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The Nursing Home Industry

ABSTRACT

Nursing home regulation in most U.S. states is oriented more to compliance than to deterrent strategies. Voluntary compliance is surprisingly high. The major problem is not resistance to state commands but what Merton called ritualism—going along with institutionalized means for achieving regulatory goals while not attaining the goals themselves. The nature of state regulation has driven the American industry away from informal, intimate caring toward institutionalized care in larger nursing homes and toward the ascendancy of large corporate chains. These trends lead to the extraordinary disciplinary quality of U.S. nursing homes. Practices are regimented and documented from above—the federal government disciplines the states, state supervisors discipline inspectors, inspectors discipline nursing home operators, operators discipline nursing home staff, and staff discipline residents. Achieving quality of life and quality of care for residents requires substantial abandonment of this hierarchy of discipline in favor of local debate about outcomes in which residents and their advocates are empowered.

This essay is based on data from an international comparative study of nursing home regulation in the United States, England, Japan, and Australia. At the time of writing, only the U.S. fieldwork is complete and analyzed. Hence, the situation in the United States is dealt with

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systematically, though frequent comparisons are made to the situations in other nations.

In investigating regulation of the nursing home industry in the United States, my colleagues and I in Australia first worked to understand the enforcement and regulatory system, which is largely a state government responsibility. Then we pursued greater depth of understanding in one locale—the city of Chicago. To accomplish a general understanding of the system, we sought to interview the key regulatory players in half the states and to observe at least one nursing home inspection in each state. Only one state government, Pennsylvania, refused to cooperate with the study. A letter of introduction from the Australian minister for aged care was effective in securing cooperation from the others.

In all twenty-four states where cooperation was secured, we observed at least one nursing home inspection, totaling forty-four inspections overall. Unstructured interviews were conducted at all levels of the state regulatory agency or agencies—inspectors, middle management, and senior management. In all states, at least some of the specialist staff were also interviewed—complaints officers, ombudsmen, lawyers, or criminal investigators. In addition to observing meetings of inspectors at the nursing homes, we sat in on some tactics meetings with more senior staff in head offices and some meetings that decide or review the imposition of penalties on nursing homes. In most states, we interviewed representatives of industry associations and consumer organizations. At the national level, we met with the influential industry, professional, and consumer groups in Washington and with the Health Care Financing Administration (HCFA) in Baltimore. Most of the key regulatory players nationally and in the twenty-four states were included among more than three hundred people whom we interviewed for the study. I conducted most of the U.S. fieldwork, the remainder being undertaken by my colleagues Valerie Braithwaite, David Ermann, and Diane Gibson, whose assistance I gratefully acknowledge. Fieldwork was conducted during six visits to the United States, which totaled fifteen months between 1987 and 1991.

The states were selected purposively rather than randomly. First, the twenty states with the largest numbers of nursing home beds were selected. These accounted for three-quarters of the nursing home beds in the country. Second, five smaller states were selected because these were states where we were advised that distinctive regulatory strategies were being adopted. For example, Rhode Island was selected because

it had the most frequent nursing home inspections (state law mandates at least six inspections per year). The states visited were California, Washington, Arizona, Colorado, Oklahoma, Missouri, Indiana, Illinois, Wisconsin, Michigan, Ohio, Massachusetts, Rhode Island, Connecticut, New York, New Jersey, Maryland, Virginia, North Carolina, Florida, Texas, Tennessee, Georgia, and Louisiana.

In Chicago, it was possible to range more widely in choosing what kinds of actors to interview (e.g., to interview private attorneys who represent nursing homes, to observe ombudsmen and inspectors from other agencies doing their job) and more systematically to observe the regulatory process. All but one of the twenty-two state nursing home inspectors working in the city of Chicago (in 1988) were observed doing their job, most of them many times during the eighteen inspections that were observed. These were all the inspections that occurred in the city during a three-week period in 1988, a one-week period in 1989, and a one-week period in 1990.[1] Because we returned to Chicago for each of our six fieldwork visits, we were able to interview the same actors many times during the five years of fieldwork. In Chicago, we also spent a lot of time observing self-regulatory processes in nursing homes—staff meetings where regulatory issues were discussed, care planning conferences, and meetings of quality assurance committees.

Here is how this essay is organized. Section I describes the nature of law violations in the nursing home industry. How the industry came to acquire its present structure and the regulatory framework is discussed in Sections II and III. Sections IV and V, respectively, examine governmental and self-regulatory strategies used to secure compliance. Section VI gives an account of the structure and culture of nursing homes that sees them as profoundly shaped by regulatory structure and culture.

I. The Nature of Law Violations in the Nursing Home Industry

The focus in this section is on violations of regulatory standards by nursing homes—including building and fire safety standards, but mostly quality-of-care standards. Financial fraud is also a major prob-

[1] This meant they were not inspections that were especially selected for us, which was the case with some of the inspections we attended in the other states. But even with our visits to most states, there was little choice involved, as we generally attended whatever inspection happened to be on at the time within reasonable proximity to where we were doing our interviews.

lem in the nursing home industry. The Medicaid program is an easy target for unscrupulous nursing home operators, many of whom get most of their income from these programs (Vladeck 1980, pp. 174–91). Claims are frequently made for the care of residents who have been discharged permanently or temporarily to the care of relatives. Claims are made in higher categories of dependency than apply to the resident concerned. Claims are made for ghost staff. Since our fieldwork involved quality-of-care rather than financial inspectors, fraud is not a major focus in this essay. It is worth pointing out, however, that some of the homes we saw that were infamous for poor quality care were also infamous for welfare fraud. One reason for this is that similar types of rationalizations or techniques of neutralization are used to justify both types of offending. As the deputy director of one state department of social services put it, "They say 'The reason we can't meet the standards is that you're not giving us enough money.'" Because of the professional acceptability of fraud that is seen as necessary to "stand by [their] patients," many in the industry were surprisingly open about admitting it. Even the head of one state nursing home regulatory agency said, "When I worked in the industry I tried to keep reimbursement up by keeping records of people being on services they didn't need."

Some nursing homes owned by organized crime are regarded by regulators as less than exemplary on both quality of care and fraud. This, however, could be a stereotypical reaction fostered by disconcerting practices such as putting a gun on the table for the duration of the regulatory negotiation at an exit conference.

Nursing homes also sometimes conspire with residents to conceal assets so that they satisfy the eligibility threshold for Medicaid benefits. Fraud against Medicaid by residents and their families shuffling assets is pandemic in the United States. The temptation is huge because even well-to-do middle class people are sure to be rendered indigent by an extended period of nursing home care. In this sense, the United States does not have a social security system; it has a social insecurity system. For anyone concerned that infirmity or accident will cause a need for long-term care (as opposed to acute care, which is covered by Medicare), there are only two paths to social security in the United States: being wealthy or being dishonest.[2] As the nation ages, this simple

[2] If you are very wealthy, you can afford to pay thousands of dollars for every month you spend in a nursing home. If you are moderately wealthy, you can afford expensive long-term care insurance to cover you against such a catastrophe.

structural reality of public policy is making the United States more and more a nation of crooks. In nations like Australia that have universal nursing home benefit systems, this type of fraud does not exist at all.

There is also fraud connected with quality-of-care regulation. We observed the detection of falsification of medical and other records at many nursing homes. In one case, for example, the falsification of minutes of an "infection control committee" (required by law) was detected by reference in the minutes to a man who had died a year before the meeting supposedly took place. This type of fraud is never, in our experience, punished under the criminal law of fraud. In the case just described, the nursing home was cited for failing to convene a meeting of the infection control committee, and no action was taken against the nurse manager who committed the fraud. One experienced criminal investigator with a state regulatory agency saw the connection between criminal neglect of residents and fraud as an iron law: "If it's a neglect case that rises to the standard of criminality under American law that crosses that line, you will find falsified records."

Besides fraud, the other problem that is clearly worse in the United States than in Australia (and other countries as well, we suspect) is abuse. We cannot prove this with systematic, comparable statistics on abuse, nor can we report that we have directly observed much violence against residents during our American fieldwork (apart from many shocking cases of physical and chemical restraint). Even so, we believe that there is a sharp contrast to report here.

The basis for our claim of a huge difference between Australia and the United States is our interviews with inspectors and complaints coordinators. Ask the complaints coordinator in an Australian state to tell you the worst abuse case they have known in the past year and most tell a story of a nasty shoving or bruising incident. To the follow-up question: "Haven't you had a worse case than that? What about someone punching or slapping a resident?" some answer "No we haven't had a complaint like that since I started in the job." Ask the same question of people in a comparable position in the United States, and they often tell a story of the murder of a nursing home resident by a staff member. In one state, the story was even of the murder of five residents by two staff members in a single nursing home. Moreover, the details of the American stories are comparatively horrific. They will tell of a male resident having his penis severed with a razor blade (a story that actually recurred in two different times and places).

