. were equally well recognized in 1916, as can be seen from the following excerpt: (Nascher 1916)

"One fundamental difference between the aged at home and in the asylum is in the mental attitude. In the asylum there is freedom from care about the future, from worry about the family to whom the individual had probably been a burden, and from fear that the family is trying to get rid of him and might go to extreme measures to secure relief from the incubus. There is on the other hand the feeling of dependence and a sense of lost independence, restrictions in many directions, in actions, in food, perhaps in clothes. The inmate must obey rules, perform tasks, and above all he must not complain. In the public asylums there is a sense of absolute helplessness; the inmate feels that he is dependent upon the bounty of every individual in the community, that complaint will be followed by punishment, that he is virtually a beggar without rights. Under such circumstances the inmates of almshouses become morose, apathetic, they lose interest in everything except themselves, and melancholia and senile dementia follow. It is impossible to arouse in them any sense of pride in appearance, any ambition, or interest in anything."

Today we recognize this dilemma of institutionalization and try to prevent the "melancholia" and "senile dementia" by providing mental stimulation. We do not talk about alms houses but about nursing homes, homes for the aged and long term care facilities. However the same potential for problems with institutionalization remain.

Recent Developments in Geriatric Medicine in the U.S.

In May 1976 the Institute of Medicine (IoM) sponsored an Anglo-American conference on the care of the elderly. (Exton-Smith and Grimley Evans 1976). At this conference J.C. Brocklehurst, professor of geriatric medicine, University of Manchester, in presenting the topic of "Education and training: Inculcating appropriate attitudes and skills", gave this definition of geriatrics:

"Geriatrics is a form of caring and the special skills that it requires are not those in the practical sense as with cardiac catheterization or gastroscopy, but in the development and deployment of a special system of care and in the the understanding of complex and unique problems. A geriatrician is an organizer of geriatric care, a coordinator of community and medical resources, an educator (both of his colleagues and his patients), an innovator, something of an epidemiologist, an expert in rehabilitation as well as being (and this is his essential basis) a competent clinician."

The United States Special Report on Aging (1979) had this to say about geriatric medicine:

"The National Institute on Aging's (NIA)

continuing interest in facilitating the teaching of geriatric medicine as part of a basic medical training gained momentum during 1978 with several key developments. The NIA contracted with the Institute of Medicine (IoM) of the National Academy of Sciences to examine how best to incorporate geriatric medicine into medical school curricula. The IoM report noted that current medical training in the care of the elderly is deficient, but the committee recommended against establishing a separate specialty or subspecialty of geriatrics, instead suggesting the creation of sections on geriatric medicine within departments of internal medicine. By encouraging the inclusion of geriatric medicine in the mainstream of medical practice, the report avoids possible arguments on the necessity of still another specialty and prevents the further isolation of the elderly from the mainstream of American medicine."

Aging And Medical Education in the U.S.

Dans and Kerr (1979) reported the major findings of the IoM committee on aging and medical education. They noted that there is much pertinent information on aging and care of the aged in disciplines related to the biologic and behavioral sciences, in clinical medicine and health services. The distinction between aging and diseases associated with aging is noted. Pertinent knowledge from the biological sciences, in psychosocial and clinical aspects and in health services and financing is summarized by Dans. The conclusion was reached that there was a deficiency in teaching of aging and care of the aged in medical schools, residency programs and continuing medical education courses. A major recommendation of the committee was that the care of

the aged should continue to be the responsibility of well trained primary-care physicians.

Beeson (1979) noted that medical schools, teaching hospitals, and specialty certifying boards had paid far too little attention to the predicted health care needs of the older person in the future. Part of the reason for this was thought to be that:

"Those medical educators who exert the most influence now are mainly products of an era of exciting biomedical scientific activity, the years between 1950 and 1965, and their attention, understandably, remains orientated to such matters as the science base, high technology tertiary care, and the unquestioned need for subspecialty talent. As a result, courses in medical school have been tailored to a bare-minimum core of basic science and clinical medicine in order to allow up to a year of elective work, during which students can try their hands at research or get started toward a specialty interest. Then comes residency training in which the main emphasis is on in-patient, tertiary care medicine."

Beeson also noted the difficulty in finding nursing homes where medical students and residents can observe exemplary long-term care.

Training Programs In The U.S.

In the United States although geriatrics has not achieved specialty status a few residency programs have been established.

Libow (1976) reported on a four year experience with a geriatric medical residency program.

"The goals of this training are to develop special clinical skills to deal with the medical and psychosocial problems of the elderly, and to achieve the ability to develop health care systems for the elderly. Emphasis is on a multilevel system, including home, outpatient, acute hospital, convalescent unit, and long-term institution care. The training period is 12 to 24 months, after an initial 24 to 36 months of standard internal medicine, thus fulfilling the requirements for board eligibility in internal medicine."

The Mount Sinai city hospital center at Elmhurst, New York developed the first residency training program in geriatrics in the United States in 1972.

Moore (1979) describes the development of a geriatric training program for family practice residents at Duke University, North Carolina and Pattee (1978) outlines a program in the department of family practice and community health at the University of Minnesota.

Manpower Requirements in the U.S.

The future need of geriatric manpower in the United States has been recorded by Kane (1980). It was estimated that by the year 1990 the United States will require between 7000 and 10,300 geriatricians with a best guess intermediate figure of about 8000. It should be noted that the United States has approximately ten times the population of Canada

so that the comparative figure for Canada would be 800. Kane focussed on the projected activities of physicians and closely related health care providers in solving the problems of inadequate care of the elderly. The role of non-medical practitioners was emphasized but also the need for encouraging physician involvement because of the known indifference of the majority of physicians to the problems of the aged. The attitude of physicians towards the care of their elderly patients is examined in more detail later in this chapter.

Canada

In Canada the discipline of geriatric medicine, in the early days of its development, centred around the veterans hospitals. In 1950 a group of concerned physicians formed a committee from the Veterans hospitals across the country (Fahrni, B- verbal report). The Canadian Medical Association had a central committee on aging. In the 1960's there was a national conference on aging and the Canadian Association on Gerontology was formed. In the early 1970's the first geriatric day hospital was formed in Winnipeg.

In the last few years there has been increasing interest in the development of geriatric care and geriatric education. It seems inevitable that geriatrics will develop but differently from either Great Britain and the United States because of the different health insurance and health delivery systems.

Canada has universal health insurance and has primary care physicians who have continued to be involved in hospital medicine and therefore have skills in the increasing technological aspect of medical care found in the acute care hospital. This may mean that the physician has less time for and interest has not developed in the psychosocial aspects of care. His confrere in Great Britain on the other hand is excluded from direct care in the acute care hospital and not only may have more time for the psychosocial aspects of care but also has the stimulus of specialist geriatricians.

Like the United States in 1976 the Royal College of Physicians of Canada recommended that geriatrics in Canada should be a subspecialty or area of special competence within the specialty of internal medicine. It has also been recommended that it should be an area of special interest recognized by the College of Family Physicians of Canada (MacDonell 1976 (a)). Joint consultation between the Royal College of Physicians, the College of Family Physicians, the Canadian Association on Gerontology and the Canadian Medical Association will be producing recommendations for the training and examination for a certificate for physicians in geriatrics.

MacDonnell (1976 (a)) stated that most Canadian physicians on graduation are inadequately equipped to cope with the complexities of the care required by a significant number of their elderly patients. It was also noted that the

quality of health care delivered to the elderly was related to the knowledge base, the attitudes and the skills of a physician regarding geriatrics and gerontology which are developed during his undergraduate and post-graduate education. MacDonell (1976 (b)) stated that there had been long recognized the shortfall in education in geriatrics and made detailed recommendations for solving the problem. These recommendations came from committees that had been formed following comments made by the Special Senate Committee on Aging (1966)

"a serious bottleneck in the provision of health services for old people is the shortage of professional personnel interested and trained in this field."

Training Programs In Canada

The first approved resident in geriatrics in Canada began his year of specialty training at the University of Western Ontario on July 1st 1977. There are now residency training programmes at the universities of Toronto and Saskatoon. In 1979 a division of geriatric medicine was formed at the University of British Columbia.

The Canadian Association on Gerontology has been active in promoting interest in gerontology and geriatrics across the country. In addition, the Gerontology Association of British Columbia has an annual meeting at which there are presentations of interest to the many disciplines involved in the care of the aged. In 1978 the British Columbia Medical Association formed a geriatrics committee as part of

their Health Planning Council.

Definition Of Geriatric Medicine In Canada

Cape (1976) has put forward a concept of geriatric medicine which he calls the five "O"s (like the five Olympic rings): falling, confusion, incontinence, homeostatic disturbance and iatrogenic illness which highlight five major medical problems and the fact that they overlap. Later (1979) he recognized that family physicians will continue to provide most of the medical care of elderly people. The internist is seen as the expert in the continuing care of those with chronic illness and a leader of the many health professionals needed to assist these people. Gryfe (1979) outlines several roles for the geriatrician - teacher, researcher, clinical consultant and primary care giver and compares the geriatrician to the pediatrician. The following outlines his concept of the need for geriatricians:

"The characteristic geriatric patient recognized by most practitioners is usually over 70 years of age and has several chronic disorders of different systems, with multiple, often nonspecific, symptoms, and apparently irreconcilable, conflicting therapeutic needs. The busy family practitioner usually lacks the time to unravel a lengthy complex history and the plethora of notable physical findings, a veritable knot woven by a slow-moving, forgetful patient. The internists, either committed to their favourite anatomic system or indifferent to psychosocial factors, often fail to serve the full needs of the patients. Family practitioners or internists may agree to provide continuous

primary care, but they are frustrated by the difficulty in finding perspective or priority in the many problems these patients present. Geriatric physicians can help elderly patients as much with clinical perspective as with psychosocial insight."

Psychogeriatrics In Canada

Psychogeriatrics has developed as a separate discipline in Britain with different hospital facilities. Whether this will occur in Canada will depend on the training programs that develop. Goldstein (1979) writes about the role of the psychogeriatrician who may act as a teacher, consultant, liaison officer, researcher and innovator. He recommends the psychogeriatric unit and the team approach as being of prime importance for the assessment of the elderly with these types of problems.

Institutionalization And Physicians In Canada

Kraus, Spasoff, Beattie, and Rodenburg (1978) express the concern that physicians, who play a key role in the decisions to apply for institutional care, may, because of their institution-based training and experience, encourage more institutionalization than is in the best interests of the patient. They recommended the expansion of home care programs to include chronic care of the elderly, foster homes for the elderly, financial support for home support programs, better remuneration for physicians for home visits and social support facilities such as cafeterias in all senior citizens housing projects.

This bias in geriatric medical training towards the solving of the geriatric patients problems by institutionalization, if it continues, is important to recognize because unless the proportion of elderly institutionalized in Canada can be reduced this will be a major economic burden for the country (Gross 1978).

THE ATTITUDE OF PHYSICIANS TOWARDS OLDER PATIENTS

A recurrent theme occurring in articles about physicians and geriatric care and about the medical coordinator in long term care is the attitude and interest of the physician in such care. When the opinions of more than one thousand physicians, administrators and nurses were obtained, 77% of physicians, 86% of administrators, and 90% of nurses agreed that

"Lack of physician interest in geriatric medicine is a major problem in long term care (Ingram (1978))"

Dans (1979) stressed the importance of attitude:

"Given contemporary society's fascination with youth and the unwillingness of individuals to deal with their own mortality, it is not surprising to hear in university hospitals terms like "old crock" and "goner", an ironic mocking of future selves. Such negative attitudes are detrimental to the training of physicians who will take care of so many elderly and who now and for the foreseeable future will play a "gatekeeper" role in the distribution of health services received from others. Teachers who can translate the appropriate knowledge and attitudes into

the clinical care of the aged are essential."

Hunt (1975) considered the negative attitude due to lack of understanding of the aging process and the implications for care of the aged person. She considered that any staff, of all disciplines, pursue a "death-course" philosophy. This usually says, "the patient is too old, or has too many disabilities. Therefore, he needs only custodial care and it is worthless to use expensive services of highly trained professional staff even when available".

Pattee (1974) raises the subject of physician interest in the nursing home and long term care resident. He quotes a nursing director as saying

"The uninterested and apathetic physician that enters my nursing home has a devastating effect on the morale of the patients, nurses, nurses aids, occupational therapists, housekeeping and dietary staff".

He considers the apathy results from the frustration physicians feel with the magnitude of their responsibility in rehabilitating the elderly disabled, from the poor psychological and philosophical preparation of physicians for their role in caring for the disabled and from the lack of definition of the physicians role.

He sees the physician's role in long term care as to provide support, understanding and encouragement to all. To do this he must understand his own feelings and attitudes towards disease and towards death. He must learn rather than

to cure to support the resident, the family and the staff.

Pattee sees four roles for the physician in geriatric care:

- . "An encouraging and supporting confident of resident, staff and family.
- . The traditional role of visiting residents but on a regular basis rather than just on an emergency basis.
- . As a teacher
- . As a collaborator with staff, community and other physicians."

Levenson (1980) reported on the attitudes of medical students, educators and general practitioners towards training in geriatrics and gerontology. When asked whether geriatric and gerontology training in medical schools should be required, be an elective or neither of these two, medical students, in general, disregarded "neither". Two percent of them chose "neither" for geriatrics and gerontology but twelve percent of educators and practitioners chose "neither" for geriatrics and eight percent for gerontology. The fact that ninety-eight percent of the medical students considered that geriatrics and gerontology should either be required or an elective suggests that they have been made aware of a need for more training in these disciplines.

Williams (1980) reported on the attitudes of family physicians. He reviewed twenty-three publications on health professionals' attitudes and made a study of 180 family physicians and residents. The problems mentioned in treating the aged were - difficulty in communication with those with

memory loss or deafness, inadequate medical education and lack of time. Physicians who have considerable experience with geriatric patients are more likely to think that they can be treated successfully than physicians (including residents) who see fewer old patients. Again the conclusion is made that there is a need for improved education at the undergraduate, graduate, and continuing education levels which emphasize a realistic approach to illness and health in the elderly.

Cape (1978) has presented a clinical guide to the internal medicine of old age for the benefit of internists, family physicians and medical students. Bollard, Slade, Christ, McGee and Summers (1980) outline the challenges to the family physician in Canada in the development of geriatric care. Peck (1980) lists major problems in the management by the family physician of the geriatric patient and suggests some practical steps that can be taken to enable the physician to cope with the complexities of the health of the older person who is beginning to fail in his abilities to live an independent life.

My experience and this literature review suggest that there are five reasons for the negative attitudes toward the elderly disabled that can occur in physicians and others. These are outlined with a view to developing solutions for each problem:

Complexity of Problems

The elderly who are beginning to fail in their abilities to live independently have complex problems comprised variously of at least five medical diagnoses, often diminished mental function or psychiatric disorder and accompanying social problems. The health professional with the help of others must be highly skilled and organized if he is not to be overwhelmed by the complexity of the problems.