They will tell a story of rape of an elderly woman or of stuffing a washcloth with feces on it in the mouth of a ninety-year-old woman on two separate occasions.[3] In the United States there seems to be more of a problem of pathological individuals moving from job to job in the nursing home industry so they can prey on vulnerable people. Ask the complaints coordinator of an American state nursing home regulatory agency how many confirmed abusers she knows of, and in a number of states the answer is that she has a list of more than fifty people, or even over a hundred, who are on her blacklist of abusers. Most or all of these will have been referred for criminal investigation to a local or state prosecution office. Most Australian counterparts have no cases that have been referred for criminal investigation and only a few cases "that I have concerns about" where informal warnings have been given to nursing homes contemplating employment of these people. Partly, we think that this difference is because Australian authorities are much less vigilant and systematic in their attention to the problem of nursing home abuse than they should be. Equally, we think it is because the problem of abuse is much less in Australia than in the United States. In the United States, 197 individuals were convicted criminally in 1989 for abuse of nursing home residents; there have been no such criminal cases in Australia during the five years of our study.

Physical restraint of residents is a form of abuse that can be shown statistically to be much worse in the United States than in other nations. Judging by the number of residents we observed with symptoms of long-term psychotropic drug use (e.g., repeated blinking or facial movements and protruding tongue), we suspect the same is true of chemical restraint, but there is no credible, systematic way of confirming that this impression is correct because of the lack of credible surveys in Australia.[4] Only in the last few years has widespread use of restraint ceased being a professionally and legally sanctioned way to deal with management problems in American nursing homes. In 1988, 41 percent of nursing home residents were subject to daily physical restraint—mostly tie restraints around the lap.[5] Unknown numbers of

[3] The latter case was the subject of a criminal conviction in Jefferson County Court, New York, on October 28, 1987. See the National Association of Attorneys General (1987), p. 23.

[4] Also see n. 15 below.

[5] Figures are supplied by the Health Care Financing Administration from annual surveys (see also United States Senate, Special Committee on Aging 1990, p. III: "an estimated 50 percent of all nursing home residents are restrained in some form").

further residents were subject to chemical restraint and lesser forms of physical restraint such as the routine use of bedrails to restrict freedom of movement at night. In Australia, too, there is excessive use of restraint, but in no Australian nursing home have we seen a level of physical restraint approaching the average level for U.S. nursing homes (and we have visited one-third of the 1,400 nursing homes in Australia during the course of our study).

The contrast with Britain is even more striking. In the fifty homes we visited during our English fieldwork, we did not notice a single tie restraint. An English inspector who has twenty or thirty nursing homes on her beat can often name the one or two residents who are physically restrained in her nursing homes, so rare is physical restraint. Caring for the frail elderly is no simple challenge; fragility and proneness to broken bones cannot be dismissed. But the evidence of British restraint practices and the growing number of restraint-free homes in the United States are powerful testimony that for every problem there is almost always a better way to solve it than tying people down.

The foregoing comments should not be interpreted as an attempt to show that in all ways American nursing homes are worse places than nursing homes in other countries. American nursing homes have higher fire safety standards than Australian nursing homes, better food and nutrition standards than English nursing homes, better trained administrators, better care planning, and more varied activities programs than in both these other nations. Nor should my comments later on the deficiencies of the U.S. regulatory process be read to mean that the U.S. process is necessarily inferior: in some important respects it is superior to those in England and Australia. My purpose here, however, is not to give a balanced international comparison of nursing home standards, it is to identify law-breaking and regulatory problems that are particularly acute in U.S. nursing homes.

In all countries, including the United States, the most serious problems of law-breaking in nursing homes are neither fraud nor abuse, but neglect. The suffering of residents left in their own feces, sometimes with massive bedsores, sometimes with bodies infested with maggots, is suffering hard to imagine for those who have not seen it, hard to forget for those who have. The nonphysical suffering of bedfast or chairfast residents who spend years in one spot without adequate mental or physical stimulation is also terrible and is getting worse as lives are further extended in a medicalized care system. That it is against the law for residents to be denied the opportunity for the stimu-

lation, activities, and conversation they need to be human does not change the reality of widespread denial of such opportunities.

Those of us lucky enough to live into our eighties will likely have a direct personal interest in ensuring that these regulatory challenges are met. By the end of this essay, I hope to cast some light on how this might be achieved. First, however, I set the scene by briefly telling the story of how the nursing home industry came to be the way it is.

II. The Structure of the Industry

The nursing home industry is a twentieth-century phenomenon. The predominantly private nursing home industry that we see in the United States today is a late twentieth-century phenomenon. The industry is a product of increased life expectancy. However, it is also a result of increasing geographical mobility, the changing nature of the extended family, and changing patterns of care. In the nineteenth century, the aged infirm were cared for at home, though poor laws introduced throughout the Western world saw expanded opportunities for institutional care for the indigent aged without family. Nineteenth-century poorhouses accommodated the aged infirm together with a motley collection of younger persons requiring institutional support, a situation that continued through the 1930s. The expansion of mental hospitals also increasingly picked up the aged infirm. By 1930, there were more people over sixty-five in mental hospitals than in almshouses and private nursing homes combined (Vladeck 1980, p. 35).

The first half of the twentieth century saw considerable growth in specialist charitable (mainly church) and governmental institutions for the aged. These dominated the nursing home scene until after World War II, when a rapid proliferation of private nursing homes occurred. The turning point was the Johnson administration's introduction of Medicare and Medicaid in 1965, which provided government benefits for those who needed nursing home care and could not afford it. In 1954, there were fewer than 250,000 nursing home beds in the United States, but around 1970 it passed the one million mark (Vladeck 1980, p. 103). For elderly people who do not require continuous nursing care, there has also been an expanding continuum of care—from home nursing to retirement villages to board and care homes that approach the level of care in nursing homes.

Medicaid is not the only way in which the state shaped the structure of the industry. Other essays in this volume have many interesting things to say about the way the structure of an industry shapes the

nature of law enforcement and law violation within it. The more interesting phenomenon with the nursing home industry is the way that law enforcement has shaped the structure of the industry. Today in the United States, the conventional economic wisdom of the industry is that a nursing home with fewer than eighty beds is of suboptimal size; the result is that most nursing home residents live in institutions of more than one hundred beds. In Australia, the median number of beds for nongovernment nursing homes is thirty-eight; in England and many European countries, smaller still. The reason a thirty-bed nursing home is economically viable in Australia but not in the United States is to be found in the nature of the regulatory system.

The structure of the industry in the United States once was rather more like that in Australia or England. In upstate New York, for example, the average number of beds in private nursing homes in 1949 was fourteen, increasing to twenty-four by 1958 and thirty-four by 1964 (Thomas 1969, p. 157). Data supplied to us by the Rhode Island Department of Human Services shows how this trend continued—with the average size of nursing homes increasing from thirty-two beds in 1972 to seventy-three by 1978. We get a clue to how this happened by noticing that the number of nursing homes in Rhode Island dropped during the same period from 180 to 110. Continuing a trend that started earlier, how much earlier varying from state to state, a combination of tougher regulatory standards and economies of scale began to close down the smallest nursing homes. Fire safety standards were preeminently important here. The trend started in 1971 in Rhode Island when eighteen homes that failed to meet the "life safety code" were closed. The "mom-and-pop" nursing home run by a family in a large converted house that had been the backbone of the industry during the 1950s rarely survived the 1970s. Larger purpose-built homes were the way to meet tougher fire safety standards. This development was not without paradox. More than anything, what fire safety standards do is ensure design principles that will contain fires within limited sections of large buildings. This way, say, only twenty beds will be exposed to fire instead of the 140 beds in an entire facility—an ironic accomplishment since a major effect of modern fire safety standards has been the abandonment of stand-alone twenty-bed facilities.

While fire safety standards were the most important regulatory factor in rendering the "mom-and-pop" nursing home uneconomic, they were not the only one. The United States has higher regulatory standards than other countries requiring access of nursing home residents

to specialist professionals such as social workers, physical therapists, consultant pharmacists, and dieticians. Small nursing homes are not required to have a full-time dietician, but they must at least have a part-time dietary consultant working with the cook.[6] Specialist overheads such as these are more easily borne by nursing homes with a large income base than by smaller homes that pay the same overhead from a smaller income. Australian nursing homes, because they are not required to have these specialist overheads, can be cost-efficient with fewer beds than in the United States. American law imposes much more detailed documentation requirements for residents than does Australian law: again there are economies of scale in setting up the information systems required by the regulators.

Regulation is even more directly implicated in the smaller average size of nursing homes in England. Most English health authorities believe that smaller nursing homes provide better quality care than do larger, more institutional facilities. Consequently, they are extremely reluctant to issue a licence to any facility that approaches the size of the average American nursing home. They almost certainly have no legal authority to refuse licences to larger nursing homes, but they do it anyhow.