Physician Satisfaction

Physicians obtain personal satisfaction from curing people of their complaints and when cure is not possible the satisfaction must come from being able to assist a person to live with their disabilities with the maximum amount of independence possible. In order to be able to do this the physician must be knowledgeable of and believe in a different philosophy of care when relating to those with chronic disability. This long term care philosophy is referred to later in this chapter.

Dementia

Dementia is present in 60-80% of those persons in nursing homes (Wershow 1977) which means that the physician cannot relate to this group of older persons in the ways he is accustomed to relating to other adults. However, if the physician has interpersonal skills similar to those of the

pediatrician who finds out about the child by relating to the parent then he will not find the management of the older person with dementia so difficult. There is a similarity in the approach to the management of the child with multiple handicaps and the older person who is beginning to fail in his or her ability to live independently.

Problems Seen

Physicians' attitudes are influenced by the fact that they see the elderly with problems and often with insoluble problems. White (1979) contends that physicians operate under false negative assumptions about old people, and that acting on these negative assumptions "sentence older adults to earlier deaths." The conscious and unconscious attitudes are transmitted to other staff members.

Diminished Functional Status

Gerontological research (Frolkis 1975) shows that normal physiological functions diminish with age and if a graph is drawn of these functions it appears that aging is all "downhill". Knowledge of these physiological functions may cause a negative attitude from the physician. However, when one observes the majority of older persons they appear and feel healthy and lead independent happy lives. Only about 15% of those persons over the age of 65 need assistance in their activities of daily living. A calculation by the author in March 1980 based on estimated figures from B.C.

Hospital Programs Division of the Ministry of Health and actual figures from the Long Term Care program showed 14.4% of those 65 years and over in B.C. were receiving extended or long term care.

THE PHILOSOPHY OF LONG TERM CARE

Those who are associated with the elderly and other persons who need long term care become aware of a philosophy of care which is different from that perceived in the acute care hospital.

The purpose of this section is to gather together the writings of a number of authors on subjects which relate to a philosophy of long term care. Before the technological revolution in medical care the kind of philosophy which is needed for long term care may have been much more apparent in all medical care since the skill of care providers was more directed to prolonged illness and to giving supportive treatment or care while the body's natural healing processes cured the disease. These skills now have taken second place to the highly technical knowledge of drugs, laboratory tests, investigative procedures, surgery etc.

Shore (1976) differentiates a "medical model" which is used to describe a disease - orientated short term hospital system emphasizing such words as sickness, patient, disease, treatment, therapy, clinic, hospital and doctors. This model is directed towards cure. He contrasts this "medical

model" with the "psychosocial health model". In the latter there is stress on the "wellness" of the resident (rather than the patient) and the need for sensory awareness, educational, creative and religious activities. The aim is to strengthen the resident's self image so that he can view himself as a vital, significant part of society, not an unwanted burden. These psychosocial services are provided by social workers, activity directors, chaplaincy personnel and volunteers.

Weiler (1974) stresses the need to develop a long term care model so that long term care facilities can be operated under this model rather than the acute care model. Having defined this long term care model he suggests that the proper objectives may be developed upon which a cost-effective analysis may be made. The following is Weiler's model showing the contrasts of the acute and long term care:

Figure 1

Comparison Of Acute Care Model And Long Term Care Model

(from Weiler, 1974)

Dimension	Acute Care Model	Long Term Care Model
Medical Needs	Dominant	Secondary
Social and related needs	Secondary	Dominant
Settings for delivery	Hospital	Home, day centers, nursing facilities
Success	Number cured or number rehabilitated	Actual level of functioning compared to potential level
Professional approach	Physician/nurse Diagnosis orientated	Team function orientated
Problems Addressed	Specific and chief complaint orientated	Comprehensive social/health orientated
Role of Patient fostered	Regression-dependent type	Independence-progression type

Weiler's model is more helpful than Shore's since Shore's is too general - suggesting everything to do with the acute care setting is unsuitable for the long term care resident. Weiler's seven areas of comparison promote more understanding of the different approach to care needed in the long term care facility.

Halstead and Halstead (1978) describe a "humanistic" approach to rehabilitation and compare it with the "scientific" approach.

The following table shows the contrast the Halsteads make between these two approaches. They state that the differences are intentionally emphasized even though there may be an overlap between the two contrasted elements in this model.

Figure 2
 Comparison Of Scientific And Humanistic Medicine For Selected
 Health Care Elements
 (from Halstead and Halstead (1978).)

Health care elements	Scientific medicine	Humanistic medicine
A. Process		
1. Problem orientation	Disease	Illness
2. Physician's role	Doer, Knower	Teacher, Learner
3. Patient's role	Passive	Active
4. Physicians' relation to patient	Reserved	Empathetic
5. Physician's relation to health team	Dominant	Facilitative
6. Physician's relation to colleagues	Competitive	Collaborative
7. Therapeutic approach	Treatment of disease	Management of illness
B. Organizational		
8. Physical setting	Impersonal	Personal
9. Care orientation	Physician (staff)	Patient oriented
C. Outcome		
10. Objectives	Curing Enhancing physiological function	Healing Enhancing functional performance

Although the model is called "humanistic" there are some similarities to Weiler's model. The "humanistic" model could be improved by changing "illness" for "physical, mental and social functioning" and "the management of problems" in each of these areas of function. The words empathetic, facilitative, collaborative and enhancing functional performance add up to the encouragement of the individual to achieve maximum independence. The objective of "healing" needs interpretation and the Halsteads define this as

"decreasing discomfort and enhancing a sense of physical and psychological well-being. For both patient and physician, healing is more active, curing more passive. Healing does not exclude curing but extends beyond it to include caring".

Objectives For Long Term Care

While Weiler (1974) only mentions the need to develop objectives for long term care upon which cost effective analyses may be made, a set of objectives has been outlined by Manherz (1974) after reviewing government guidelines and declared goals of individual institutions. The following are his objectives from his summary:

- " . To create a milieu which recognizes that each patient, including the terminally ill, has a potential for growth.
- . To respect the autonomy of each patient.
- ./ To assist each patient to expand his purpose, his interests and to have more meaning in his life.

- . To develop an inter-disciplinary team approach for the assessment of each patient's goals, identification of the problems to be overcome, and implementation of a total treatment program.
- . To provide an appropriate environment for long-term care, one that encourages activity, stimulates visually and pleases esthetically.
- . To ensure that the staff will have the appropriate personal qualities to support the patients in their own growth.
- . To improve the quality of treatment by encouraging the continuing study of chronic illness, by playing a role in the education of health personnel, and by promoting research in long term care."

There is some jargon in these objectives such as "milieu" which means surroundings or environment and "growth" which could be interpreted to mean improvement in physical, mental or social functioning or at least their maintenance.

In defining the objectives for long term care, however, one must not forget an overall objective which has been stated by Gingras and Sherman (1976)

"the primary objective of geriatric medicine should be to maintain the elderly person in his own home as long as is consistent with his health and happiness and the well-being of his relatives. The ultimate goal and proper course for society to pursue is to assist old people to maintain their independence in the community to a maximum degree"

A facility may wish to include this latter statement in its objectives. However, in practice, once an older person has become a resident of a long term care facility it can

be difficult to relocate them home. The implication from this is that it is important to be certain that institutionalization is necessary for the resident at a particular time. The individual should have been adequately assessed by different professionals prior to admission to try and ascertain whether there is some improvement that can be made with alternate programs such as day care, special rehabilitation, or short term admission to an institution. Bayne (1977) writes about health and social needs and the importance of assessing these in older people. As stressed by Weiler, Bayne mentions the increased importance of the social needs of the older person such as relationships with spouse, family and friends, their sexuality, their residential needs, their career potential and their living costs. He mentions, as do other writers, the value of the team assessment. Although mental or psychological functioning is not mentioned as a specific need, Bayne includes this in health and includes the problems of depressive illness, anxiety state and loss of intellectual functioning.

Attitude Of Care Givers

Encompassed in any description of a long term care philosophy will be an implied attitude towards the resident/client. The physician becomes aware of many physical, mental and social problems and it is important for him to maintain a very positive attitude in spite of this. It is not only the physician's attitude that is important, as

Evans (1976) said:

"Before the aged can be participants and not spectators in society, there must be a fundamental attitudinal change in the community, the medical profession and the aged themselves".

The physician's role in maintaining the patient's identity is mentioned by Harris (1975)

"The physician must express by word, action, or attitude his genuine interest and concern for his geriatric patient as a person and with his health problems. Such concern with interpersonal relations and health problems will elevate the patient's self-esteem, self-image, and independence and strengthen his spirits, hopes, and aspirations, all of which constitute importance in the patient's identity and life. By these actions and attitudes, the physician can favourably influence his patient's identity."

Nursing Models

Nurses provide care throughout the 24 hours of a day to residents of long term care institutions. A medical coordinator must understand the philosophy and attitudes of nurses and how the nurse perceives her role. Riehl and Roy (1974) say that nurses are beginning to identify their unique body of knowledge. They review different models that have been proposed and discuss the benefits of one model. This model they say should be a problem solving process similar to that used by physicians with assessment, diagnosis, inter-

vention and evaluation. These are the words used to describe nursing goals:

"The goal of nursing is to maintain man's system and to help him realize his maximum potential which includes health and harmonious interaction with the environment. Nursing fulfills this goal through the use of protection, nurturance, stimulation and restoration activities in an interactional framework."

The stress on realizing maximum potential seems important for the long term care resident. Hatton (1977) stresses the importance of the nurses interaction with the resident and suggests that this can be observed in positive interactions which include personal recognition, respect for the individual, verbal responses as necessary and information exchange. She mentions that in encouraging these positive interactions the nurturing role of the nurse is being fostered. However this nurturing role may not be in the resident's best interests because it is paternalistic and may encourage dependency. All professionals should be aware of the need for a long term care philosophy which encourages maximum independence.

Rehabilitation

As part of a complete diagnostic assessment of an older person prior to provision of long term care - whether it be at home or in a facility - a rehabilitative environment should be created. This environment should include opportunities for the person to improve in physical, mental

and social functioning. The amount of rehabilitative stimulus should be tailored to suit each individual resident. This rehabilitation may take place away from home through visits to a day hospital, day centre or special rehabilitation facility or even a change in environment such as staying with a member of the family where improvement can be encouraged. Rehabilitation therefore can be defined as any activity which helps the person to improve in some aspect of his functioning. Some people (e.g. after a stroke) continue to improve for long periods of time - a year or more - given the appropriate stimulus. The opportunity for rehabilitation must therefore be made available and the amount of rehabilitative activity tailored to suit the individual based on an assessment by a team of professionals. Hunt (1980) has outlined guidelines for the rehabilitation of the aged:

- "..Set realistic goals with the patient
- . Allow for temporary relocation confusion.
- . Restore and maintain water and electrolyte balance.
- . Arrange priorities for drugs and schedules, to suit needed activity.
- . Search for treatable cause of instability and falls; provide stable walking aids.
- . Aim for early mobilization, always.
- . Take immediate measures to offset incontinence.
- . Use special care in assessing pain

- . Prevent overheating
- . Schedule active concentrated therapy for the morning.
- . Keep assistive devices simple.
- . Promote community support services."

This list concentrates on the physical aspects of rehabilitation. "Reduction of medications to a minimum" - could be added. The community support services should include the involvement of family and friends and the encouragement of social, recreational and spiritual activities.

Anderson (1975) emphasizes the skills of psychology, social work and counseling, which he calls "the helping professions" in the rehabilitative process. In this approach the professional assists the client to make his own decisions after having explored the choices together. There is a close analogy with the models of Shore, Weiler and Halstead.

Caring

Mount (1978) from his experience with a palliative care service, accents the dehumanizing events and depersonalization that can occur in hospitals and points out that people need to be recognized as human beings even when all sorts of impersonal activities are being carried out on their body. This recognition of the person is what caring is all about. In long term care there seems to be even

more need to stress this caring. Mount quotes Nelson (1973) who defined caring as involving the following:

- " . a profound respect for the "otherness" of other people, grounded in a sense of the individual's unique worth.
- . Helping others to care for themselves.
- . Meeting other people where they are rather than where we would like them to be.
- . Knowledge of other people's social context and needs.
- . Trust.
- . Humility and willingness to learn and receive from others.
- . Flexibility enabling change when mechanical application of the rules may not suffice.
- . Not essentially a severe and strenuous demand placed on us in regard to others, but an opportunity to further our own development."

A philosophy of long term care can be summarized. It involves the recognition that modern medical care typified by the highly technical services in parts of an acute care hospital result in the creation of dependency and the depersonalization of the individual. In order for a person with a long term disability to remain functionally independent his personal motivation must be retained. This can be achieved by respecting him as a person and by

encouraging activities and interaction with others in an environment that stimulates this personal motivation.

The Change in Philosophy For The Resident

While different writers contrast the professional's approach to care for the individual resident this change from one approach to another will depend on the assessed needs of the individual at the time. The medical coordinator in extended and long term care will change his approach to suit the residents' needs at a particular time. Most geriatricians will stress the need for a complete diagnostic assessment by the multidisciplinary team on entry to long term care to make sure there is no condition present which can be cured. At this time the process is more that of the medical or acute care model. Similarly if an incident occurs (e.g. A fall causing a fractured hip) there will be need to revert to the medical or acute care model for the early stages of case management. The encouragement of all those providing care in the acute setting is needed to get the resident (or patient) back into a setting with a long term care philosophy, whether it be within an acute care hospital or in a long term care facility.

A ROLE DESCRIPTION

The following information taken from writings in the field of social psychology is included to answer the question - "What is a role?"

Sarbin (1968) states that the word 'role' is a meta-

phor which carries implications drawn from the theatre. It is intended to denote that conduct which adheres to certain "parts" (or positions) rather than to the players (or individuals) who read or act them. Role theory is psychological theory about people enacting "real-life dramas". Roles can be seen as work - genuine, serious and self-involving rather than those in a play which can be thought of as sham, without serious intent and non self-involving.

A Role Description And A Job Description

A role description and a job description may be differentiated. In describing a role it is accepted that this is a continually changing state which responds to the persons with whom there are interactions: the satisfaction the individual obtains from the role, and the persons occupational identity (Graen 1976). Graen summarizes this in the following statement:

"A complex series of social interactions is assumed to occur that influence the behaviour of the person in his organizational role."

A job description on the other hand can be seen as a stable entity which may not be expected to change and which will also include the constraints of time and resources available.

Consensus On Role Expectations

Role theory research has shown (Gross 1958) that it is an erroneous notion that there is complete consensus on role

expectations amongst the incumbents of positions in a social system. There are significant variations in role expectations held by role occupants in complimentary positions and by people in general. Gross analyzed the school superintendent's role and found that if a school superintendent was perceived to be doing a good job, the board members conformed to the superintendent's expectations of his role even if they disagreed with him. Hanson (1961) examined the role expectations of hospital administrators, board members and community leaders as seen by each other by means of a structured questionnaire. He concluded that a person's obligation to others is dependent on their respective positions in a social structure which in turn is defined by the character of the social interaction between them.