American regulation created conditions in which approved beds (for which the state had issued a certificate of need) were available for sale by the "mom-and-pop" nursing home to large corporate owners that built chains of nursing homes with standard designs of economically optimal size. By the mid-1980s there were some fifteen thousand nursing homes in the United States, a thousand of them owned by the largest chain, Beverly Enterprises.

But as the chains were built on the ashes of an old industry razed by a new regulatory order, so some of the chains have been threatened by a second wave of regulatory change that has been under way for the past five years. This is particularly true of the largest, Beverly Enterprises. Nursing homes owned by some of the largest chains became dispiriting places—regimented, standardized, institutionalized, relying heavily on restraint to maintain order, and devoid of a warm, homelike atmosphere. They were often excellent at getting the standardized inputs mandated in the law right—the fire rating of building materials, the minimum number of grams of protein required in the diet for each resident each day, and the charts recording the time each

[6] According to Vladeck (1980, p. 154), "Consultants receive exorbitant fees at public expense, essentially for filling out forms."

resident was toileted. Even on these standardized inputs, which are the forte of the chains, however, problems emerged as the chains got bigger and management control became increasingly remote from actual care giving. The largest chains had such a large span of control as to make flexible response to ever-changing care needs difficult. The chains drew on the same labor force as the fast food chains to deliver the hands-on care (often paying even less to nurses aides than McDonalds did to counter workers). But the nursing home chains found that it is easier for massive organizations to sustain high quality with hamburgers than with people who have radically different and constantly changing care needs.

The advocacy groups and regulators increasingly reached the conclusion that the chains—particularly Beverly Enterprises, which came to symbolize the new corporate care in the eyes of the critics—delivered cold and unresponsive care. Beverly was vilified by consumer groups, subjected to major law-enforcement actions in a number of states, had many of its homes closed as a result of these actions, and in some states was forbidden from operating altogether. As a result of this regulatory and consumer onslaught, Beverly suffered substantial losses in 1987, 1988, and 1989. It sold off many of its nursing homes, reduced its work force to 92,000, rethought a decentralized management system for the smaller organization, increased investment in quality assurance, and returned a modest profit in 1990.

Like the nuclear and pharmaceutical industries, regulation is so important in the nursing home industry that it has shaped the fundamental structure of the industry.

III. The Regulatory Framework

Health-care programming in the United States, including regulation, was dominated by state governments until Medicaid and Medicare emerged as federal programs in 1965. Medicaid and Medicare shifted the center of decision making about funding and standard setting to the federal government, but responsibility for program delivery and regulatory implementation remained with the states. Today, the U.S. Congress enacts the most important nursing home regulatory laws and these are fleshed out into regulations by the HCFA. The standards cover health-care quality, activities, resident rights to privacy, information, personal possessions and control of patients' financial affairs, dietary standards, pharmaceutical services, physical environment, infection control, and disaster preparedness, among other issues of vital

concern to the quality of life of institutionalized people. These standards are then monitored and enforced primarily by state governments. The HCFA runs "look-behind" inspections to check that the state governments are doing their jobs and takes its own enforcement actions on problems it discovers.

In addition to enforcing federal laws that are conditions of participation in Medicaid and Medicare, state governments have their own additional standards that are conditions of state licensure. The latter are the only standards that apply to facilities that choose not to participate in Medicare and Medicaid (i.e., nursing homes catering exclusively for better-off private pay residents). State surveyors (inspectors) have the awesome task of assessing compliance with some five hundred federal standards, plus in some cases hundreds of additional state regulations. Some cities and counties also have nursing home inspectors, as does the federal Veterans Administration. During our fieldwork there were many occasions when, on entering a nursing home with one agency, we encountered an inspector from another government agency in the facility.

For all this, the main game is the work of the state Medicaid and licensure surveyors, and it is on their work that I concentrate, contrasting them with other government inspectorates where appropriate. Federal law requires annual surveys for nursing homes participating in Medicaid. Some state laws require more frequent visitation. Unlike the situation in many regulatory settings in which an inspection policy of annual visits is rarely achieved, in practice the annual visitation cycle in the United States is virtually universally achieved. This is a consequence of the regulation of the state regulators by the HCFA, which cuts off funds for nursing homes that are not certified in time, with the state government in effect then having to find those funds.

Not only is the consistent frequency of inspection much more impressive than in other areas of regulation, the intensity of the scrutiny is far more fine-grained than for occupational health and safety, environmental, food, or pharmaceuticals inspectors in any country we know. Typically, a team of at least three and often five or six inspectors will spend three days or more at a facility. A 1990 HCFA survey found that the average inspector-hours on site was 156, but to this must be added time paid for by the state to survey additional state requirements. Where there have been serious problems in large facilities, we are aware of cases where as many as ten inspectors have been camped in the nursing home for two weeks.

The inspection (or survey as the federal government calls it) begins with an initial tour of the facility and then selection of a sample of residents who are interviewed and whose charts are audited for evidence of compliance with the standards. Most surveyor time is spent on the checking of charts. But in addition, there is a physical inspection of the building, observation of treatments, calculation of an error rate for the administration of medications, observation of the cooking, distribution and eating of meals, interviewing of staff, checking nursing home policies, and a meeting with the residents' council. At the conclusion of the survey, an exit conference is held at which nursing home management, and often a representative of the residents' council, are informed of the results of the survey. Some preliminary discussion of what sort of plan of correction will be required may occur at the exit conference.

In all states, over 90 percent of failures to meet standards are dealt with by lodging a satisfactory plan of correction without any law-enforcement action being taken. Formal enforcement action occurs only where there is a very serious initial offense or where there is repeated failure to correct a violation. In the situation of a serious initial offense, administrative penalties have become an increasingly popular sanction. For example, an error rate for the administration of medications over 5 percent in some states results in an immediate administrative penalty of some hundreds of dollars. Most states have had administrative penalties available as a sanction for some years, and recent amendments to federal law have given all state regulators access to them. In 1989, almost all states actually imposed administrative penalties on fewer than a hundred occasions, though California imposed 1,800 and Texas 1,700 administrative penalties (Gardiner and Malec 1989, pp. 7–8). Some of the states that make heavy use of administrative penalties—such as California and Wisconsin—did not use the next most popular sanction, suspending new admissions (Gardiner and Malec 1989, pp. 8–9). Almost all states have this sanction available in their law, and most of them use it. It is a sanction that is generally more damaging to nursing homes than relatively low administrative penalties. In addition to the greater financial cost of reduced income, there is the adverse publicity from having to advise residents that they cannot be admitted to empty beds in the facility because of an enforcement action. New Jersey used this sanction on more than 130 occasions in 1989, Texas on 218 occasions (Gardiner and Malec 1989, pp. 8–9). Most states have had for some years the capacity to

appoint a receiver to run a noncompliant nursing home or designate a monitor paid for by the nursing home to report back to the regulators on progress. Few states that use these remedies do so more than once or twice a year, with the notable exceptions of comparatively frequent use of monitors in Illinois and Indiana.

The ultimate sanction in all states is license revocation—corporate capital punishment. In most years in most states it is never used for fear of what will become of residents after a home is closed. Only thirteen states used the sanction in 1989 (with three states also suspending licenses rather than revoking them). Georgia revoked ten licenses, with Kansas, New Jersey, and Illinois each revoking eight (Gardiner and Malec 1989, pp. 11–12). For most nursing homes, Medicaid decertification is as clearly a death sentence as license revocation since most nursing homes cannot survive without the majority of their residents being supported by Medicaid. There were twenty-five Medicaid decertifications in Massachusetts in 1989, thirty-seven in Texas, and fourteen in Oregon. Overall, fifty-three nursing homes in the United States had their licenses revoked in 1989, but 130 were decertified for receiving Medicaid benefits (Gardiner and Malec 1989, p. 15). It is extremely rare in all states for criminal penalties to be imposed on nursing home organizations for breaches of quality-of-care standards, and in most states organizational criminal penalties are never used. Celebrated homicide prosecutions for neglect of residents in nursing homes have failed in the courts (Schudson, Onellion, and Hochstedler 1984; Pray 1986; Long 1987). Almost all states, however, refer charges against individuals who abuse residents for criminal investigation by state prosecutors.

Some states initiate large numbers of enforcement actions that they never formally implement because they reach settlement agreements with the nursing home. States that do this routinely, such as Massachusetts at the time of our fieldwork in 1988, appear on paper to have a worse enforcement record than in fact they have. Consent agreements sometimes contain onerous provisions, such as California's 1986 agreement that Beverly Enterprises pay a fine of $800,000 and set up a substantial quality control program.

An extensive critical literature exists attacking the weakness of American nursing home enforcement (Brown 1975; Butler 1979; Blum and Wadleigh 1983; Johnson 1985; Institute of Medicine 1986; General Accounting Office 1987; Long 1987). Yet the United States has tougher nursing home enforcement than any country we know; stronger than in

Australia, and much stronger than in England or Japan. The literature attacking regulators for enforcement weakness may be one of the factors that has caused American regulation to get tougher and that continues to keep the pressure on regulators to persist with toughness. Yet armchair scholarly commentators read these critical literatures as evidence that enforcement is weak. The truth of the matter is that it is precisely in regulatory domains that lack such critical literatures (e.g., nursing home regulation in the United States during the twenty years after World War II or nursing home regulation in Japan) that we are most likely to find weak enforcement. Armchair commentators on an industry who seek truth in the weight of popular critiques, rather than through systematic empirical comparison, may obscure the truth. Yet at the same time they may play a significant role in reinforcing social constructions of an industry that lead to change. The social construction, "American nursing home enforcement is weak," is shown to have a rather limited truth claim when one asks, "Weaker than what?" It turns out that it is tougher than at any other point in American history, tougher than nursing home regulation in the rest of the world, and much tougher than most other domains of business regulation in America. Yet scholarly acceptance of the social construction reinforces it, even legitimates it to the point where opinion leaders in the community, some regulators themselves, and many legislators come to accept this social construction as fact. When this happens, the widespread perception of regulatory weakness will cause a response that is likely to deliver tougher regulation.

Unfortunately then, criminological constructions of enforcement weakness that are not grounded in fieldwork with the industry risk subscribing to the received wisdom of popular critique in a way that conceals more truth than it reveals. Indeed the scholarly construction may be subservient to a transformative political campaign that causes the scholarly construction to become just the opposite of the truth. In the worst (yet perhaps common) case, criminologists read the popular critiques of enforcement failure as the raw data for their own construction of the world *after* those critiques have already done their work in changing the world (see fig. 1).

In the most implausible of political contexts, such as the period of the deregulation-oriented Reagan administration, one can find evidence of popular critiques of regulatory failure effecting change. The scholarly construction of the Reagan era as a period of deregulation is also false. It was certainly a period of deregulatory rhetoric by the govern-

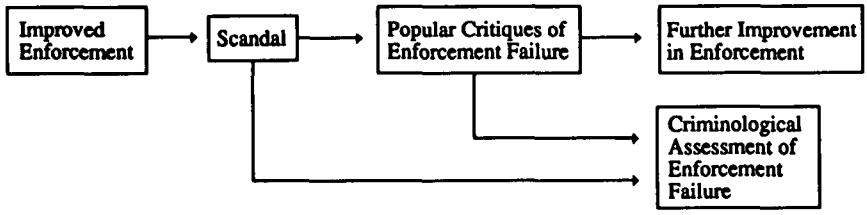

FIG. 1.—Lagged criminological assessments

ing administration, combined with denunciation of the seeming fact of deregulation by critics of the administration. In practice, it was a period of regulatory flux during which substantial shifts in both deregulatory and proregulatory directions occurred (Ayres and Braithwaite 1992, pp. 7–12). One reason why this turned out not to be an era of deregulation is that the denunciation of the social construction of the "era of deregulation" produced a lot of regulatory growth.

That this occurred with the backlash against the first Reagan administration's environmental policies is now fairly widely accepted. Nursing home regulation is a less well-known case study. When Reagan first came to power, there was a failed attempt to replace government inspection of nursing homes with a self-regulatory scheme administered by the Joint Commission on the Accreditation of Hospitals (Jost 1983, 1988). When political opposition foiled this reform, there were substantial cuts to federally funded health facility inspection personnel (mostly nursing home inspectors) from 2,400 to 1,800 in 1982. In this latter sense, there was a factual basis initially in conceiving of this as a period of deregulation. However, the reaction against it was sustained and effective by consumer groups, by the courts and members of Congress who supported consumer groups, and by supporters of strong regulation within the health care professions and state and federal bureaucracies.[7] While the turnaround in nursing home regulation by the end of the Reagan administration was not as visible as enforcement growth on Wall Street, where handcuffs were being slapped on the rich and famous, it was perhaps more fundamental in its implications for regulatory strategy. In terms of regulatory resources, the bottom

[7] In the courts, the most important case was *Smith v. Heckler*, 747 F.2d 583 (10th Cir. 1984), while the preeminently important legislative extension to nursing home regulation was the Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100–203, paras. 4203–13. An authoritative document by the Institute of Medicine (1986) was the most important watershed where regulatory bureaucrats, consumer advocates, and, most important, health care professionals came together to urge stronger regulations and tougher enforcement.

line of the Reagan administration was a period of unparalleled regulatory growth. The cut of federally funded health facility inspectors from 2,400 to 1,800 in 1982 was more than erased by the end of the Reagan administration, by which time there were over 4,000. There was substantial further growth under President Bush, with a 40 percent increase in inspection resources promised in the early nineties to implement reforms passed in the 1987 Omnibus Budget Reconciliation Act (OBRA). More fundamentally, during the Reagan era, the federal policy of support for a "consultative" approach to nursing home regulation was sharply reversed and replaced with a law enforcement policy.

The next section, however, shows that policy and practice are not exactly the same thing. While inspection practice has shifted from consultation toward enforcement, consultation remains a major part of the practical reality of regulation.

IV. Regulatory Strategies

Day and Klein (1987) conducted an exploratory study of nursing home regulation in New York, Virginia, and their own country, England. They concluded that, in terms of Reiss's (1984) dichotomy, New York was a case of deterrence regulation, England and Virginia of compliance regulation. Our own fieldwork generally confirms their conclusions, though we would want to advance even more strongly the qualifications they concede to the categorization of New York state as a deterrence regulator. Day and Klein (1987, p. 333) found New York program administrators to be strongly animated by the desire to prevent field staff from playing a consultancy role: "We have continuously to remind them that they shouldn't be consultants." We found this, too. But in New York and in other states that rejected the consultancy philosophy (most states were more like New York than Virginia in this regard), we found a great deal of consultancy going on in defiance of official policy.

These agencies are "street-level bureaucracies" (Lipsky 1980) where the real work is done by surveyors out in nursing homes remote from their supervisors. As noted earlier, in all states over 90 percent of detected violations are dealt with by means other than formal enforcement action (in some states over 99 percent). It is simply not an option to launch enforcement actions for a majority of detected violations. Comparatively well resourced as American nursing home inspectorates are (compared to, say, the Occupational Safety and Health Administration or foreign nursing home inspectorates), there are not, and never

can be, sufficient resources to impose deterrent sanctions against a majority of infractions. So when New York is described as a deterrence regulator, something of comparative force has been said, but we are still describing a regulatory agency that gets most of its compliance by means other than deterrence.[8] Moreover, even in New York, inspectors see cooperative compliance strategies as a good way of working the cross-cutting allegiances within regulated organizations to get staff to volunteer information that might later be used in a formal enforcement action. A New York inspector commented, "How do you get staff to give you incriminating evidence? You don't get it by going in as a poker-faced regulator."[9]

The street-level bureaucrats, even in New York, tend to regard it as their job to get compliance even though deterrence will not be an option for more than 90 percent of the violations they detect. In a sense, this overstates the problem, however. Voluntary compliance, even in the comparatively adversarial, litigious New York described by Day and Klein (1987), is high. Without exception, in the forty-five jurisdictions in four countries where we did fieldwork, overwhelmingly, the most common industry response to a detected violation was to accept it and agree on a plan of correction without any threats being issued. Making threats about enforcement action is almost as rare as enforcement action itself. At the same time, making threats is hardly necessary in jurisdictions like New York that do have a demonstrated capacity to take tough enforcement action. The record speaks for itself: if the nursing home "plays the game" (an expression that recurred cross-nationally during our fieldwork) and agrees to fix the problem, the regulator is most unlikely to take enforcement action, even if the initial problem is quite serious; if the nursing home refuses to play the voluntary compliance game, it will not shake the regulator off its back so easily, and if it persists with resistance on a matter of some seriousness, enforcement action becomes likely.

[8] Even when voluntary compliance breaks down and the state of New York proceeds with a formal enforcement action, most of these are resolved at a settlement conference before the proposed penalty even goes to an administrative hearing, let alone the courts. New York is a comparatively litigious jurisdiction, but even in New York, going to court is a rare event. A number of informants also argued that there is a big difference between New York City and Upstate: "It's not for the most part a problem in getting compliance Upstate, even without regulations to cover it. They will take notice if we suggest something. But it's a different story in New York City" (Upstate New York supervisor).

[9] Australian inspectors proffer the same advice: "I try to call them [the staff] by name always to encourage familiarity. Then by the second day it's all 'Hello Mary,' and they are at ease with me and will start to tell me things about the place."