For some positions, the role expectations may appear uniform from one person to another or from one group to another (for example, Catholic priest). One suspects however that if viewed on a superficial or broad level this may be so but if an in depth enquiry is made then the expectations of themselves and those of others may be varied even for a priest.

THE DELPHI METHOD

The Delphi method was first described by Dalkey and Helmer (1963) who had used it ten years previously. Their experiment was designed to obtain the opinion of a geo-

graphically dispersed group of experts, who were anonymous to each other. The experts were asked to estimate, as an imaginary Soviet strategic planner, the prime U.S. industrial targets and the number of A-bombs required to reduce the munitions output by a prescribed amount. The seven respondents took part in five rounds or iterations with controlled feedback from the researchers. The consensus from the final round or iteration would have been used for planning policy. The authors claimed that the method described

"is highly conducive to producing preliminary insights into the subject matter at hand on which a more effective research program may be based, even though the predictions obtained in the form of an opinion consensus may be lacking in reliability".

Description Of Method

Lindstone and Turoff (1975) describe many different applications of the Delphi method. They defined it as

"a method for structuring a group communication process so that the process is effective in allowing a group of individuals, as a whole, to deal with a complex problem".

All applications of the Delphi method provide for:

- . The recording of ideas (input, opinions, knowledge) from individuals who are geographically dispersed.
- . The feedback of these ideas anonymously to the group.

- . The assessment of the group's opinion of the ideas.
- . An opportunity for individuals to revise their ideas or opinions.

Effectiveness

The Delphi method and the nominal group technique (NGT) are alternatives to the interacting or discussion group method for opinion finding or decision making. Van de Ven and Delbecq (1974) compared the effectiveness of the three. Their criteria for effectiveness were:

- . The quantity of ideas generated and
- . The perceived satisfaction of groups with the decision making process they were involved with.

They used a stratified random sampling procedure with controls and concluded that the Delphi method and NGT were more effective than the conventional discussion group process for the obtaining of the pooled judgement from a group of people because the quantity of ideas generated and the perceived satisfaction was better.

Gustafson, Shulka, Delbecq and Walster (1973), however, found a variation of the Delphi method worse than NGT and interacting groups. It is likely this result was affected by the fact that in this study there was written feedback among group members in the presence of one another rather than in dispersed locations. Campbell (1966), Dalkey and Helmer (1963) and Dalkey (1969) found the Delphi method more effec-

tive than committee discussions using different criteria.

Problems Of A Committee

Loughlin (1977) summarizes the problems of an interacting committee or discussion group that are overcome with the Delphi method:

- " . Perceived status differentials between group members
- . Bandwagon effects
- . The domineering personality who takes over the committee process.
- . The reluctance of an individual to change his position after a public stance has been taken.
- . The unwillingness of individuals to take a position until all of the information is in, or until it is clear which way the majority opinion is directed.
- . The reluctance of an individual to contradict a person in a higher position.
- . The reluctance to make suggestions, in the face of that he may appear foolish in the light of additional information."

The question should always be asked - "How accurate are the results of a Delphi method?" The answer should probably be - "At least as accurate as the information obtained from a discussion group". However, there may be more information obtained by the use of the Delphi or NGT; the information obtained may be different and the priorities may come in a different order because the process or interaction

between the individuals is different. The implications for this will be of concern to those who are accustomed to the committee process and feel confident in the value of the decisions made by a committee.

Problems With A Delphi Method

There are potential problems with a Delphi method and Lindstone (1975) reviews the critics and outlines eight basic pitfalls. The following is a summary of these pitfalls:

- . Even though the Delphi method may be used for forecasting, people tend to discount the future because uncertainty increases as we move further from the present. Decision making becomes more difficult as uncertainty grows.
- . It is human nature to readily believe a precise prediction and therefore the researcher using a Delphi method may be tempted to put more emphasis on a theoretical consensus. If however the method is used to bring out opposing views rather than consensus this danger will be overcome.
- . Simplicity is preferred to complexity but if some issue is simplified it may be less valid.
- . Individuals may list their preferences on paper differently from those expressed in an interacting group. It may be dangerous to compare two persons' estimates of a future event when each views the past, present, and future in his own subjective way.
- . The specialist or expert is not necessarily the best forecaster. It should be noted that a simple definition of an expert can be - anyone who has relevant input to the question being asked.

- . The selection of the panel will have some researcher bias unless steps are taken to randomize and have controls. The responses will be affected by the style of execution of the study and by the researchers' own interpersonal skills when interviewing. The analysis needs to be carefully done preferably with the help of impartial observers. Lindstone considers lack of imagination by the designer to be a major problem with the Delphi method.
- . Optimism - Pessimism bias. There is a tendency for pessimism in long range and optimism in short range forecasts.
- . Miscellaneous disadvantages - There will be more time involved for the researcher; the participants may have to spend more time rather than less; larger numbers do not necessarily make better decisions and the goals of individuals are not necessarily those of the organizations.
- . Deception - the process is vulnerable to manipulation or deception by the researcher.

Benefits of a Delphi method

One is left to wonder whether there is a benefit from using the Delphi method. The following summarizes some benefits that may occur from the use of the Delphi method or an NGT.

- . The creative production of a group will be increased, with the creation of critical ideas.
- . A group decision will be facilitated.
- . There is structured guidance in the aggregation of individual judgements, particularly valuable for the generation of conflicting ideas.

- . Anonymity and isolation of respondents provides freedom from conformity pressures.
- . Human effort and energy will be saved for the respondents.
- . Participants will be left with a sense of satisfaction.

(Adapted from Delbecq, Van de Ven and Gustafson 1975)

The Use of a Delphi Method to Define a Role

A comprehensive search for journal publications on the use of a Delphi method to define a role did not reveal any such study but there are two PhD theses - Carpenter (1977) and Travis (1974) where the method was used for this purpose. Carpenter examined the future role of the pharmacist in comprehensive personal health care. There were thirty respondents from four groups - physicians, nurses, pharmacists and consumers. They were asked to examine the role of the pharmacist in the year 1985 during a three round Delphi study. Sixty roles were elicited and finally twenty-six were found to be desirable and probable for 1985. Travis examined the role of the physician's assistant in Oregon. Twenty-eight respondents took part in a three round study. There were nine professional groups represented - physicians, medical educators, nurses, nurse educators, nurse practitioners, physician's assistants, a member of a medical examining board, a hospital administrator and a medical sociologist. A difference of this study from that of

Carpenter is that in Travis' study the thirty-two role statements were created only by the researcher with minor changes after pretesting of his round I questionnaire. This means the Delphi method will not have been used to its full advantage of generating new ideas from the respondents.

III. METHODOLOGY

ETHICAL REVIEW

A submission was made to the University of British Columbia screening committee for research and other studies involving human subjects: behavioural sciences (Appendix IV). The certificate of approval is included with this appendix. At this committee's request a letter was written to senior administrators of facilities introducing the study and advising that senior staff persons would be contacted (Appendix V).

THE SAMPLE

The study is concerned with medical coordination in extended and long term care facilities in British Columbia.

The majority of this province's facilities are in the cities of Vancouver and Victoria. Because of the difficulty of travelling for interviews, those facilities outside Victoria and Vancouver were excluded from the sample. The city of Vancouver has a population of 414,435 with 59,765 persons aged sixty-five years and over (14.4% of total population). The Greater Victoria region has a population of 230,610 with 35,470 aged sixty-five and over (15.4% of total population) (1976 census).

There are 111 facilities listed in Vancouver (Directory of long term care centres 1980) and fifty-eight facilities

listed in Victoria. These numbers include extended care facilities which are free standing but exclude those extended care units attached to acute care hospitals of which there are at least four. Each facility (n=23) with over 100 residents, including those extended care units attached to acute care hospitals in Vancouver (n=16) and Victoria (n=7), was contacted by the researcher, by phone, to inquire as to whether it had a physician acting in some way as a medical coordinator or was aware of a possible role for a medical coordinator. These numbers were reduced after talking to a senior person at each facility to eight extended care and eight personal/intermediate care units who acknowledged such a role. The criteria for inclusion was that the facility either had a medical coordinator or the staff was interested in defining the role of a medical coordinator. More of the extended care facilities than the personal/intermediate care facilities had experience and knowledge of medical coordinators (See Appendix II). The researcher intentionally, by selectively excluding some extended care units with less perceived interest in the medical coordinator made the numbers of extended and personal/intermediate care facilities equal in the sample.

After having identified the sixteen facilities, one administrator, one director of nursing and one physician was identified for each facility. Where there were more than one nursing coordinator or physician by random selection (coin spin) the numbers were reduced to one of each.

THE DELPHI PROCESS

The First Round

The first round questionnaire with its introductory letter (see Appendix VI) was mailed to forty-eight persons. There were sixteen each of administrators, directors of nursing and medical coordinators. Eight of the facilities provided extended care and eight personal/intermediate care.

A few days after mailing the first round a phone call was made by the researcher to each person to request an interview. Eight persons said they did not wish to take part; eight persons were either on vacation or unavailable at the time of the requested interview; thirty-five persons were interviewed (twelve administrators, twelve nursing directors and eleven physicians). One person took the place of another who was unavailable when the interviewer arrived. Two extra nurses became part of the study at the request of a respondent and these three nurses were interviewed together in the first round. This increased the original sample to 51 (see table 1).

There was equal representation of extended and personal /intermediate care facilities among those originally contacted. However of those persons interviewed twenty-four came from extended care units, nine from personal/intermediate care and two from a facility that had both types of care. Six of those who declined an interview were from personal/intermediate care facilities and two from extended care.

Nine of the physicians interviewed were also in active primary care private practice.

At the interviews the researcher introduced himself and posed the question "What is the role of a medical coordinator in extended and long term care facilities in B.C.?" He invited the participants to respond to the six listed headings. Figure 3 shows these six headings.

Figure 3

Headings Used in the Round I Interviews

Activities related to residents (patients).
Activities in relation to staff training and education
Activities relating to the work of other physicians.
Activities related to planning, development evaluation of care services.
The training, experience and skills of a medical coordinator.
Other activities or issues that should be included in a description of a medical coordinator's role.

These headings had been defined by the researcher to broadly represent possible roles for a medical coordinator as found in reviewing publications and after discussions with the thesis advisors.

The responses were recorded in writing by the interviewer at the time of the interview. During the interviews, which lasted approximately one hour, the researcher encouraged the participants to respond in more detail to certain issues (e.g. "administrative experience" and "long term care philosophy") when it was felt that the issue needed more detailed description or the interviewee wished to comment further.

After completion of the thirty-five interviews of round I the researcher collected all the responses that had been recorded at the interviews. Where there were similar responses from individuals the wording was adjusted to bring the responses together without altering the implied intent of the response.

The responses were then put together in groups and figure 4 shows the headings that evolved from this grouping.

Figure 4

Headings for the Round II Questionnaire

Role of a medical coordinator

Related to resident care

The multidisciplinary team

Private patients

Relatives

Related to private physicians

Related to planning, development and
evaluation of care

Related to nursing care

Related to education

Related to administration

Training and experience of a medical
coordinator

Skills and attitude of a medical
coordinator

Long term care philosophy

The Second Round

As described above the responses from the first round were grouped under major headings and constructed into a second round questionnaire. Each item was listed with a space (box) against it where the respondent could indicate his ranking of that item. The following table shows the ranking scale used in the round II and III questionnaires:

Figure 5

Likert five point ranking scale used in Rounds II and III Questionnaires				
Very Important	Important	Somewhat Important	Unimportant	Not Important
1	2	3	4	5

With this ranking scale the respondent had an opportunity to give his opinion of the importance of an item. He was not given the opportunity to say that an item should not be included in a role description. It is concluded that when the high numbers were chosen the respondents were either ranking an item as not important or stating it should not be included in a role description.

The questionnaire was mailed to the participants with a covering letter or letters (Appendix VIII). This second round was mailed to forty-three persons (thirteen administrators, sixteen nurses and fourteen physicians).

This number of forty-three included the thirty-five persons who were interviewed plus eight who were either on vacation or unavailable at the time of the first round interviews but who were part of the original sample. In addition to being asked to rank each item on a scale of one to five in order of importance the respondents were asked to add any further items which should be included in the role description.

The responses from the second round were analyzed by calculating the mean score for each item for all participants and by calculating the mean for each of the three sub-groups (administrators, directors of nursing and medical coordinators).

The purpose of calculating these mean scores was to allow respondents to change their ranking of each item after seeing the mean scores of all the respondents and each of the three sub-groups.

The third round questionnaire comprised the same items of the round II questionnaire under the same headings. Opposite each item were shown the mean scores and the respondents' previous ranking of that item. Additional items were included that had been recorded in the round II

questionnaire with a space (box) to rank them in round III.

The Third Round

In the first part of the round three questionnaire there were 103 items from the second round and fifteen new items recorded by the respondents to make up 118 items describing the role of a medical coordinator. Those items for the "long term care philosophy" were fifteen from the second round plus seven items added by the respondents for a total of twenty-two items. The third round questionnaire was mailed to the same forty-three persons that received the second round. The respondents recorded their new ranking after seeing their previous ranking and the mean scores of the whole group and the three sub groups. The responses to round three were analyzed in the same way as those in round two - the mean for each item was calculated for the whole group of respondents along with the mean for the sub-groups for each item. In addition to the measure of central tendency (the mean) a measure of variability (the standard deviation) was calculated for the whole group but the three sub-groups were not considered large enough for a calculation of this statistic.

Response rate

In Round I there was a 69% response rate - that is 69% of those persons in the original sample (n=51) were interviewed (n=35) including the three extras (as described

in the methodology). In Round II 74% of those interviewed (n=35) responded (n=30) and there was a 70% response (n=30) to the questionnaires sent (n=43). In Round III 77% of those interviewed (n=35) responded (n=31) and there was a 72% response rate (n=31) to the questionnaires sent (n=43).

This response rate is considered to be good particularly since the study was conducted during the months of June and July when many people take their annual vacations.

The following (Table 1) shows how the original sample was put together and the numbers and percentages of the sample interviewed in round I.

Table 1

Total Study Sample, Questionnaires sent and Number and Percentage of Respondents Interviewed from each of the Three Groups - Administrators, Nurses, and Physicians - Round I.

	Questionnaires Sent Round I		Interviewed Round I	
	N	%	N	%
Administrators	16	31.4	12	23.5
Nurses	16	31.4	12	23.5
Physicians	16	31.4	11	21.6
TOTALS	48	94.2	35	68.6
Extras (see methodology)	3	5.8		
Declined			8	15.7
Away			8	15.7
TOTAL SAMPLE	51	100.0	51	100.0

The following table (Table 2) shows the responses to the second and third round questionnaires.

Table 2

Questionnaires Mailed, Numbers and Percentages
Received from Respondents, Round II and Round III.