In jurisdictions that, unlike New York, lack a credible will to enforcement (e.g., Louisiana, most English health authorities) the process is still very similar in this fundamental way: most of the action is voluntary compliance without threat. Whereas in New York resistance triggers a regulatory attention cycle that may well lead to enforcement, in Louisiana or England resistance triggers a regulatory attention cycle that gives the *appearance* that it may well lead to enforcement, without the fact of enforcement. Hawkins (1984) calls the latter process "bargain and bluff." But note that "bargain and bluff" is not the standard approach of toothless nursing home regulators; the standard approach is to eschew all suggestion of threat; "bargain and bluff" only comes into play in the unusual cases where there is resistance.

Yet, in a way it is wrong to say that 90 percent of the time compliance is achieved without an invocation of deterrent threats; in these cases deterrence is either implicit and real (New York) or implicit and imaginary—based on bluff (England).[10] This is not to say that at the moment of voluntary compliance, it is fear of implied sanctions that mostly motivates the compliance. The empirical evidence suggests that this is not the main story (e.g., see Braithwaite and Makkai 1991). The capacity for deterrence is part of what lends authority to the state when it requests compliance with the law (or the doing of things that will make life better for nursing home residents even if that is not strictly required by the law). Or perhaps Durkheim (1961, p. 10) was closer to the truth on this question: "Punishment does not give discipline its authority, but it prevents discipline from losing its authority." Nursing home compliance arises more from a desire to go along with authoritative requests to comply with the law or authoritative suggestions to act in a professionally responsible way than from any rational weighing of the costs and benefits of compliance. This is why bargain and bluff, while it sometimes fails, works better than would be predicted by a rational actor model. Voluntary compliance is underwritten by deterrence, but not in a way that often leads the nursing home operator to calculate about the actual levels and probabilities of deterrent threats. Because of this, even when these actual levels and probabilities are zero, orchestration of an appearance that they are nonzero will often be enough to do the job: "This is the government talking. And ultimately they have the authority to make their demands stick

[10] Actually, in many English health authorities, bluff is replaced by a creative use of alternatives to formal punishment—like the power of adverse comment in relevant professional circles or threatening the license of a nurse to practice her profession.

when you are acting outside the law." Needless to say, however, such state authority is a fragile accomplishment and therefore hardly a basis for sound regulatory policy.

In this respect, it is New York that has the more robust and principled policy settings. The following statement by a New York inspector could never be made by an inspector from a typical English health authority: "You can maintain the same demeanor when confronted with tension and stress, when the facility gets aggressive and unpleasant. You can be friendly if they don't correct. You just pass it on. You never have to be anything but assured and friendly. The enforcement system will take on the battle. . . . The team leader just tells them [the nursing home] what the repercussions are if you don't correct. You just let the system take over. That's all you have to do. A good team leader is confident, friendly, and explains consequences. She never uses a standover approach."

This assurance and composure in New York is underwritten by the capacity to "pass the case on" to the agency lawyers. It enables accomplished New York inspectors to project a demeanor of inevitability about compliance, an inexorability about enforcement escalation when confronted with resistance, a capacity to communicate the (slightly misleading) implication that "if you want to go off and fight with the lawyers about this, that's fine and that's your right. It won't be my problem; it will be your problem and the lawyers' problem." When inspectors have productivity targets to meet and another inspection to start tomorrow, they really don't mind handing over a recalcitrant noncomplier to the enforcement system.

The foregoing discussion might be read as suggesting that the major problem with nursing home regulation is the resister to regulatory commands. This is not so: determined resistance to regulatory commands by nursing homes is quite rare, even in comparatively adversarial and litigious New York.[11] The politics of rebellion against regulatory commands is much more common at the level of industry association resistance than at the individual nursing home level. At the nursing home level, what Merton (1968, p. 194) calls "ritualism" is the greater problem than what he calls "rebellion." Merton identifies the

[11] The following statement of a surveyor from a southern state is typical: "In most cases—95 percent—the plan of correction is acceptable. We write back to the 5 percent saying it's not an acceptable plan of correction. Mostly it's unacceptable dates—beyond ninety days. Then the vast majority come back with an acceptable plan. Much of it is sorted out on the telephone."

TABLE 1

Merton's Typology of Modes of Adaptation

Modes of Adaptation	Goals	Institutional Means
I. Conformity	+	+
II. Innovation	+	−
III. Ritualism	−	+
IV. Retreatism	−	−
V. Rebellion	±	±

SOURCE.—Merton (1968), p. 194.
NOTE.—See text for explanation of symbols.

five types of adaptation to a normative order in table 1, where + signifies "acceptance," − signifies "rejection," and ± signifies "rejection of prevailing values and substitution of new values." Here we apply Merton's model, with only a little distortion, to acceptance and rejection of regulatory goals (outcomes) and means to achieving those goals institutionalized in regulatory specifications (inputs).

Ritualism is a more effective means of resistance to regulation than rebellion because it is less confrontational and more subtle. Rather than resist the objective of reducing chemical restraint that management does not really accept, the services of a captive physician can be retained to complete medication orders required by the law whenever management requests them. It is generally regarded as imprudent in the nursing home industry to force a confrontation with the state by openly refusing to comply. Typically the legal costs of such a confrontation will exceed the expected penalties one is seeking to avoid and the costs of compliance, which are usually not high (Braithwaite et al. 1990, p. 94). Moreover, nursing home regulatory agencies in most of the jurisdictions we have studied, even in New York, have a good track record at winning their infrequent legal battles. As a result, rebellion is often motivated by reasons such as professional pride rather than rational economic calculation, as in the anger of a nursing home client reported by one American defense attorney: "I didn't do this. I want to fight it whatever it takes." Exceptions where legal resistance occasionally becomes economically rational arise in U.S. states—like Illinois and California—that provide for automatic severe consequences of repeat violations. But generally the "check's always in the mail" strategy, as some regulators refer to it, is the more effective one for those who wish to cut corners on compliance. First, all regulatory

agencies have less than perfect mechanisms for confirming that checks are actually paid or that plans of correction are implemented. Second, it is often possible to write a plan of correction that follows institutionalized means for securing regulatory goals but that in practice can be implemented in a perfunctory fashion, as the following exchange illustrates:

> *Administrator for chain:* "You can win the battle and lose the war. There's the fear of retaliation next time round. When we disagree, sometimes the best policy is to lie down and play dead. Just put in a plan of correction that will make them happy."
>
> *Interviewer:* "And then what? Do you mean you have only perfunctory compliance with the plan of correction, enough to get them off your backs?"
>
> *Administrator:* "Yes."

The nursing home can agree to write a new policy—a piece of paper that changes little in terms of how things are actually done—or it can agree to run an "in-service" program to train staff in how to avoid noncompliance in future. Such plans of correction can be hard to reject as unsatisfactory and can readily be shown to have been implemented. But organizations that opt for such ritualism are likely to become what the regulators call "roller-coaster" nursing homes—that make a few changes to come into compliance only to be found out of compliance again at the next survey because of their fundamental lack of commitment to regulatory goals. Some large American nursing home chains are like this. They respond to a finding of noncompliance in one nursing home with a plan of correction to put extra staff onto the problem. The extra staff are simply shifted from another nursing home in the chain and once the first nursing home has been certified as back in compliance the extra staff may drift back to the second home, which meantime has been out of compliance in some other area because of the staff shortage. If this violation is detected by another survey team, staff may be temporarily shifted from a third facility to plug this gap. In this way a ritualistic corporation can have roller-coaster compliance in all its facilities. Chains that claim to be "playing the game" can actually be taking the regulators for a ride.

Industry informants in both Australia and the United States were often quite open about their commitment to ritualism: "I wrote it [the plan of correction] to pacify them [the regulators]." Our favorite exam-

ple of ritualism is of an Australian director of nursing who did not want to oppose an inspection team who "made a big heap out of ethnic diet" under an Australian standard that requires sensitivity to cultural preferences for different types of food: "So we bought ethnic diet books—a ragout, goulash is a stew—give it a foreign name and they'll be happy." In many American states the virtues of ritualism are a deeply ingrained part of the received wisdom of the industry: it is repeatedly pointed out to you that the facilities with the highest levels of compliance are not the best facilities: "They are the best facilities at keeping the paperwork on the particular things required," said one Chicago nursing home administrator. Ritualism can also be a source of profound injustice. With more serious matters, the administrator will sometimes fire the director of nursing in a plan of correction as a ritualistic sacrifice because, said a Midwestern inspector, "It's his butt or hers when actually it's him who is the problem and she's doing a reasonable job."