	Sent Round II & III		Received Round II			Received Round III	
	N	%	N	%	%	N	%
Administrators	13	30.2	8	26.7		10	32.3
Nurses	16	37.2	13	43.3		10	32.3
Physicians	14	32.6	9	30.0		11	35.4
TOTALS	43	100.0	30	100.0		31	100.0

IV RESULTS

Appendix XII shows all the tabulated results of Round III. The means and the standard deviations (SD) have been calculated for the whole group (n=31) for the 140 items in the questionnaire. Where not all the respondents ranked the total number of items the number who ranked each item is shown in the tabulated results. The means of the sub-groups - nurses, (n=10), administrators, (n=10), and physicians, (n=11) are also shown. Because of the small numbers in the sub-groups the value of the SD would not be so great and so this was not calculated. Where there was a reduced response to an item this was only shown in the number for the whole group.

Before recording the results of the consensus of opinion as to the role of a medical coordinator and a long term care philosophy, attention will be focussed on the differences of opinion between the three groups. Being aware of these differences may be as important to the understanding of the role as being aware of the consensus of opinion. Later in the discussion (Chapter V) suggestions will be made as to why there may be some of these differences of opinion.

The consensus of the respondents is affected by the number of rounds of the study since the mean scores differ with each round. After recording the differences of opinion the effect of performing a third round of the study is

analyzed.

DIFFERENCES BETWEEN GROUPS

After calculation of the mean scores for each of the three groups it is possible to see where there is a diversity of ranking between groups. Where the mean scores between two groups are 0.75 or greater this is recorded below. (This cut off point is arbitrarily chosen). Thirty-four items have this magnitude of difference in the mean scores. Most of these items did not meet the criteria for inclusion in the final role description because they either did not have a mean ranking of 2.0 or above or had an SD of 1.0 or more for the whole group together. There were six of these (indicated below) that were included in the final role description.

Differences Between Nurses And Physicians

The nurses ranked as more important (i.e. the mean score of the groups differed by 0.75 or more) than the physicians that a medical coordinator should:

- . recognize that another professional may be the leader of a multidisciplinary team
- . be legally responsible for care provided by private physicians
- . act as a consultant to private physicians

- . arrange for specialists to act as consultants to the facility
- . enforce rules set down by a medical advisory group
- . ensure that his peers maintain agreed standards of care (Included in role)
- . do some clinical research
- . advise whether or not extraordinary means should be used in treatment
- . have a good liason with acute and psychiatric hospitals
- . be active in local community affairs

That a medical coordinator's knowledge should include:

- . health care planning
- . organizational behaviour
- . the facility's staffing
- . government regulations (Included in role)
- . the responsibilities of the board (Included in role)
- . management skills

And that a medical coordinator's skills and attitude should include:

- . being an optimist
- . being non-domineering
- . avoiding the dogmatic 'old style' approach (Included in role)

The physicians considered it more important than did the nurses that a medical coordinator should assist the administration to:

- . develop suitable patient care records

And that in a "long term care philosophy" should be included

- . "being prepared to make do with what you have"

Differences Between Nurses And Administrators

The nurses ranked as more important than administrators that a medical coordinator should:

- . present briefs to government for additional services
- . have some knowledge
 - . of administration
 - . and of the conducting of meetings (parliamentary procedure)

Differences Between Administrators and Physicians

The administrators ranked as more important than physicians did that a medical coordinator should:

- . be available to assist families to overcome guilt feelings towards the admission of residents
- . be available for discussions with relatives.

- . have extra training and experience in geriatrics (Included in role)
- . have a specialist certificate in geriatrics
- . a specialty degree in psychiatry
- . have a degree in administration
- . should have knowledge of the facility's staffing

The physicians ranked as more important than administrators that a medical coordinator:

- . may have his own private patients in the facility
- . should assist the board of trustees to maintain a suitable environment and high quality care (Included in role)
- . should assist the administration to plan new types of care and coordinate care in the facility

EFFECT OF THE DELPHI METHOD ON CONSENSUS

It is expected that by having several rounds in a Delphi study participants will be more likely to come to some consensus. The mean scores for the whole group were analyzed to see how they changed between round II and round III. Eighty-two items of round II had a decreased score in round III (i.e. considered more important after seeing the mean scores of all the respondents), thirteen items had an increased score and twenty-three items remained the same.

With these changes in score, five items were affected

as to whether they were included in the final role description. The following item was excluded:

- . that a medical coordinator should recognize that another professional may be the leader of a multidisciplinary team

The following four items became included--

That a medical coordinator should:

- . encourage the development of a library containing books and journals on gerontology and geriatrics
- . have training in psychogeriatrics
- . have knowledge of services available in the community
- . avoid the dogmatic 'old style' approach

DEFINING THE CONSENSUS

The Delphi method, like a committee, has its consensus point arbitrarily defined. It was decided that in this study items to be included in the role description would be those in which the mean score was 2.0 or less and the SD 1.0 or less. These numbers were chosen because 2.0 is at least a ranking of "Important" and the SD of 1.0 will ensure there are not numbers at each end of the scale contributing equally to the mean.

There were 140 items included in round III. Seventy-six of these items met the criteria and are included in the

descriptions following. Sixty items make up the role description and sixteen items the "long term care philosophy". This was included because during the first round of the Delphi method many of the respondents mentioned a "long term care philosophy". In order to clarify the meaning of this term the respondents were asked to describe what should be included in this philosophy. The round III responses showed "that a medical coordinator should promote a 'long term care philosophy'" had a whole group mean score of 1.28, and a SD of 0.45. The nurses gave it a mean of 1.00 meaning that all ten of them rated it "very important".

The following is a summary of a medical coordinator's role description bringing together the sixty best ranked items. In the Appendix III the items included are marked with an asterisk. Those items included in this role description had a mean score of 2.0 or less and an SD of 1.0 or less.

SUMMARY OF A MEDICAL COORDINATOR'S ROLE

Resident Care

A medical coordinator should participate in a multidisciplinary team that reviews individual resident's care. He should recognize the expertise of other members of the multidisciplinary team. He should preserve the right of each patient to have his own private physician. He should recognize the needs of relatives and friends of residents.

Private Physicians

A medical coordinator should encourage the continuation of long term doctor-patient relationships. He should assist the facility to maintain good relations with private physicians. He should establish in consultation with his peers, standards of physician care for the facility, and should encourage and ensure his peers maintain agreed standards of care and assist the facility to maintain the agreed standards.

Staff of a facility

A medical coordinator should support the role of the nurse as being the guardian of the total needs of residents (medical, psychological, social), should respect and encourage nursing expertise in the care of normal physiological functions and appreciate a collegial relationship with nursing personnel rather than a subservient role. He should support the roles of other staff - pharmacists, social workers, nutritionists, occupational therapists, physiotherapists, activity aides, nurses aides - in the team approach to resident care.

Education

A medical coordinator should enjoy sharing knowledge, should be prepared to give some lectures or 'in service' on subjects related to residents' care and be involved in teaching and learning at multidisciplinary meetings. He should attend postgraduate courses in geriatrics and gerontology for his own education and encourage the development of a library containing books and journals on gerontology and geriatrics.

Management

A medical coordinator should be part of the multi-disciplinary management team, should assist the board of trustees to maintain a suitable environment and high quality care and should provide a medical opinion for the administrator. He should assist the administration to comply with accreditation requirements and ensure standards of total resident care (including such activities as clinical audit, infection control, pharmacy and safety committees). His knowledge should include government regulations, the responsibilities of the board and the legal responsibilities of the facility. He should be prepared to be innovative in the development of services and assist in setting up an audit of total resident care. He should not be in a position to profit from the operation of the facility.

Training and experience

A medical coordinator should be a competent physician, have experience working as a primary care physician in the community, have knowledge of services available in that community and be an MD licensed to practice there. He should have experience working with groups of people. He should have a wide knowledge of drugs and drug interaction and have training, knowledge and experience in geriatrics (including gerontology), psychogeriatrics, and in chronic disease management.

Skills and attitude

Of prime importance to his skills and attitude is that he should have an interest in geriatrics, gerontology and chronic diseases. He should have a mature rounded personality, should have the ability to sustain morale, be an optimist, be non-domineering, approachable, patient and should avoid the dogmatic 'old style' approach. He should have well-developed communication skills, have demonstrated an ability to work cooperatively with other professionals, should employ tact and diplomacy in relating to his peers, be sympathetic and emphatic with other professionals and residents and have the skill needed to get people to work together. He should show leadership, be innovative within the physical and fiscal constraints of the facility and should promote a "long term care philosophy". He should be able to accept unusual behaviour and should be aware of residents' social needs. The medical coordinator should be able to adjust to the pace of long term care - allowing sufficient time for response and results. When his time is

limited, he should primarily aid the staff in clinical evaluation and in dealing with severe management problems.

During the first round of the study respondents who mentioned a different philosophy of care in long term care facilities were asked to contribute statements which described some aspect of this philosophy. In the second round seven additional items were added. The means and SD's of the items were calculated, as for the role description, and those with a mean of 2.0 or less and an SD of 1.0 or less marked with an asterisk (Appendix XII). The following description is made up of sixteen of the twenty-two items in the round III questionnaire describing a long term care philosophy.

A LONG TERM CARE PHILOSOPHY

There is encouragement of each resident to reach 'full potential'. This is achieved by focussing on the resident's self esteem and self management and by involving residents in decision making concerning care and programs. Residents have the right to choose whether or not to receive care/treatment. Relatives participate in the residents' care.

The emphasis is on care rather than cure, of care of the "total" resident rather than a single disease ("total" meaning physical, psychological, and social needs) and on the management of multiple problems.

The environment needs to be home-like, where there is an appreciation that time and pace are different, a 'people-orientated' rather than a 'task-orientated' approach to care and there is attention to the geographic location and layout of facilities.

There is coping with progressive disability (physical and social), the understanding of the needs of the dying and the acceptance of dying and death.

V. DISCUSSION

The method of enquiry into a question inevitably will affect the results. Those who are chosen and agree to participate in this 'Delphi' study will be different from those who would be chosen and would agree to participate in a committee. For a voluntary committee there may be more of the participant's time involved and therefore a greater interest in the question before agreement to participate.

The quantity of information processed in the 'Delphi' may be more than a committee or interacting group would have the patience to vote upon. It is likely that a greater amount of information is generated by the 'Delphi' which is useful for forward planning when alternatives must be considered.

The role description developed from this study using the Delphi method has produced many items which might be considered obvious. Some items even evoked a comment of "motherhood" in the margin from two respondents. However the individual comments may not all be obvious to everyone who might make use of the description and there will be other items which individuals might not have thought of but which will be important for the understanding of the role.

There are items dealing with personal skills which a committee or a group meeting together might not be prepared to discuss, because of the sensitivity of the group. They

were mentioned in a "one to one" interview (the first round) and are able to be voted upon in a Delphi study where the respondents are geographically dispersed.

In addition to having defined the items for inclusion in a role description of a medical coordinator and of a long term care philosophy the study has shown the areas of conflict or difference between professional groups. These differences can be caused by either one professional group having unacceptable expectations of the other or of the medical coordinator being given tasks which the other professional group perceives as part of its domain.

There were nineteen items that the nurses considered more important than the physicians did for the medical coordinator. If nurses (who are responsible for the care of the resident for most of the time) have these unacceptable expectations of the coordinator then there is likely to be strained interprofessional relationships.

There are many facets to each of these items. One example - "That a medical coordinator should enforce rules set down by a medical advisory group" is illustrative. Physicians in their normal professional relationships with each other are reluctant to create regulations to be enforced or like to be an enforcer of each other. The nature of a physician's work is such that he needs to be defensive of his fellow physicians because of the uncertainties in the practice of medicine and the knowledge that he may need

his fellow professionals' support when a disease or treatment does not turn out as expected. Nurses practice is more closely controlled and much care is only carried out following the order of a physician so nurses are used to the idea of regulation of their activities and therefore identify with the idea of enforcement.

Leadership of the professional team is another issue of disagreement. It seems in today's geriatric or chronic disease teaching that it is common for another professional to be the leader but this concept was not taught in the training of physicians a few years ago.

The administrators ranked seven items more important than the physicians. Two of these were to do with relatives - perhaps the administrators find this a difficult part of their own role - it may be a time factor or skill and knowledge that causes this difference of opinion. The expectations of training and experience in geriatrics may be caused by the fact the administrators are not aware that there is little training and experience available, in Canada at this time.

There could be several reasons for these differences of opinion and it is only if these are discussed between the different professional groups that an individual's role will be clearly defined.

Finally - in this discussion it should be pointed out that the study has not attempted to answer the question -

should there be medical coordinators in extended and long term care but has presumed there is some role and has answered the question - what is this role after it has been accepted that there is a need for this person.

RELIABILITY AND VALIDITY

The reliability (reproducibility) of the information has been increased by having three rounds of the Delphi and allowing changing views. It might be increased by having extra rounds but this is not clear. The reliability has been increased over a committee by having a greater number of participants (thirty-five) than is usual for a committee. The emphasis on subjects included could have affected the reliability in the first round because of the researcher's interaction but not in later rounds when there was an opportunity to include extra items.

The validity (accuracy) could be confirmed by repeating the study with a different observer or by submitting the findings to a committee or interacting group to discuss and vote upon. It is estimated that there would be a good test of validity if a comparison study used the Delphi method. It is unknown whether a committee might not produce different items for inclusion.

BIAS

An unavoidable bias which will have affected the initial recording of views of the respondents will be the researcher's professional experience. This could have been reduced or checked with more than one observer with differing professional experience or by running two parallel studies with different observers. Although the original design of the study attempted to have equal representation from extended and intermediate/personal care facilities there were twenty-four participants from extended care and eleven from intermediate/personal care interviewed in round I.

THE DEVELOPMENT OF THE ROLE

An unanswerable question is - will the process of performing the 'Delphi' on this subject affect the development of the role? Forty-three people have had an opportunity to think about 140 items and each person may have changed his thinking to some degree about the items being considered. The results of the study will be available to administrators, physicians, nurses, planners, and policy makers.

LIMITATIONS

The respondents in this study came from extended and long term care facilities with greater than 100 residents. Respondents were given the opportunity to decline to take

part. It must be assumed that those taking part were interested in defining a role of a medical coordinator. There may be limitations in the applicability of the defined role to smaller facilities and where staff do not appreciate such a role. Even though forty-three persons have been involved in defining a role of a medical coordinator the role of each individual medical coordinator will be unique because it will be affected by the personality, skills, knowledge, attitude, training and perception of his own role and how those with whom this person interacts perceive him and his role. For a role to be effective it should be continually redefined in response to the environment (social setting, physical setting, work opportunities) with which the role interrelates. Therefore a stated role is flexible and continually changing. The findings of this study are a framework upon which these changes may occur.