That ritualism, rather than rebellion, is the main problem with nursing home regulation, takes us back to the claim that inspectors cannot rely on deterrence to deliver compliance most of the time. Unless they can coax and caress nursing home management into a commitment to regulatory goals, they will confront endemic roller-coaster compliance from organizations that correct some institutionalized means without tackling the underlying causes of chronic noncompliance. Effectiveness therefore crucially depends on embracing both compliance and deterrence strategies. Compliance without deterrence regulation puts inspectors at risk of having their bluff called; deterrence without compliance regulation puts inspectors at risk of accepting ritualism rather than conformity with regulatory goals. American street-level bureaucrats who are perceptive enough to realize the truth of the latter claim (actually, quite a large proportion of them) defy federal and state policies that forbid the evil practice of "consultancy." They usually do not recommend institutionalized means that the nursing home must follow to secure compliance. This really would be an evil of consultancy since commitment to regulatory goals is most likely when nursing home staff own the solutions designed to meet regulatory goals. The goal is more often to be a catalyst, to get the administrator to analyze and remedy the root causes of failure to attain regulatory goals, as is explained by one experienced New York inspector: "The feds say: 'Do not survey for root causes.' New York State has always surveyed for underlying causes [a statement that would horrify those in head office in Albany

who espouse the official line]. We talk with the administrator prior to the exit: 'Gee, there's a lot of problems here [in this area]—*X*,*Y*, and Z. What do you think about the competence of the department head?' Or, 'Why do you think these systems aren't working?' "

Sophisticated street-level bureaucrats first seek to persuade management that regulatory goals really are desirable if evidence of this management commitment is lacking. Then they will help the nursing home do their own diagnosis of the problems of their organization that must be solved if compliance is to be sustained (see Bardach and Kagan 1982, pp. 148–49; Braithwaite 1985, pp. 101–3). Unfortunately, however, the regulatory process in most American states does not readily accommodate the coaxing of compliance at these two levels. Consider the following example of a citation of a Southern nursing home:

> Each resident did not receive care necessary to prevent skin breakdown as evidenced by three decubiti that developed in the facility.
>
> *Plan of Correction Written by Nursing Home:* The medical director examined the residents in which the alleged decubiti were found. He did not feel that two of the three residents had evidence of decubiti. However, all three residents were placed on treatment schedule to prevent further skin breakdown.

Legally, it is hard to reject such a plan of correction as unsatisfactory. Yet its acceptance succumbed to two regulatory failures. First, there was a failure to persuade the nursing home that they had a serious problem (or if not that failure, a failure of the inspection team to admit they were wrong and that there was no problem).[12] Dialogue is needed to persuade the nursing home that skin breakdowns representing even the early stages of decubiti on three separate residents is a problem of a seriousness that should not be tolerated by responsible management. Second, there was a regulatory failure to persuade the nursing home to rethink their whole prevention program with regard to skin breakdowns instead of just offering to patch up the three detected cases. Dialogue is needed to diagnose the deficiencies in prevention programs

[12] Sometimes these failures of persuasion are even more explicitly portrayed in plans of correction, as in the following (admittedly unusual) submission by a Chicago nursing home: "These 'plans of correction' are being submitted only because they are asserted to be required by law. In submitting these plans, the facility does not intend to admit to any of the allegations in this statement or elsewhere, or to the violation of any regulation or law, nor does it intend to waive or limit in any way its right to contest any alleged violation or other action of any governmental authority or person."

and to catalyze the serious redesign of policies and procedures required. What happened instead was the triumph of ritualism with the acceptance of the proffered plan of correction. The U.S. process leaves little space for the required dialogue: "Anything that's the least bit acceptable will be approved because we have to turn these around in 45 days. Unless it's right out of left field, we'll accept it," said a Midwestern inspector.

The deadlines that deliver the impressively reliable annual inspection cycle in the United States, combined with the official policies against "consultation," make the dialogue difficult. Yet we have seen some rays of hope, of change. One reason for the oppressively high levels of restraint in American nursing homes has been a failure to engage in regulatory dialogue with nursing homes that respond ritualistically to concerns raised about high levels of restraint. Repeatedly during 1988 and 1989 we observed regulatory inertia in the face of nursing homes that inspectors knew, or should have known, had unacceptable levels of restraint. As soon as management could produce signed physicians' orders for all residents who were restrained, that was the end of the story. The right piece of paper would keep them out of trouble even if it were signed by a medical automaton who rarely saw the residents, who was a captive of nursing home management (for a suitable fee), and who signed everything that the nursing home put in front of him. In 1990, in the aftermath of the brilliant "untie the elderly" campaign run by a coalition of consumer groups, nursing home professionals and progressive state regulators were required to put their stamp on the interpretation of nursing home reform laws implemented that year, and we observed regulatory practices becoming more dialogic on the restraint issue. Even where the nursing home could produce physicians' orders for all restraints, inspectors persisted with questioning. "But why is the restraint needed? Don't you think you need a more detailed assessment than this? What about an assessment by a psychiatrist? What are your procedures for reviewing restraints? Aren't you worried about litigation for the improper use of restraints? Have you thought about why you have so many more restrained residents than other facilities in our region? Did you know that X [an industry opinion leader] has halved the number of physically restrained residents in her facility in the past six months, and she says that it's the best thing she's ever done for the residents and for the staff?" The aides rose to the challenge.

Levels of restraint in American nursing homes are falling dramati-

cally; some states having already halved the percentages of their residents who are physically restrained. Deterrence has not produced this change; deterrence may even have decreased in this area during 1990 and 1991. It is the combination of the processes of regulatory dialogue described above driven by the communitywide clamor for reform of the "untie the elderly" campaign and the 1987 OBRA regulatory reforms that is delivering dramatic change. So often scholars of regulation lose sight of the possibility that the year-by-year regulatory failures they see during long periods of regulatory inertia ought to be qualified by noticing that there are periods of history when dramatic regulatory accomplishments are secured in a relatively short space of time. Sometimes these are later reversed. But often they are not. I predict that the regulatory progress on nursing home restraint will not be reversed, but will be cumulative; twenty-first century Americans may look on twentieth century practices of tying up the infirm elderly as incomprehensible barbarism to which it would be unthinkable to return.

While regulatory dialogue over the restraint issue manifests some mellowing of the official U.S. doctrine that inspectors are law enforcers whose job is simply to rate the nursing home for compliance with the standards, and not "consultants," the dialogue remains limited. Moreover, U.S. inspectors receive training, consistent with the official policy, which is unsuitable for preparing them for a dialogic role. At least until 1990, HCFA training of state inspectors emphasized the need for inspectors to be in control during exit conferences, not to be distracted by questions raised by nursing home staff, to stick to the facts of the deficiencies that require a written plan of correction. Occasionally, we have seen surveyors take this training depressingly seriously, as by refusing to answer questions from nursing home management as to whether, in spite of their deficiencies, they had improved since the last survey. This particular survey team was strongly of the view that there had been great improvement at this nursing home, but they declined to express this view at the exit lest it compromise their demeanor as "law enforcers" whose function does not extend beyond dispassionate monitoring and reporting of compliance with the law. Here, as Albert J. Reiss, Jr., pointed out in commenting on an earlier draft of this essay, it is the inspectors who are being ritualistic by shying away from positive feedback that might help sustain regulatory goals. Fortunately, such an extremist interpretation of law enforcement

ritualism is not typical among the street-level bureaucrats who make the regulation work.

In terms of Merton's typology, I have so far discussed conformity, rebellion, and ritualism. Retreatism, where there is a disengagement of commitment to both regulatory goals and institutionalized means for attaining them, does occur from time to time, particularly when the chief executive of the organization is "burnt out" by the pressures of running a health care institution (see Braithwaite et al. 1992, app. E). Indeed, it is when "burnout" happens that some of the more draconian regulatory interventions occur, such as putting in a government-appointed administrator to run the facility. Some of the disengaged nursing home managers we have seen have been alcoholics, one of Merton's classic types of retreatists. While it is a less common occurrence in the United States than ritualism, when retreatism does occur, the consequences for everyone concerned can be serious.

Innovation—achieving regulatory goals but by other than the institutionally approved means—has been substantially destroyed by decades of input-oriented regulation. As the head of one large state industry association put it, "You manage facilities according to the standards written rather than according to what's best for patient care. You quickly learn how to play the game, to give them what's required to meet the standards." This is today widely recognized—by scholarly commentators, governments, industry, and professional and consumer groups—to have been a bad thing. American nursing home regulatory policy today claims that it is undoing this regulatory stultification of innovation by shifting strategy from input- to outcome-oriented regulation. The theory is that the law should specify quality of life and quality of care outcomes for nursing home residents, allowing nursing homes to achieve them through whatever means they see fit. In my view, the shifts in U.S. policy toward more outcome-oriented nursing home regulation have been very marginal. Australian government policy has matched the rhetoric with more genuinely outcome-oriented regulatory practices than one sees in the United States, even though input regulation still has an important place on the Australian scene. To illustrate the difference, if an Australian nursing home achieves good outcomes for residents with staffing levels that are below the industry average, or with professionally unqualified staff, regulators might applaud this as cost-efficient accomplishment of the outcomes. Notwithstanding the rhetoric of outcome-orientation, regulatory prac-

tice in the United States will punish nursing homes that skimp on staffing inputs or that fail to use staff with mandated professional qualifications, regardless of resident outcomes.

In summary, then, American nursing home regulation achieves a surprising degree of voluntary conformity, a great deal of ritualism, and occasional retreatism and rebellion, and it tends to systematic destruction of innovation. While American nursing home regulation uses deterrence much more than in other countries, it still relies heavily on compliance strategies, though not heavily enough to grapple with widespread regulatory resistance through ritualism.

V. Self-regulation

Our fieldwork was attentive to self-regulation as well as government regulation. We interviewed people at industry associations who claimed to run self-regulation schemes; we visited the Joint Commission on Accreditation of Healthcare Organizations and interviewed both surveyors and nursing homes that had been through, or were preparing for, their accreditation process in different parts of the country; we attended a meeting of the Accreditation Committee of the American College of Health Care Administrators; we sat in on thirty-six care planning conferences in nursing homes and eight meetings of facility quality assurance committees.

In its short history, the U.S. nursing home industry moved quickly from being totally unregulated to heavy government regulation. There has never been an era when self-regulation was the primary control strategy. The Reagan administration, as I have noted, tried unsuccessfully to change this situation in 1981. There has long been the Joint Commission on Accreditation of Hospitals (JCAH), which changed its name to the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) in the 1980s, with an eye to the nursing home business in particular. In Texas, JCAHO accreditation is deemed to satisfy state licensure, but not federal certification, which requires a government inspection. The penetration of the commission's voluntary accreditation has always been weak, as the vice president for quality assurance with one nursing home chain explained: "The Joint Commission accredits only three percent of the nursing homes in the country and it's decreasing. Forget it, we're up to here [signifies her neck] in inspection." Most of the industry is not remotely interested in applying for accreditation and is totally unaffected by this self-regulation process.

The 1981 proposal to waive federally mandated inspection for nursing homes accredited by the JCAHO was resisted on a number of grounds (Jost 1983, 1988). First, the JCAH had no enforcement powers. Second, its reports were treated as confidential quality assurance feedback to management that was not available to consumers. Third, its standard accreditation cycle is three years instead of the one-year government cycle. Fourth, it was rightly criticized for an extremely input-oriented (ritualistic) approach to self-regulation. The JCAH has been as bad as government regulation in the United States in stultifying innovation to deliver better health care outcomes. Accepting some truth in the latter criticism, the JCAHO has sought to move to a somewhat more outcome-oriented approach in the last few years, but as with U.S. government regulation, outcome-orientation at JCAHO remains more a matter of rhetoric than reality.

Over the years, some state industry associations have developed self-regulatory schemes to ensure that their members had satisfactory quality assurance programs as a condition of membership. The most ambitious of these was the Washington Health Care Association's (1990) Quality Validation Program conducted in cooperation with the JCAHO. At the time of our visit to Seattle in 1990, this seemed about to fold, effectively removing industry associations from any substantial involvement with self-regulation, though some state associations (e.g., Virginia) run low-key voluntary peer review programs for administrators. Professional associations continue to play important roles in accrediting health care professionals. Of particular interest in the nursing home industry is the American College of Health Care Administrators, which accredits 6,500 administrators. Some of the professional development plans developed with nursing home administrators during their accreditation process amount to quality assurance programs for the facilities they run (American College of Health Care Administrators 1987). Doctors are subject to peer review organizations (Jost 1988). This may be important in hospitals where doctors exercise great power, but in nursing homes where doctors are generally part-timers with minimal involvement in organizational decision making, this form of self-regulation has a small impact. In any case, in the entire American health care sector up to September 1987, only fifty-four health care providers had been excluded from Medicare, with another twenty-five being subjected to monetary penalties, as a result of peer-review organization deliberations (Jost 1988, p. 591).

The self-regulatory action that counts most is at the level of particu-

lar nursing home organizations themselves rather than at the level of national or state associations. For years, many nursing home chains have had quality assurance programs, often headed by a vice president for quality assurance. Some of these have impressive manuals. Our observation is, however, that most corporate quality assurance programs demand no more than is required by government regulation. This contrasts with quality assurance programs in the pharmaceutical industry that often demand much higher standards than those imposed by the law (Braithwaite 1984). The function of the vice president for quality assurance in a nursing home chain tends to be to get her facilities up to speed when a government inspection is due. The objective, in other words, is not so much to improve quality as to minimize deficiencies detected by the regulators. This reality is reflected in the incentive systems of the chains, which pay bonuses to administrators who obtain low numbers of deficiencies in government inspections rather than to administrators who are rated by corporate quality assurance systems as delivering good quality outcomes. At worst, corporate quality assurance personnel train staff in the art of ritualism. But this is not always the case. For example, the national quality assurance program mandated by a 1986 Californian consent agreement with Beverly Enterprises—a past master of ritualism and roller-coaster compliance—according to several knowledgeable informants and our own limited observation of the Beverly quality assurance program in operation, is seriously oriented to improving the quality of care and has probably done so.

The Beverly consent agreement was a pioneering example of government-mandated self-regulation in this industry. This has been taken a big step further with the implementation of OBRA in 1990.[13] Under OBRA, each nursing home is required to have a quality assurance program coordinated by a quality assurance committee. The nursing home is allowed a lot of discretion in choosing whatever quality assurance objectives seem most needed to the nursing home in each area of its operation. This seems a paradigm shift away from command and control regulation and toward fostering self-regulation, and in impor-

[13] See n. 7 above. This was legislated in 1987 after a stunning campaign in which the National Citizens Coalition for Nursing Home Reform effectively persuaded the nursing home industry and professional associations to support the reform, even though it involved measures such as tougher enforcement. Regulations and a new inspection protocol to give effect to the law did not come into force until October 1990.

tant ways it is. However, the culture of an industry inured to government command and control, indeed, to government discipline, as I argue in the next section, pervades the quality assurance process. Ritualism is endemic. The question that holds center stage during quality assurance meetings is not, "What is the best way to design this program to deliver maximum improvement in quality of care?" It is, "What is it that they [the regulators] want of us here? What is the minimum we have to do to satisfy the requirement of having a quality assurance program?" We could illustrate this with some shameless instances of ritualism during quality assurance meetings. The following interaction is a more subtle case that is closer to the modal reality of quality assurance ritualism:

> *Director of nursing:* "Are you looking for 100 percent [with your outcome evaluation]? What are you going to do about it if it's 95 percent?"
>
> *Dietician:* "An in-service."
>
> *Quality assurance coordinator:* "Shoot for 100 percent and put 90 percent [on the written evaluation plan]. Don't hesitate to change the design to make it more realistic. They [the state] don't mind that. You don't get penalized for not meeting your quality assurance objectives. You'll get penalized for failing to take action on the problems you find. Do we all agree? Ninety percent."

Here the parameters of the quality assurance program are being set so as to avert the need for any follow-up action to improve quality. In the most blatant cases of ritualism, the very selection of quality assurance evaluation is driven by a search for nonproblems that will guarantee a near-100 percent result. Ritualism cannot therefore be simply fixed by changing the structure of the law away from command and control. Ritualism is a deeper problem of regulatory culture. It is also a problem of infinite regress. This was illustrated in one quality assurance committee meeting when linking quality assurance data to employee evaluations was discussed: "In my area, if we specify clearly their employee evaluation criteria, they won't do anything else." Ritualism is such a deeply embedded, multilayered problem in the American nursing home industry that nothing short of a cultural revolution in the industry and its regulation may be needed to conquer it. I turn to this question in the next section.

VI. The Structure and Culture of Nursing Homes

Nowhere, not even in prisons, do I get so powerful a sense as in American nursing homes that there may be some merit in the social theory of Michel Foucault (1977). American nursing homes (like Japanese nursing homes, though less so with English and Australian homes) are disciplinary societies. Many of them have explicitly panoptic designs—nurses' stations are hubs from which radiate wings of rooms. The corridors of each wing and the front rooms of each—usually public areas such as activities rooms, TV and dining rooms—can be subjected to surveillance from the nurses' station in such homes. Residents whom it is thought unwise to leave unsupervised in their room are put into, often tied into, a wheelchair and positioned adjacent to the nurses station. Often a dozen or more silent, sullen, slumped subjects are congregated around the nurses' station. Occasionally, homes that are architecturally ill-suited to surveillance compensate with closed-circuit television surveillance. In these nursing homes, television monitors adorn the nurses station. I am not saying that panoptic design or television surveillance characterizes a majority of American nursing homes. What is remarkable from the perspective of another culture is that they exist at all and exist in significant numbers; they would, for example, be in clear breach of Australian "homelike environment" and "privacy and dignity" standards. In more subtle ways, almost all American nursing homes are designed as surveillance institutions.[14] My hypothesis about this is much stronger than simply a failure of American regulation to prevent this; it is that American regulation was centrally involved in causing it.