COMPARISONS

The role described has been compared with that of the American Medical Association's (AMA) description of the functions of a medical director in a long term care facility, and with the guidelines for the role of a medical coordinator in extended care hospitals in B.C. (Appendix II).

The AMA's description mentioned responsibility for employee health policies, the representation of the facility

in the community and arranging for emergency care, items which did not come into the Delphi study description. However the Delphi study mentioned - the multidisciplinary approach; the needs and rights of residents; that the physician should not profit from the operation of the facility; the supporting of the role of the nurse and other professionals and the physician's own education. As well, the physician's knowledge, training, experience, skills and attitude were described. The promotion of a long term care philosophy and its definition were included in this study but not mentioned by the AMA.

All the items in the B.C. Hospital Programs' role for a medical coordinator (Appendix II) are included in the study's role description. The wording is not identical but the intent is interpreted as being the same. The study's role description mentions in addition - the multidisciplinary team; the needs and rights of residents/patients and relatives; the recognition of other professionals; the coordinator's education, knowledge, skills and attitude and a long term care philosophy.

B.C. Hospital Programs' description of a coordinator, who may be from one of several health disciplines (Appendix I), mentions many more duties than that for the medical coordinator such as - staff evaluation; overall responsibility for assignment of professional duties; coordination of outside consultations; equipment and supplies; maintenance and use and communication with outside agencies.

VI. RECOMMENDATIONS

It is recommended, firstly, that those facilities planning to seek the services of a medical coordinator should consult the summary (p. 73) of a medical coordinator's role and use it as a basis for discussion between themselves and any prospective medical coordinator, prior to defining this physician's role.

Secondly, B.C.'s Ministry of Health planners who are discussing funding of medical coordinators for extended and long term care facilities should be aware of the role description developed from this study. If it was agreed that a medical coordinator should perform the activities outlined in the role description then an estimate of the time needed for each activity would follow before deciding on the funding arrangements.

Thirdly - nurses, administrators and physicians providing long term care should be aware of those areas of lack of consensus between the three professional groups so that they may be discussed between them. This may prevent unreasonable expectations of another group or invasion of domains (p. 67).

Fourthly, those professionals and non-professionals caring for long term care residents (or patients) whether it be in a long term care facility or in an acute care hospital should be aware that a long term care philosophy (see p. 76) is different from that which has been described

as an "acute care model" or a "medical model" (see p. 31).

Finally, geriatric medical education programs should be developed to enable physicians to obtain training, experience and skills which will result in changed attitudes towards the geriatric patient. (see Chapter 2 - "The United States", "Canada" and "The attitude of physicians toward older patients").

OPPORTUNITIES FOR FURTHER RESEARCH

Having defined a role for a medical coordinator it would be interesting to examine individual medical coordinator's roles and see to what extent they fit into this role defined by the administrators, physicians and nurses. The observations would again be made by the three professional groups.

It may be that medical coordinators in extended and long term care become more widespread and become accepted for smaller facilities. The performance of this study may make some difference to the development of the role. The effect of performing the study on the development of the role could be evaluated.

Smaller facilities tend to look after old people with lesser disabilities whose needs are more psychological and social rather than medical. A committee of the B.C. Medical Association (Fahrni 1980), has recommended medical coordinators for all long term care facilities. It would be

of interest to do a similar study to this with representation from the smaller facilities.

Eleven of the physicians involved with the study were in active primary care (fee for service) private practice. There may not be agreement with these physicians who were identified as being coordinators and those physicians who are not involved with the overall care in facilities. A fourth group could have been created to include these physicians in the original study. However, in the total sample, it would be better to have equal representation from each professional group as occurred in the study.

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APPENDICES

APPENDIX I

From:

(Hospitals for extended care guide for operation
of extended care programs 1980: appendix I)

COORDINATOR OF AN EXTENDED CARE UNITI

The duties outlined below may be carried out by the coordinator, or may be delegated when appropriate.

1. Promote effective relationships between all disciplines in the unit.
2. Ensure the concept and objectives of the unit are understood and practised by all health care staff.
3. Coordinate with the health professional team the planning and establishment of goal-oriented programs to meet the physical, mental and social needs of the patients.
4. Participate in all appropriate hospital committees involving the well being of the patient, such as patient care coordination committee.
5. Foster an environment emphasizing the social and restorative aspects of the daily patient program.
6. Ensure a high standard of patient care is achieved, including adequate medical records, audit procedures and patient safety.
7. Ensure policy and procedure manuals are current and all staff are aware of their contents.
8. Arrange for frequent in-service educational programs for all staff, utilizing the special knowledge of in-hospital staff and outside expertise when available.

9. Carry out staff evaluations, in conjunction with the staff member's immediate supervisor.
10. Carry over-all responsibility for assignment of professional duties.
11. Support all professional staff members in such a way that their special skills can be utilized to promote an appropriate program for each patient.
12. Foster good communication within the hospital (e.g. other departments, medical staff).
13. Identify and coordinate outside consultations services when required e.g. psychology, speech therapy, laboratory services, etc.
14. Ensure that equipment and supplies used for patient care are adequately maintained and used correctly.
15. Develop communication with community services and agencies (e.g. long term care program).
16. Interpret the role of extended care within the hospital and also to local organizations, agencies or professional groups.

II Qualifications:

1. Degree or diploma in any one of the health fields such as administration, medicine, nursing, occupational therapy, physiotherapy, psychology (with a medical orientation), social work, or others.
2. Of even more importance are the following qualifications: -
 - 2.1 Ability and experience in communication.
 - 2.2 Demonstrated ability in leadership.
 - 2.3 Training and experience in the operation of a multi-disciplinary group.
 - 2.4 Broad working knowledge of the skills of other health professional staff.

APPENDIX II

From:

(Hospitals for extended care guide for operation
of extended care programs 1980: appendix VII-2)

THE ROLE OF THE MEDICAL COORDINATOR

The hospital may appoint a physician to fulfill this responsibility. The duties of the medical coordinator should be set out in writing. There should be a clear definition of this supervisory physician's position relative to other medical staff and the extent of his or her authority.

I Special Areas of Responsibility:

1. Membership on all committees functioning as hospital advisory or patient program co-ordination and others as appropriate.
2. Providelliason with other physicians on hospital staff.
3. See that medical audit function is carried out to ensure acceptable standards of patient care.
4. Help ensure correct utilization of the hospital facilities.
5. Interpretation of the concepts, goals and function of extended care to the hospital board, other physicians and the public.
6. Report regularly to the board on the quality of care provided.

II Qualifications

Licensed to practise medicine in the province of British Columbia. Exceptions may be made when special circumstances apply (e.g. physician employed by federal government).

Member of the medical staff of the hospital.

Training and experience in geriatrics.

APPENDIX IIIGUIDELINES FOR A MEDICAL DIRECTOR IN A LONG TERM CARE FACILITY
(Committee on aging, council on medical service, American
Medical Association (AMA) 1977)

I FOREWARD

Although professional health services in long term care facilities have generally improved, many facilities need to take additional steps to insure quality health care for their patients. To assist in achieving quality health care, the AMA believes that long term care facilities should have either a medical director and/or an organized medical staff.

The organized medical staff has the responsibility for assuring quality care in the general hospital. However, physicians with patients in a long term care facility seldom organize themselves into a formal medical staff as they do in hospitals because the mode of practice is quite different. Where a medical director has been appointed in the long term care facility, he ordinarily performs functions similar to those performed by an organized medical staff.

Many long term care facilities have retained a principal physician for consultation on general medical policies, for patient emergencies, and for participation in utilization review. Nevertheless, there generally has been a lack of adequate medical supervision by the principal physician. Too often, there has been a failure by the principal physician to check out his view of his role in the facility with the administrator and the director of nursing, and as a consequence, all three have had difficulty in their professional relationships.

In many facilities where there has been realization of these problems and a desire for a satisfactory solution, the principal physician's role has evolved into that of a medical director. The AMA recommends that if a long term care facility has both an organized medical staff and a medical director, the medical director should be appointed with the approval of the medical staff. The conditions of employment for the medical director should be spelled out in a formal agreement. The agreement should specify the amount of time deemed necessary for the medical director to fulfill assigned administrative duties.

The medical director should be compensated for his administrative services. Compensation should not be in the form of rebate, referral of patients, or referral for consultation. This arrangement does not preclude the medical director from providing direct patient care under other financial agreements.

II GUIDELINES

To assist the medical director, the administrator, and the director of nursing to achieve coordinated patient care the AMA has developed guidelines for the medical director of a long term care facility. These guidelines were taken from Report B of the Council on Medical Services which was approved by the AMA House of Delegates in June 1973.

To help ensure the adequacy and appropriateness of the medical care provided to patients, the AMA recommends that wherever feasible the medical director should:

1. Assist in arranging for continuous physician coverage for medical emergencies and in developing procedures for emergency treatment of patients.
2. Participate in development of a system providing a medical care plan for each patient, which covers medications, nursing care, restorative services, diet and other services, and, if appropriate, a plan for discharge.
3. Be the medical representative of the facility in the community.
4. Develop liaison with attending staff physicians in efforts to ensure effective medical care.
5. In the absence of an organized medical staff, be responsible for the development of written bylaws, rules and regulations applicable to each physician attending patients in the facility.
6. If there is an organized medical staff, be a member, attend meetings and help assure adherence to medical staff bylaws, rules and regulations.

7. Participate in developing written policies governing the medical, nursing and related health services provided in the facility.
8. Participate in developing patient admission and discharge policies.
9. Participate in an effective program of long term care review.
10. Be available for consultation in the development and maintenance of an adequate medical record system.
11. Advise the administrator as to the adequacy of the facility's patient care services and medical equipment.
12. Be available for consultation with the administrator and the director of nursing in evaluating the adequacy of the nursing staff and the facility to meet the psychological as well as the medical and physical needs of patients.
13. Be available for consultation and participation in in-service training programs.
14. Advise the administration on employee health policies.
15. Be knowledgeable concerning policies and programs of public health agencies which may affect patient care programs in the facility.

DESCRIPTION OF POPULATION

PAGE 2

11 HOW MANY SUBJECTS WILL BE USED?

Thirty

12 WHO IS BEING RECRUITED?

Medical Coordinators, Directors of Nursing Care, and Administrators

13 HOW ARE THE SUBJECTS BEING RECRUITED AND SELECTED? (If initial contact is by letter, attach a copy; UBC policies prohibit initial contact by telephone)

By letter

14 WHAT ARE THE CRITERIA FOR THEIR SELECTION?

They are working as Medical Coordinators; are Directors of Nursing Care; or are Administrators of an Extended Care or Long Term Care Facility in B.C. at this time.

DESCRIPTION OF METHODOLOGY AND PROCEDURES

15 SUMMARY (must be complete in this space)

The study will use a method known as the 'Delphi' technique. This technique provides for the systematic solicitation and collation of judgements from a group of 'experts' on a particular topic through a set of carefully-designed sequential questionnaires interspersed with summarized information and feedback of opinions derived from earlier responses. The participants in the 'Delphi' technique are physically dispersed and do not meet face-to-face, for group decision making.

The letter and first-round questionnaire will be mailed to the subjects. The researcher will then visit each subject. The responses will be condensed and tabulated. In the second round (by mail and phone), the subjects will rank the responses by a five-point Likert scale. This ranking will then be analyzed for overall consensus and consensus within the groups. In the third round, the subjects will be shown the second-round results and will be asked to record their suggestions for resolving the areas of non-consensus.

The study will be recorded in the form required for an MSc thesis in Health Care Planning for the Department of Health Care and Epidemiology at UBC.

16 WHERE WILL THE PROJECT BE CONDUCTED? (room or area)

At a location selected by the subject.

17 WHO WILL ACTUALLY CONDUCT THE STUDY? (e.g. principal investigator, assistants)

Dr. Shaun H.S. Peck

18 HOW WILL THE PROJECT BE EXPLAINED TO THE SUBJECTS?

By means of the introductory letter.

19 HOW WILL YOU MAKE IT CLEAR TO THE SUBJECTS THAT THEIR PARTICIPATION IS VOLUNTARY AND THAT THEY MAY WITHDRAW FROM THE STUDY AT ANY TIME THEY WISH TO DISCONTINUE PARTICIPATION?

It is written at the top of the questionnaire

20 WILL YOUR PROJECT UTILIZE: (check)

- | | | |
|--------------------------|--|------------|
| X | <input type="checkbox"/> QUESTIONNAIRES (submit a copy) | } Combined |
| X | <input type="checkbox"/> INTERVIEWS (submit sample of questions) | |
| <input type="checkbox"/> | <input type="checkbox"/> OBSERVATIONS (submit a brief description) | |
| <input type="checkbox"/> | <input type="checkbox"/> TESTS (submit a brief description) | |

DATA

21 WHO WILL HAVE ACCESS TO THE GATHERED DATA?

Research and Thesis Committee

22 HOW WILL CONFIDENTIALITY OF THE DATA BE MAINTAINED?

Subjects' names known only to the researcher. Numbers on questionnaire will be used instead of names

23 HOW WILL THE DATA BE RECORDED? (instruments, notes, etc)

Notes

24 WHAT ARE THE PLANS FOR RETENTION OF DATA?

To be destroyed after completion of the study.

25 WHAT ARE THE PLANS FOR FUTURE USE OF DATA AS PART OF THIS STUDY OR USE BEYOND THIS STUDY?

None

26 HOW WILL THE DATA BE DESTROYED AND WHEN?

By fire at the end of the study.

BENEFITS, COSTS, RISKS

27 WHAT ARE THE POTENTIAL BENEFITS TO THE SUBJECTS?

Minimal

28 WHAT MAY BE REVEALED THAT IS NOT CURRENTLY KNOWN?

The diversity of views on the question and the areas of consensus.

29 WHAT MONETARY COMPENSATION IS OFFERED TO THE SUBJECTS?

None

30 WHAT ARE THE COSTS TO THE SUBJECTS? (monetary, time)

Two Hours

31 WHAT RISKS TO THE SUBJECT ARE MOST LIKELY TO BE ENCOUNTERED? (e.g. physical, psychological, sociological)

Some anxiety in answering questions where there may be conflict between different professional groups.

32 WHAT APPROACH WILL YOU MAKE TO MINIMIZE THE RISKS?

A personal approach.

33 WHO WILL CONSENT? (check)

- X ☐ SUBJECT
☐ PARENT/GUARDIAN
☐ AGENCY OFFICIAL(S) (specify: e.g. school board, hospital director etc.)
 (No institution will be identified in the study results)

34 WHAT IS THE COMPETENCE OF THE SUBJECT TO CONSENT?

Excellent

35 HOW WILL THE CONSENT FORMS OR QUESTIONNAIRES BE EXPLAINED TO THE SUBJECTS? (consider language or any other barrier)

By letter and interview

36 QUESTIONNAIRES

THE INTRODUCTORY PARAGRAPH HEADING THE QUESTIONNAIRE SHOULD PROVIDE A BRIEF SUMMARY THAT INDICATES THE PURPOSE OF THE PROJECT, THE BENEFITS TO BE DERIVED & A FULL DESCRIPTION OF THE PROCEDURES TO BE CARRIED OUT IN WHICH THE SUBJECTS ARE INVOLVED. THE FREEDOM OF THE SUBJECT TO WITHDRAW AT ANY TIME OR TO REFUSE TO ANSWER ANY QUESTIONS WITHOUT PREJUDICE AND THE AMOUNT OF TIME REQUIRED OF THE SUBJECT MUST BE STATED.

INCLUDE THE STATEMENT THAT IF THE QUESTIONNAIRE IS COMPLETED IT WILL BE ASSUMED THAT CONSENT HAS BEEN GIVEN.

FOR SURVEYS CIRCULATED BY MAIL SUBMIT A COPY OF THE EXPLANATORY LETTER AS WELL AS A COPY OF THE QUESTIONNAIRE

37 WRITTEN CONSENT (other than questionnaires)

UBC POLICY REQUIRES WRITTEN CONSENT IN ALL CASES. THE CONSENT FORM SHOULD CONTAIN ALL THE INFORMATION SUMMARIZED UNDER QUESTIONNAIRES ABOVE OR, IF AN ORAL PRESENTATION IS PLANNED, A SHORT STATEMENT OF WHAT WILL BE SAID SHOULD BE PROVIDED. IN EITHER CASE THE CONSENT FORM MUST INCLUDE A STATEMENT OF THE SUBJECT'S RIGHT TO WITHDRAW AT ANY TIME AND A STATEMENT THAT WITHDRAWAL WILL NOT PREJUDICE FURTHER TREATMENT, MEDICAL CARE OR INFLUENCE CLASS STANDING AS APPLICABLE.

SUBMIT A COPY OF ALL CONSENT FORMS

38 AGENCY CONSENT

IN THE CASE OF PROJECT CARRIED OUT AT OTHER INSTITUTIONS, THE COMMITTEE REQUIRES WRITTEN PROOF THAT AGENCY CONSENT HAS BEEN RECEIVED. SOME EXAMPLES ARE:

- Research carried out in a hospital - approval of hospital research or ethics committee
- Research carried out in a school - approval of School Board and/or Principal
- Research carried out in a Provincial Health Agency - approval of Deputy Minister

CHECKLIST OF ATTACHEMENTS TO THIS SUBMISSION

39 CHECK ITEMS ATTACHED TO THIS SUBMISSION (incomplete submissions will not be considered)

- X ☐ LETTER OF INITIAL CONTACT (item 13)
 X ☐ QUESTIONNAIRES (items 20, 36)
 X ☐ INTERVIEW QUESTIONS (item 20)
☐ DESCRIPTION OF OBSERVATIONS (item 20)
☐ TEST DESCRIPTION (item 20)
 X ☐ EXPLANATORY LETTER WITH QUESTIONNAIRE (item 36) (same as letter of initial contact)
☐ SUBJECT CONSENT FORM (item 33,37)
☐ PARENT/GUARDIAN CONSENT FORM (item 33,37)
☐ AGENCY CONSENT (item 33,38)

DELPHI ROUND 1

Subject No. _____

A MEDICAL COORDINATOR IN EXTENDED AND LONG TERM CARE FACILITIES IN BRITISH COLUMBIA

[You are free to withdraw from this study at any time and to refuse to answer any question without prejudice. It is assumed that, if the questionnaire is completed, your consent has been given to participate in the study.]

The following headings have been developed to help define the broad areas where the Medical Coordinator may have responsibilities. Under each heading, would you please list those activities that you see the Medical Coordinator carrying out at this time or in the future?

1. Activities related to residents (patients)

2. Activities in relation to staff training and education

3. Activities relating to the work of other physicians

4. Activities related to planning, development and evaluation of care services

B. Please list below what training, experience and skills you consider the Medical Coordinator should have

C. Please list below other activities or issues that should be included in a description of the Medical Coordinator's role that are not included above.

DELPHI ROUND II QUESTIONNAIRE

DELPHI ROUND II

Subject No. _____

THE ROLE OF A MEDICAL COORDINATOR IN EXTENDED AND LONG TERM CARE FACILITIES IN B.C.

(You are free to withdraw from this study at any time and to refuse to answer any question without prejudice. It is assumed that, if the questionnaire is completed, your consent has been given to participate in this study.)

INTRODUCTION

The following statements summarize the views expressed by the participants as to the role of a medical coordinator in extended and long term care facilities in B.C.

For the purpose of this study, the words his/her are interchangeable as are resident/patient and Director/Coordinator/Advisor/Supervisor.

Please rank each statement by placing a number in each box according to the following scale:

Very Important Important Somewhat Important Unimportant Not Important at all

EXAMPLE

The medical coordinator should have an MD

means that it is very important that this statement be included in the role description of a medical coordinator.

A. Role of the Medical Coordinator1. Related to Resident Carea) The Multidisciplinary Team

- A medical coordinator should - participate in a multidisciplinary team that reviews individual residents' care
- be the leader of a multidisciplinary team
- recognize that another professional may be the leader of a multidisciplinary team
- recognize the expertise of other members of the multidisciplinary team

b) Private Patients

- A medical coordinator should - preserve the right of each patient to have his own private physician
- examine all new residents

A medical coordinator may have his own private patients in the facility

A medical coordinator's role should be recognized as separate from the role of the private physician

c) Relatives

- A medical coordinator should - recognize the needs of relatives and friends of residents
- be available to assist families to overcome guilt feelings towards the admission of residents
- be available for discussions with relatives
- involve the family in the diet and activities (i.e. care plan) of the residents
- attend some social functions with relatives

A. Role of the Medical Coordinator (continued)

2. Related to Private Physicians

- A medical coordinator should
- establish in consultation with his peers, standards of physician care for the facility
 - assist the facility to maintain the agreed standards
 - encourage his peers to maintain agreed standards of care
 - assist the facility to maintain good relations with private physicians
 - be legally responsible for care provided by private physicians
 - act as a consultant to private physicians
 - arrange for specialists to act as consultants to the facility
 - encourage the continuation of long term doctor-patient relationships
 - enforce rules set down by a medical advisory group

3. Related to Planning, Development and Evaluation of Care

- A medical coordinator should
- participate in a facilities management committee
 - be prepared to be innovative in the development of services
 - assist in setting up an audit of total resident care
 - do some clinical research
 - be involved in admission and discharge planning
 - not be in a position to profit from the operation of the facility

4. Related to Nursing Care

- A medical coordinator should
- support the role of the nurse as being the guardian of the total needs of residents (medical, psychological, social)
 - respect and encourage nursing expertise in the care of normal physiological functions
 - be available (or his delegate) for discussion of problems on a 24-hour basis
 - be available (or his delegate) for a medical opinion on a 24-hour basis
 - appreciate a collegial relationship with nursing personnel rather than a subservient role
 - advise as to whether or not extraordinary means should be used in treatment

5. Related to Education

- A medical coordinator should
- be involved in teaching and learning at multidisciplinary meetings
 - be prepared to give some lectures or 'in service' on subjects related to residents' care
 - be available for the education of all staff, residents, relatives and volunteers
 - encourage the development of a library containing books and journals on Gerontology and Geriatrics
 - attend postgraduate courses in Geriatrics and Gerontology for his own education

A. Role of the Medical Coordinator (continued)

6. Related to Administration

A medical coordinator should - provide a medical opinion for the administrator

- make reports to the board of management
- assist the administration to:
 - ensure standards of total resident care (this includes such activities as clinical audit, infection control, pharmacy and safety committees)
 - create an environment in which health professionals can interact
 - plan new types of care (this includes activation programs, nursing procedures, day care, community visits, transportation, podiatry, dental care, speech therapy, and new facilities)
 - coordinate care in the facility
 - develop problem-oriented records
 - develop suitable patient care records
 - establish a credentials committee for medical staff
 - have a good liaison with acute and psychiatric hospitals
 - comply with accreditation requirements
 - present briefs to government for additional services
 - set up procedures and equipment for emergencies

- assist the administration to:

- ensure standards of total resident care (this includes such activities as clinical audit, infection control, pharmacy and safety committees)
- create an environment in which health professionals can interact
- plan new types of care (this includes activation programs, nursing procedures, day care, community visits, transportation, podiatry, dental care, speech therapy, and new facilities)
- coordinate care in the facility
- develop problem-oriented records
- develop suitable patient care records
- establish a credentials committee for medical staff
- have a good liaison with acute and psychiatric hospitals
- comply with accreditation requirements
- present briefs to government for additional services
- set up procedures and equipment for emergencies

B. Training and Experience of a Medical Coordinator (continued)

A medical coordinator should - have some knowledge of administration

This knowledge should include:

- funding arrangements for the facility
- budgeting
- health care planning
- organizational behaviour
- the facilities staffing
- employee relations
- government regulations
- equipment purchasing
- hospital bye-laws
- the legal responsibilities of the facility
- the responsibilities of the board
- management skills
- the conducting of meetings (parliamentary procedures)

C. Skills and Attitude of a Medical Coordinator

A medical coordinator should - have an interest in Geriatrics, Gerontology, and chronic disease

- have demonstrated an ability to work cooperatively with other professionals
- employ tact and diplomacy in relating to his peers
- be sympathetic and empathic with other professionals and residents
- be able to take an overview of problems
- have the skill needed to get people to work together
- have well-developed communication skills
- be innovative within the physical and fiscal constraints of the facility
- show leadership
- be aware of residents' social needs
- be able to accept unusual behaviour
- be aware of the needs of the poor
- have the ability to sustain morale
- be an optimist
- be non-domineering
- be approachable
- be patient
- avoid the dogmatic 'old style' approach
- have a mature 'rounded' personality
- be kind, understanding, fatherly, but not a 'push-over'
- promote a 'long term care philosophy'

Please add any additional statements you would like included in the role description:

During the first round, the respondents who mentioned a 'long term care philosophy' were asked to describe this. The following is a summary of the comments.

Very Important ☐ 1 Important ☐ 2 Somewhat Important ☐ 3 Unimportant ☐ 4 Not Important at all ☐ 5

- the encouragement of residents' self management
- the encouragement of residents' self esteem
- the right of residents to choose whether or not to receive care/treatment
- emphasis on care rather than cure
- care of the 'total' resident rather than a single disease ('total' meaning physical, psychological and social needs)
- the management of multiple problems
- rehabilitation
- coping with changing roles
- coping with progressive disability (physical and social)
- a 'people-oriented' rather than a 'task-oriented' approach to care
- the acceptance of death and dying
- understanding the needs of the dying
- an appreciation that time and pace are different
- a home-like environment
- the suitable geographic location and layout of facilities

[illegible][illegible]

Shaun H. S. Peck

DELPHI ROUND III

Subject No. _____

THE ROLE OF A MEDICAL COORDINATOR IN EXTENDED AND LONG TERM CARE FACILITIES IN B.C.

(You are free to withdraw from this study at any time and to refuse to answer any question without prejudice. It is assumed that, if the questionnaire is completed, your consent has been given to participate in this study)

INTRODUCTION

Following are shown the statements from Round II of the study: - your ranking (Column 1), the average of all respondents (Column 2), of the nursing coordinators (Column 3), of the administrators (Column 4), and of the physicians (Column 5).

The purpose of showing the averages is to enable you to restate your ranking in order to influence the group's consideration of the importance of the statement being included in a description of the role of a medical coordinator.

Also, additional comments by respondents have been included for ranking.

Please again rank each statement by placing a whole number in Column 6 according to the scale shown.

Very Important Important Somewhat Important Unimportant Not Important at all

EXAMPLE

'The medical coordinator should have an MD' means that it is very important that this statement be included in the role description of a medical coordinator.

DELPHI ROUND III

A. Role of the Medical Coordinator

1. Related to Resident Care

a) The Multidisciplinary Team

A medical coordinator should:

- participate in a multidisciplinary team that reviews individual resident's care
- be the leader of a multidisciplinary team
- recognize that another professional may be the leader of a multidisciplinary team
- recognize the expertise of other members of the multidisciplinary team

b) Private Patients

A medical coordinator should:

- preserve the right of each patient to have his own private physician
- examine all new residents

A medical coordinator may have his own private patients in the facility

A medical coordinator's role should be recognized as separate from the role of the private physician

c) Relatives

A medical coordinator should:

- recognize the needs of relatives and friends of residents
- be available to assist families to overcome guilt feelings towards the admission of residents
- be available for discussions with relatives
- involve the family in the diet and activities (i.e. care plan) of the residents
- attend some social functions with relatives
- be available for consultation with relatives

1	2	3	4	5	6
Your First Ranking	Average of All (N=29)	Average			YOUR NEW RANKING
		Nurses (N=12)	Administrators (N=8)	Physicians (N=9)	
	1.2	1.1	1.0	1.4	
	2.9	3.3	2.9	2.6	
	2.0	1.7	2.0	2.6	
	1.2	1.0	1.5	1.1	
	1.4	1.4	1.8	1.0	
	3.2	3.6	2.8	3.2	
	3.3	3.3	3.9	2.7	
	1.3	1.3	1.6	1.0	
	1.6	1.3	1.6	1.9	
	2.8	2.7	2.9	3.0	
	2.6	2.7	2.1	3.0	
	3.1	3.2	3.0	3.0	
	3.4	3.2	3.3	3.8	
	-	-	-	-	

A. Role of the Medical Coordinator (continued)

2. Related to Private Physician

A medical coordinator should:

- establish in consultation with his peers, standards of physician care for the facility
- assist the facility to maintain the agreed standards
- encourage his peers to maintain agreed standards of care
- assist the facility to maintain good relations with private physicians
- be legally responsible for care provided by private physicians
- act as a consultant to private physicians
- arrange for specialists to act as consultants to the facility
- encourage the continuation of long term doctor-patient relationships
- enforce rules set down by a medical advisory group
- ensure that his peers maintain agreed standards of care

3. Related to Planning, Development and Evaluation of Care

A medical coordinator should:

- participate in a facilities management committee
- be prepared to be innovative in the development of services
- assist in setting up an audit of total resident care
- do some clinical research
- be involved in admission and discharge planning
- not be in a position to profit from the operation of the facility

1	2	3	4	5	6
Your First Ranking	Average of All (N=29)	Average			YOUR NEW RANKING
		Nurses (N=12)	Administrators (N=8)	Physicians (N=9)	
	1.3	1.3	1.1	1.3	
	1.4	1.5	1.4	1.3	
	1.4	1.4	1.6	1.3	
	1.4	1.5	1.6	1.1	
	4.3	3.6	4.7	4.6	
	2.3	1.9	2.1	2.9	
	2.6	2.1	2.6	3.2	
	1.6	1.8	1.8	1.2	
	2.3	2.3	1.8	2.8	
	-	-	-	-	
	1.6	1.5	2.0	1.4	
	1.5	1.3	1.9	1.6	
	1.7	1.6	1.8	1.8	
	2.8	2.2	3.3	3.3	
	2.2	2.3	1.9	2.4	
	1.9	1.8	2.6	1.3	

A. Role of the Medical Coordinator (continued)

4. Related to Nursing Care

A medical coordinator should:

- support the role of the nurse as being the guardian of the total needs of residents (medical, psychological, social)
- respect and encourage nursing expertise in the care of normal physiocological functions
- be available (or his delegate) for discussion of problems on a 24-hour basis
- be available (or his delegate) for a medical opinion on a 24-hour basis
- appreciate a collegial relationship with nursing personnel rather than a subservient role
- advise as to whether or not extraordinary means should be used in treatment
- support the roles of all others - nurses, pharmacists, social workers, nutritionists, occupational therapists, physiotherapists, activity aides, nurses aides, and others in the team approach to resident care

5. Related to Education

A medical coordinator should:

- be involved in teaching and learning at multidisciplinary meetings
- be prepared to give some lectures or 'in service' on subjects related to residents' care
- be available for the education of all staff, residents, relatives and volunteers
- encourage the development of a library containing books and journals on Gerontology and Geriatrics
- attend postgraduate courses in Geriatrics and Gerontology for his own education
- enjoy sharing knowledge

1	2	3	4	5	6
Your First Ranking	Average of All (N=29)	Average			YOUR NEW RANKING
		Nurses (N=12)	Administrators (N=6)	Physicians (N=9)	
	1.6	1.1	2.3	1.9	
	1.5	1.1	1.9	1.8	
	2.4	2.4	2.6	2.1	
	2.5	2.3	2.9	2.6	
	1.5	1.3	1.6	1.8	
	2.5	1.9	2.6	3.1	
	-	-	-	-	
	1.5	1.3	1.5	1.7	
	1.7	1.4	1.9	2.0	
	2.3	2.1	2.4	2.7	
	2.1	1.9	2.5	2.1	
	1.8	1.8	2.0	1.8	
	-	-	-	-	

A. Role of the Medical Coordinator (continued)

6. Related to Administration

A medical coordinator should:

- provide a medical opinion for the administrator
- make reports to the board of management
- assist the board of trustees to maintain a suitable environment and high quality care
- assist the administration to:
 - ensure standards of total resident care (this includes such activities as clinical audit, infection control, pharmacy and safety committees)
- create an environment in which health professionals can interact
- plan new types of care (this includes activation programs, nursing procedures, day care, community visits, transportation, podiatry, dental care, speech therapy, and new facilities)
- coordinate care in the facility
- develop problem-oriented records
- develop suitable patient care records
- establish a credentials committee for medical staff
- have a good liaison with acute and psychiatric hospitals
- comply with accreditation requirements
- present briefs to government for additional services
- set up procedures and equipment for emergencies
- create a suitable environment for care

The medical coordinator should be part of the multidisciplinary management team

1	2	3	4	5	6
Your First Ranking	Average of All (N=29)	Average			YOUR NEW RANKING
		Nurses (N=12)	Administrators (N=8)	Physicians (N=9)	
	1.6	1.3	2.3	1.3	
	2.4	2.4	3.1	1.9	
	-	-	-	-	
	1.5	1.8	1.4	1.3	
	1.8	1.7	1.8	1.9	
	2.1	2.0	2.5	2.0	
	2.4	2.6	2.9	1.8	
	3.0	2.8	3.3	3.0	
	2.4	2.8	2.9	1.4	
	2.3	2.0	2.6	2.3	
	1.7	1.3	1.8	2.3	
	1.3	1.3	1.3	1.6	
	2.4	1.9	3.0	2.6	
	2.4	2.5	2.6	2.0	
	-	-	-	-	
	-	-	-	-	

B. Training and Experience of a Medical Coordinator

A medical coordinator should:

- have an MD with a license to practice in the location community
- have experience working as a primary care physician in the community
- continue to be active in private practice
- be a competent physician
- have extra training and experience in Geriatrics (the medical care of the elderly)
- have knowledge of Gerontology (the study of normal aging)
- have some experience in chronic disease management
- have a specialty degree in internal medicine or rehabilitation
- have training and experience in Psychogeriatrics (the diagnosis and treatment of psychiatric disorder in the elderly)
- have a wide knowledge of drugs and drug interaction
- be an ex-chief of staff or president of the local medical society
- be active in local community affairs
- have knowledge of services available in the community
- have experience working with physicians on committees
- have experience working with groups of people
- have some knowledge of administration
- have the Certification in Family Medicine
- have a specialist certificate in Geriatrics

(continued)

1	2	3	4	5	6
Your First Ranking	Average of All (N=29)	Average			YOUR NEW RANKING
		Nurses (N=12)	Administrators (N=6)	Physicians (N=9)	
	1.1	1.1	1.1	1.0	
	1.7	1.7	1.8	1.6	
	2.3	2.5	2.0	2.2	
	1.1	1.0	1.1	1.2	
	1.8	1.4	1.5	2.4	
	1.5	1.3	1.5	1.8	
	1.6	1.4	1.8	1.6	
	3.3	3.0	3.0	4.0	
	2.1	1.6	2.4	2.6	
	1.6	1.3	1.9	1.4	
	4.3	4.2	4.4	4.3	
	3.7	3.3	4.1	3.8	
	2.1	2.1	2.5	1.7	
	2.3	2.2	2.4	2.6	
	2.0	1.7	2.3	2.1	
	2.4	2.2	2.5	2.6	
	-	-	-	-	
	-	-	-	-	

B. Training and Experience of a Medical Coordinator (continued)

A medical coordinator should:

- have a specialty degree in Psychiatry
- have a degree in Administration
- have some knowledge of administration

This knowledge should include:

- funding arrangements for the facility
- budgeting
- health care planning
- organizational behaviour
- the facilities staffing
- employee relations
- government regulations
- equipment purchasing
- hospital bye-laws
- the legal responsibilities of the facility
- the responsibilities of the board
- management skills
- the conducting of meetings (parliamentary procedures)

1	2	3	4	5	6
Your First Ranking	Average of All (N=29)	Average			YOUR NEW RANKING
		Nurses (N=12)	Administrators (N=8)	Physicians (N=9)	
	-	-	-	-	
	-	-	-	-	
	2.0	1.5	2.4	2.3	
	2.4	2.2	2.6	2.7	
	2.8	2.8	2.4	3.1	
	2.0	1.7	2.3	2.3	
	2.2	1.8	2.3	2.9	
	2.4	2.0	1.7	2.8	
	2.8	2.9	2.5	2.9	
	2.0	1.5	2.3	2.4	
	3.4	3.5	3.6	3.0	
	1.9	1.7	2.1	2.1	
	1.6	1.3	1.8	1.7	
	1.9	1.7	2.3	1.7	
	2.4	2.1	2.4	2.9	
	2.6	2.1	3.4	2.4	

C. Skills and Attitude of a Medical Coordinator

A medical coordinator should:

- have an interest in Geriatrics, Gerontology, and chronic diseases
- have demonstrated an ability to work cooperatively with other professionals
- employ tact and diplomacy in relating to his peers
- be sympathetic and empathic with other professionals and residents
- be able to take an overview of problems
- have the skill needed to get people to work together
- have well-developed communication skills
- be innovative within the physical and fiscal constraints of the facility
- show leadership
- be aware of residents' social needs
- be able to accept unusual behaviour
- be aware of the needs of the poor
- have the ability to sustain morale
- be an optimist
- be non-domineering
- be approachable
- be patient
- avoid the dogmatic 'old style' approach
- have a mature 'rounded' personality

1	2	3	4	5	6
Your First Ranking	Average of All (N=29)	Average			YOUR NEW RANKING
		Nurses (N=12)	Administrators (N=8)	Physicians (N=9)	
	1.2	1.1	1.4	1.3	
	1.3	1.1	1.6	1.4	
	1.4	1.2	2.0	1.3	
	1.5	1.4	1.9	1.3	
	1.4	1.2	1.8	1.3	
	1.7	1.8	1.8	1.3	
	1.5	1.2	2.0	1.6	
	2.0	1.8	2.3	2.0	
	1.6	1.6	1.8	1.6	
	2.0	1.8	2.4	2.0	
	1.8	1.6	1.9	2.0	
	2.4	2.5	2.6	1.9	
	1.9	1.9	2.4	1.6	
	2.5	1.8	2.9	3.0	
	2.4	1.8	2.8	2.9	
	1.4	1.3	1.8	1.2	
	1.5	1.4	1.8	1.4	
	2.1	1.7	2.4	2.6	
	1.9	1.7	1.9	2.2	

(continued)

C. Skills and Attitude of a Medical Coordinator (continued)

A medical coordinator should:

- be kind, understanding, fatherly, but not a 'push-over'
- promote a 'long term care philosophy'

The personal attributes of a medical coordinator should not be included in great detail in the role description (For ranking, delete the 'not' if you wish).

General Comments

- The medical coordinator could be male or female
- The medical coordinator should be able to adjust to the pace of long term care -- allowing sufficient time for response and results
- With limited time, the medical coordinator should aid in clinical evaluation and aid staff in dealing with severe management problems

D. Long Term Care Philosophy

The following statements should be included in the description of 'Long Term Care Philosophy':

- the encouragement of resident's self management
- the encouragement of resident's self esteem
- the right of residents to choose whether or not to receive care/treatment
- emphasis on care rather than cure
- care of the 'total' resident rather than a single disease ('total' meaning physical, psychological and social needs)
- the management of multiple problems
- rehabilitation

(continued)

1	2	3	4	5	6
Your First Ranking	Average of All (N=29)	Average			YOUR NEW RANKING
		Nurses (N=12)	Administrators (N=6)	Physicians (N=9)	
	2.4	2.3	2.6	2.2	
	1.5	1.1	1.9	1.6	
	-	-	-	-	
	-	-	-	-	
	-	-	-	-	
	-	-	-	-	
	1.4	1.3	1.8	1.4	
	1.1	1.1	1.1	1.1	
	1.7	1.5	2.1	1.4	
	1.5	1.3	1.9	1.4	
	1.1	1.0	1.0	1.4	
	1.6	1.6	1.8	1.3	
	2.1	2.1	2.0	2.3	

D. Long Term Care Philosophy (continued)

The following statements should be included in the description of a 'Long Term Care Philosophy':

- coping with changing roles
- coping with progressive disability (physical and social)
- a 'people-oriented' rather than a 'task-oriented' approach to care
- the acceptance of death and dying
- understanding the needs of the dying
- an appreciation that time and pace are different
- a home-like environment
- the suitable geographic location and layout of facilities
- responsibility for staff development and the quality of the working environment
- the stressing of the 'wellness' of the person
- the encouragement of each resident to reach 'full potential'
- a safe, secure and noise-controlled environment
- 'Being prepared to make do with what you have'
- the involvement of residents in decision making concerning care and programs
- the participation of the relatives in residents' care

1	2	3	4	5	6
Your First Ranking	Average of All (N=29)	Average			YOUR NEW RANKING
		Nurses (N=12)	Administrators (N=8)	Physicians (N=9)	
	2.0	1.7	2.5	2.1	
	1.6	1.4	2.0	1.6	
	1.5	1.2	1.9	1.6	
	1.6	1.5	2.1	1.1	
	1.2	1.3	1.4	1.1	
	1.9	1.4	2.6	1.8	
	1.4	1.3	1.6	1.4	
	1.8	1.8	1.7	1.8	
	-	-	-	-	
	-	-	-	-	
	-	-	-	-	
	-	-	-	-	
	-	-	-	-	
	-	-	-	-	
	-	-	-	-	
	-	-	-	-	
	-	-	-	-	

This is the end of the final round (Round III) of this Delphi questionnaire. Thank you for taking part.

Please would you place the completed questionnaire in the stamped addressed envelope for return to me.

Shaun H. S. Peck

RESULTS OF DELPHI ROUND III (for explanation see text page)

[S.D. = Standard Deviation. * = Means 2.0 or less, S.D. 1.0 or less for whole group]

A. Role of the Medical Coordinator

1. Related to Resident Care

a) The Multidisciplinary Team

A medical coordinator should:

- participate in a multidisciplinary team that reviews individual resident's care
- be the leader of a multidisciplinary team
- recognize that another professional may be the leader of a multidisciplinary team
- recognize the expertise of other members of the multidisciplinary team

b) Private Patients

A medical coordinator should:

- preserve the right of each patient to have his own private physician
- examine all new residents

A medical coordinator may have his own private patients in the facility

A medical coordinator's role should be recognized as separate from the role of the private physician

c) Relatives

A medical coordinator should:

- recognize the needs of relatives and friends of residents
- be available to assist families to overcome guilt feelings towards the admission of residents
- be available for discussions with relatives
- involve the family in the diet and activities (i.e. care plan) of the residents
- attend some social functions with relatives
- be available for consultation with relatives

1	2	3	4	5
Means of Whole Group (N=31)	Standard Deviation (N=31)	Means		
		Nurses (N=10)	Administrators (N=10)	Physicians (N=11)
1.23	0.80	1.00	1.10	1.55
2.84	1.07	2.90	2.90	2.73
2.06	0.93	1.60	2.10	2.45
1.13	0.43	1.00	1.30	1.09
1.10	0.40	1.00	1.30	1.00
3.29	1.37	3.70	2.60	3.55
3.26	1.06	3.20	3.70	2.91
1.58	1.82	1.30	1.40	1.09
1.32	0.54	1.10	1.30	1.55
2.77	1.10	2.80	2.33	3.09
2.61	1.05	2.60	2.20	3.00
2.87	0.99	3.00	2.70	2.91
(N=30) 3.45	1.15	3.40	3.40	3.55
(N=17) 2.58	0.90	2.67	2.50	2.56

A. Role of the Medical Coordinator (continued)

2. Related to Private Physician

A medical coordinator should:

- establish in consultation with his peers, standards of physician care for the facility
- assist the facility to maintain the agreed standards
- encourage his peers to maintain agreed standards of care
- assist the facility to maintain good relations with private physicians
- be legally responsible for care provided by private physicians
- act as a consultant to private physicians
- arrange for specialists to act as consultants to the facility
- encourage the continuation of long term doctor-patient relationships
- enforce rules set down by a medical advisory group
- ensure that his peers maintain agreed standards of care

3. Related to Planning, Development and Evaluation of Care

A medical coordinator should:

- participate in a facilities management committee
- be prepared to be innovative in the development of services
- assist in setting up an audit of total resident care
- do some clinical research
- be involved in admission and discharge planning
- not be in a position to profit from the operation of the facility

	1	2	3	4	5	
	Means of Whole Group (N=31)	Standard Deviation (N=31)	Means			
			Nurses (N=10)	Administrators (N=10)	Physicians (N=11)	
	1.16	0.37	1.10	1.20	1.18	*
	1.35	0.71	1.40	1.60	1.09	*
(N=30)	1.27	0.45	1.10	1.44	1.27	*
(N=30)	1.20	0.41	1.10	1.44	1.09	*
(N=30)	4.13	1.20	3.60	4.22	4.55	
(N=30)	2.17	0.91	1.80	2.00	2.64	
	2.52	1.31	2.10	2.40	3.00	
	1.55	0.72	1.80	1.60	1.45	*
(N=30)	2.00	1.05	1.50	2.00	2.45	
(N=22)	1.73	0.70	1.25	2.00	2.00	*
	1.52	0.77	1.40	1.80	1.36	*
	1.42	0.67	1.10	1.80	1.36	*
	1.61	0.67	1.40	1.70	1.73	*
	2.81	0.91	2.20	2.70	3.18	
(N=30)	2.07	0.69	2.10	1.89	2.18	
(N=30)	1.60	0.72	1.70	1.89	1.27	*

A. Role of the Medical Coordinator (continued)

4. Related to Nursing Care

A medical coordinator should:

- support the role of the nurse as being the guardian of the total needs of residents (medical, psychological, social)
- respect and encourage nursing expertise in the care of normal physiocological functions
- be available (or his delegate) for discussion of problems on a 24-hour basis
- be available (or his delegate) for a medical opinion on a 24-hour basis
- appreciate a collegial relationship with nursing personnel rather than a subservient role
- advise as to whether or not extraordinary means should be used in treatment
- support the roles of all others - nurses, pharmacists, social workers, nutritionists, occupational therapists, physiotherapists, activity aides, nurses aides, and others in the team approach to resident care

5. Related to Education

A medical coordinator should:

- be involved in teaching and learning at multidisciplinary meetings
- be prepared to give some lectures or 'in service' on subjects related to residents' care
- be available for the education of all staff, residents, relatives and volunteers
- encourage the development of a library containing books and journals on Gerontology and Geriatrics
- attend postgraduate courses in Geriatrics and Gerontology for his own education
- enjoy sharing knowledge

	1	2	3	4	5	
	Means of Whole Group (N=31)	Standard Deviation (16-N)	Means			
			Nurses (N=10)	Administrators (n=10)	Physicians (11-N)	
(N=30)	1.58	0.79	1.10	2.05	1.60	*
	1.35	0.66	1.30	1.50	1.27	*
(N=30)	2.20	1.06	2.10	2.33	2.18	
(N=30)	2.40	1.22	2.00	2.56	2.64	
	1.32	0.48	1.10	1.50	1.36	*
(N=30)	2.35	1.09	1.90	2.39	2.73	
(N=22)	1.50	0.60	1.33	2.00	1.22	*
	1.45	07 2	1.10	1.60	1.64	*
	1.55	0.57	1.20	1.70	1.73	*
	2.13	0.72	2.00	2.20	2.18	
(N=30)	1.97	0.67	1.90	2.11	1.91	*
	1.63	0.89	1.30	1.90	1.64	*
(N=22)	1.64	0.66	1.67	1.67	1.60	*

A. Role of the Medical Coordinator (continued)

6. Related to Administration

A medical coordinator should:

- provide a medical opinion for the administrator
- make reports to the board of management
- assist the board of trustees to maintain a suitable environment and high quality care
- assist the administration to:
 - ensure standards of total resident care (this includes such activities as clinical audit, infection control, pharmacy and safety committees)
 - create an environment in which health professionals can interact
 - plan new types of care (this includes activation programs, nursing procedures, day care, community visits, transportation, podiatry, dental care, speech therapy, and new facilities)
 - coordinate care in the facility
 - develop problem-oriented records
 - develop suitable patient care records
 - establish a credentials committee for medical staff
 - have a good liaison with acute and psychiatric hospitals
 - comply with accreditation requirements
 - present briefs to government for additional services
 - set up procedures and equipment for emergencies
 - create a suitable environment for care

The medical coordinator should be part of the multidisciplinary management team

	1	2	3	4	5	
	Means of Whole Group (N=31)	Standard Deviation (N=31)	Means			
			Nurses (N=10)	Administrators (n=10)	Physicians (N=11)	
(N=30)	1.37	0.56	1.20	1.67	1.27	*
(N=30)	2.03	0.93	1.90	2.44	1.82	
(N=22)	1.59	0.67	1.33	2.33	1.30	*
	1.23	0.62	1.40	1.20	1.09	*
(N=30)	1.63	0.93	1.60	1.56	1.73	
	2.16	0.97	2.00	2.70	1.82	
(N=30)	2.40	1.22	2.50	2.89	1.91	
(N=30)	3.10	0.92	3.10	3.22	3.00	
(N=29)	2.38	1.21	3.00	2.67	1.55	
	2.06	1.15	1.60	2.30	2.27	
(N=30)	1.67	1.09	1.30	1.56	2.09	
	1.39	0.92	1.00	1.60	1.55	*
(N=30)	2.23	1.10	1.70	2.67	2.27	
(N=30)	2.23	1.01	2.50	2.33	1.82	
(N=22)	2.18	0.96	2.50	2.33	1.90	
(N=22)	1.41	0.50	1.29	1.83	1.22	*

B. Training and Experience of a Medical Coordinator

A medical coordinator should:

- have an MD with a license to practice in the location community
- have experience working as a primary care physician in the community
- continue to be active in private practice
- be a competent physician
- have extra training and experience in Geriatrics (the medical care of the elderly)
- have knowledge of Gerontology (the study of normal aging)
- have some experience in chronic disease management
- have a specialty degree in internal medicine or rehabilitation
- have training and experience in Psychogeriatrics (the diagnosis and treatment of psychiatric disorder in the elderly)
- have a wide knowledge of drugs and drug interaction
- be an ex-chief of staff or president of the local medical society
- be active in local community affairs
- have knowledge of services available in the community
- have experience working with physicians on committees
- have experience working with groups of people
- have some knowledge of administration
- have the Certification in Family Medicine
- have a specialist certificate in Geriatrics

(continued)

	1	2	3	4	5	
	Means of Whole Group (N=31)	Standard Deviation (N=31)	Means			
			Nurses (N=10)	Administrators (n=10)	Physicians (N=11)	
(N=30)	1.03	0.18	1.10	1.00	1.00	*
(N=30)	1.38	0.67	1.40	1.28	1.45	*
(N=30)	2.23	1.01	2.40	2.00	2.27	
	1.13	0.34	1.00	1.10	1.18	*
	1.55	0.85	1.30	1.20	2.09	*
(N=30)	1.33	0.55	1.20	1.22	1.55	*
	1.52	0.72	1.40	1.50	1.45	*
(N=29)	3.34	0.85	3.10	3.25	3.64	
(N=30)	2.00	0.79	1.70	1.89	2.36	*
(N=30)	1.40	0.62	1.50	1.33	1.36	*
(N=29)	4.38	0.62	4.20	4.22	4.40	
(N=29)	3.66	1.01	3.20	3.78	4.00	
(N=29)	1.86	0.64	2.00	2.00	1.60	*
(N=29)	2.21	0.86	2.00	2.22	2.40	
(N=29)	1.93	0.70	1.80	1.89	2.10	*
(N=28)	2.18	0.86	1.80	2.44	2.33	
(N=21)	3.05	1.07	3.50	2.40	3.40	
(N=22)	3.05	1.21	2.67	2.17	3.80	

B. Training and Experience of a Medical Coordinator (continued)

A medical coordinator should:

- have a specialty degree in Psychiatry
- have a degree in Administration
- have some knowledge of administration

This knowledge should include:

- funding arrangements for the facility
- budgeting
- health care planning
- organizational behaviour
- the facilities staffing
- employee relations
- government regulations
- equipment purchasing
- hospital bye-laws
- the legal responsibilities of the facility
- the responsibilities of the board
- management skills
- the conducting of meetings (parliamentary procedures)

	1	2	3	4	5
	Means of Whole Group (N=31)	Standard Deviation (N=31)	Means		
			Nurses (N=10)	Administrators (N=10)	Physicians (N=11)
(N=24)	3.75	1.11	3.86	2.57	4.50
(N=24)	3.83	1.01	3.38	2.44	4.36
(N=28)	2.04	0.79	1.50	2.50	2.20
(N=30)	2.33	1.06	1.90	2.56	2.60
(N=29)	2.66	1.01	2.60	2.33	3.00
(N=29)	1.86	1.03	1.50	1.67	2.40
(N=29)	2.28	0.92	1.70	2.22	2.90
(N=29)	2.28	0.96	2.00	2.00	2.80
(N=29)	2.76	0.99	3.00	2.33	2.90
(N=30)	1.97	0.85	1.50	2.20	2.30
(N=29)	3.28	1.00	3.50	3.33	3.00
(N=29)	1.86	0.95	1.40	1.89	2.30
(N=29)	1.52	0.83	1.30	1.44	1.80
(N=29)	1.69	0.76	1.20	1.89	2.00
(N=29)	2.24	0.91	1.80	2.33	2.60
(N=29)	2.55	1.06	2.00	3.00	2.70

C. Skills and Attitude of a Medical Coordinator

A medical coordinator should:

- have an interest in Geriatrics, Gerontology, and chronic diseases
- have demonstrated an ability to work cooperatively with other professionals
- employ tact and diplomacy in relating to his peers
- be sympathetic and empathic with other professionals and residents
- be able to take an overview of problems
- have the skill needed to get people to work together
- have well-developed communication skills
- be innovative within the physical and fiscal constraints of the facility
- show leadership
- be aware of residents' social needs
- be able to accept unusual behaviour
- be aware of the needs of the poor
- have the ability to sustain morale
- be an optimist
- be non-domineering
- be approachable
- be patient
- avoid the dogmatic 'old style' approach
- have a mature 'rounded' personality

(continued)

	1	2	3	4	5	
	Means of Whole Group (N=31)	Standard Deviation (N=31)	Means			
			Nurses (N=10)	Administrators (N=10)	Physicians (N=11)	
(N=30)	1.13	0.43	1.00	1.20	1.20	*
(N=29)	1.21	0.41	1.10	1.00	1.50	*
(N=28)	1.36	0.49	1.10	1.50	1.50	*
(N=28)	1.43	0.50	1.30	1.56	1.50	*
(N=29)	1.28	0.45	1.10	1.33	1.40	*
(N=30)	1.50	0.57	1.40	1.70	1.40	*
(N=29)	1.38	0.49	1.10	1.56	1.50	*
(N=29)	1.76	0.69	1.60	2.00	1.70	*
(N=29)	1.50	0.65	1.40	1.72	1.40	*
(N=30)	1.93	0.69	1.80	2.10	1.90	*
(N=29)	1.72	0.70	1.70	1.67	1.80	*
(N=29)	2.31	0.93	2.50	2.56	1.90	
(N=29)	1.76	0.64	1.90	1.78	1.60	*
(N=29)	2.45	0.99	2.10	2.33	2.90	
(N=29)	2.17	0.97	1.70	2.22	2.60	
(N=30)	1.43	0.68	1.20	1.70	1.30	*
(N=29)	1.41	0.56	1.40	1.44	1.40	*
(N=28)	1.79	0.79	1.30	1.89	2.22	*
(N=29)	1.72	0.65	1.50	1.67	2.00	*

C. Skills and Attitude of a Medical Coordinator (continued)

A medical coordinator should:

- be kind, understanding, fatherly, but not a 'push-over'
- promote a 'long term care philosophy'

The personal attributes of a medical coordinator should not be included in great detail in the role description

The personal attributes of a medical coordinator should be included in great detail in the role description

General Comments

- The medical coordinator could be male or female
- The medical coordinator should be able to adjust to the pace of long term care -- allowing sufficient time for response and results
- With limited time, the medical coordinator should aid in clinical evaluation and aid staff in dealing with severe management problems

D. Long Term Care Philosophy

The following statements should be included in the description of 'Long Term Care Philosophy':

- the encouragement of resident's self management
- the encouragement of resident's self esteem
- the right of residents to choose whether or not to receive care/treatment
- emphasis on care rather than cure
- care of the 'total' resident rather than a single disease ('total' meaning physical, psychological and social needs)
- the management of multiple problems
- rehabilitation

(continued)

	1	2	3	4	5
	Means				
	Means of Whole Group (N=31)	Standard Deviation (N=31)	Nurses (N=10)	Administrators (N=10)	Physicians (N=11)
(N=29)	2.17	0.80	2.20	2.22	2.10
(N=24)	1.28	0.45	1.00	1.44	1.40
(N=13)	2.46	0.88	2.75	2.33	2.33
(N= 6)	2.67	-	2.00	3.00	3.00
(N=24)	2.67	1.71	2.75	2.83	2.50
(N=24)	1.58	0.58	1.63	1.67	1.50
(N=24)	1.92	0.83	1.75	2.29	1.89
(N=29)	1.31	0.60	1.20	1.44	1.30
(N=30)	1.03	0.18	1.00	1.11	1.00
(N=29)	1.59	0.63	1.50	1.78	1.50
(N=29)	1.41	0.87	1.10	1.56	1.50
(N=30)	1.17	0.75	1.00	1.10	1.40
(N=30)	1.43	0.63	1.55	1.67	1.10
(N=30)	2.13	0.97	2.00	2.20	2.20

D. Long Term Care Philosophy (continued)

The following statements should be included in the description of a 'Long Term Care Philosophy':

- coping with changing roles
- coping with progressive disability (physical and social)
- a 'people-oriented' rather than a 'task-oriented' approach to care
- the acceptance of death and dying
- understanding the needs of the dying
- an appreciation that time and pace are different
- a home-like environment
- the suitable geographic location and layout of facilities
- responsibility for staff development and the quality of the working environment
- the stressing of the 'wellness' of the person
- the encouragement of each resident to reach 'full potential'
- a safe, secure and noise-controlled environment
- 'Being prepared to make do with what you have'
- the involvement of residents in decision making concerning care and programs
- the participation of the relatives in residents' care

	1	2	3	4	5	
	Means of Whole Group (N=31)	Standard Deviation (N=31)	Means			
			Nurses (N=10)	Administrators (N=10)	Physicians (N=11)	
(N=28)	2.04	0.64	1.80	2.11	2.22	*
(N=29)	1.69	0.60	1.50	1.89	1.70	*
(N=29)	1.29	0.45	1.10	1.33	1.40	*
(N=29)	1.34	0.67	1.10	1.89	1.10	*
(N=29)	1.17	0.38	1.20	1.22	1.10	*
(N=29)	1.66	0.67	1.30	1.89	1.80	*
(N=30)	1.43	0.77	1.30	1.40	1.60	*
(N=28)	1.71	0.94	1.80	1.38	1.90	**
(N=24)	2.13	0.90	2.14	2.43	1.90	
(N=23)	2.17	0.98	2.00	2.00	2.40	
(N=23)	1.48	0.67	1.43	1.33	1.60	*
(N=23)	2.22	0.74	2.57	2.00	2.10	
(N=22)	2.45	1.06	3.83	2.43	2.30	
(N=23)	1.78	0.52	1.43	1.83	2.00	*
(N=23)	1.74	0.54	1.71	1.83	1.70	*