My argument in this final section is that: the organizational structure of the American nursing home industry has been driven by the regulatory structure (the conclusion I reached in Sec. II); the disciplinary nature of American nursing homes is connected to their comparatively large size, distant management, and institutional structure; the disciplinary nature of American nursing homes is connected to the disciplinary nature of American nursing home regulation; the disciplinary nature of both American nursing homes and American nursing home regulation makes ritualism an inevitable pathology; and therefore, the key point of intervention to deal with the dual problems of ritualism

[14] Albert J. Reiss, Jr., has pointed out to me that this is a more general American medical institutional model: many hospitals also have panoptic designs: in the recovery room with all its monitors the surveillance institution reaches its highest form, with almost total abandonment of privacy as a value.

and disciplinary oppression is a radical transformation of the regulatory framework.

The disciplinary nature of American nursing homes is most apparent in the physical surveillance described above, which, as oppressive of privacy and dignity as are its effects, is nevertheless motivated by a well-meaning desire to protect residents from harm and to protect the nursing home from legal allegations of negligence. Similarly with the other most visible sign of the disciplinary order of the American nursing home—the shocking level of physical restraint.[15]

Consider this deficiency citation for a Beverly Enterprises home: "Resident #13 was found . . . with her right hand restrained to the bedrail with mitt in place. The hand and lower arm were swollen and cyanotic. Indentation marks from the strings were noted where tied. . . . The resident has no mitt restraint order."

Question staff and they will say (usually both mistakenly and sincerely) that restraint is necessary to protect the residents by preventing falls and to protect the nursing home from lawsuits and regulatory sanctioning.[16] Less commonly, they will concede it represents a policy of the corporation to save staff time on the management of difficult residents. These most visible manifestations of the disciplinary society are complimented by an infinity of smaller less visible disciplines. In many parts of the United States, nursing home residents do not have what we might call a "right to be fat." Mrs. Smith, who has enjoyed eating to excess and put up with being fat for eighty long years is forced to diet when she enters a nursing home. Why? Because the nursing home dietician is concerned at what might happen when the

[15] Chemical restraint may be even more pernicious, though it is less visible. Some surveys have found as many as 50 percent of nursing home residents on antipsychotic or sedative/hypnotic drugs when only 10 percent of the sample had clearly documented mental illness (Sherman 1989). National Nursing Home Survey data analyzed by the National Institute of Mental Health found 62 percent of residents to be on psychiatric drugs, though only 5 percent of them had psychiatric diagnoses (United States Senate, Special Committee on Aging 1990, p. 40). As one state inspector who was a qualified pharmacist put it, in many nursing homes "drugs can be causing more confusion than psychosis."

[16] In truth, there have been more successful lawsuits in the United States about residents strangling on restraints than about residents who fell for want of a restraint. Indeed, it is likely that there have been very few successful lawsuits of the latter type (see United States Senate, Special Committee on Aging 1990, p. 33, and elsewhere; see also Evans and Strumpf 1989). While it is true that American health care professionals are more vulnerable to lawsuits than their peers in other countries, this observation has less force in the nursing home industry because the frail aged everywhere are disinclined to sue. Also families are very reluctant to push their loved ones into a lawsuit during the last of their time on this earth.

inspectors see in Mrs. Smith's chart that she is so overweight and that the nursing home has failed to protect her health by putting her on a diet. This might get the dietary department a deficiency (and therefore cost the dietician a bonus for a deficiency-free inspection). Even if in fact the nursing home is likely to get enlightened inspectors who would not count Mrs. Smith's not being on a diet as a strike against the home, the disciplinary order of nursing home employment requires the dietician to play it safe ("Who ever got a deficiency for putting a fat person on a diet?").

A good illustration of protective discipline being applied arose during an inspection on the East Coast of the United States in a nursing home specializing in the needs of Asian residents. The inspectors observed many of the residents, as would be customary in their own homes, to remain all day in house-coats like bathrobes. Following a cultural pattern, they did not wear underwear, and old people being as they are, this resulted in various incidents of exposure of private parts observed by the inspectors. The inspectors said they did not want to discourage the residents from customary modes of dress, but they wanted staff to be more sensitive to the privacy and dignity issues involved, and in any case they could not ignore the standard. So they wrote the following citation: "Privacy and dignity was not always maintained: i.e., four patients were observed with their personal parts exposed and they lacked underwear." The following plan of correction came back from the nursing home: "Staff to be inserviced further on patient dignity and the need to maintain the privacy of all patients. Underwear to be purchased for patients who lack them; underwear to be worn."

One is reminded of Foucault's (1977, p. 222) aphorism that "the 'Enlightenment' which discovered the liberties, also invented the disciplines." Indeed, one is tempted to extend it to the present by saying that the postwar United States, which claims some credit for spreading the liberties behind the iron curtain, imposed the disciplines on its own elderly and then sought to export the disciplines through the international expansion of its nursing home chains. Even in countries like Australia, which has experienced only very minor market penetration by American nursing home chains, there is still some percolation of the American model, mediated through textbooks, gerontology journals, marketing men with new surveillance technologies, industry associations that see more of a future in corporatized caring than in a cottage industry, and visiting gurus. There is even a group which

manages thirteen Australian nursing homes called Conforme Management. A South Australian director of nursing captured well the concern some feel about the direction of change: "It's no longer a cottage industry. They are individual people with needs to us. In the new factory industry, they are units. That's why we now need complaints systems and the rest."

This is an interesting quote, I think, because by making the connection with the "factory," this director of nursing, doubtless without having read Foucault, is tapping into Foucault's key idea of the carceral archipelago: "Is it surprising that prisons resemble factories, schools, barracks, hospitals, which all resemble prisons?" (Foucault 1977, p. 228).

The large American nursing home chains cannot help but spread the disciplines. They operate in an industry that poses large regulatory risks, as the near bankruptcy of Beverly Enterprises in the late eighties illustrates. There is no choice for them, therefore, but to follow the logic of regulatory risk management. That means highly disciplined institutions in which risks (*read* people) are monitored, recorded, and subjected to preventive controls (or at least the appearance of preventive control, so that the organization can be seen not to have neglected the risks embodied in the five-hundred-plus standards). We have already seen how the large American chains owe their very existence to the imperatives of largeness and institutionalization that were products of regulatory choices made in the United States two decades ago, different regulatory choices from those made in other countries. The risk with large institutions is that people and problems can fall between the cracks. Size therefore motivates surveillance, record keeping, and control. This is the essence of Foucault's notion of power as discipline. Disciplinary power does not grow out of the barrel of a gun, not from the edicts of a monarch or a judge, not from the control of capital, as do other forms of power. Disciplinary power works through the construction of routine; it can be seen in its most developed form when a total institutional environment is designed as a technostructure of control. Bauman (1982, p. 40) summarizes well the change Foucault sees in the way power is exercised with the growth in discipline:

> Power moved from the distant horizon into the very center of daily life. Its object, previously the goods possessed or produced by the subject, was now the subject himself, his daily rhythm, his time, his bodily actions, his mode of life. . . . It wanted to impose

> one ubiquitous pattern of normality and eliminate everything and everybody which the pattern could not fit. Unlike the sovereign power which required only a ceremonial reminder of the timeless limits to autonomy, the emergent power could be maintained only by a dense web of interlocking authorities in constant communication with the subject and in a physical proximity to the subject which permitted a perpetual surveillance of, possibly, the totality of his life process.

The crucial theoretical limitation of the Foucauldian perspective for the present problem is that it assumes that disciplinary power is used for "normalization," by which Foucault means bringing under control, back to "normal," the slightest irregularity of conduct. Foucault sees the clinical sciences as instruments of normalization. Yet the clinical sciences and regulation can be instruments of individualization rather than normalization.[17] Ironically, there is a literature on "normalization" in gerontology. The author of the term, Wolfensberger (1972, 1985), a gerontologist, means exactly the opposite to the meaning Foucault gives the term.[18] For Wolfensberger and the many health care professionals influenced by the idea, normalization means shifting power back from institutional routine to individual residents—allowing them to live in a nursing home as free, choosing individuals, just as they do in the "normal" outside community. Put another way, these health care professionals have the agenda of normalizing the institution instead of normalizing the subject of the institution.

Garland (1990, p. 174) has made the point in his critique of Foucault that there is no inevitability that regulation destroys freedom; regulation, equally, can constitute freedom. Cases in point are the Australian standards that require nursing homes to guarantee "privacy and dignity," a variety of specific "freedoms," including the wonderful legal mischief of the "right to take risks" (Commonwealth/State Working Party on Nursing Homes Standards 1987, p. 49). A useful way of comprehending what is happening within the nursing home industry in the modern world is as a battle between the two normalizations. Health care professionals are warriors on both sides of this battle;

[17] Garland (1991) has made a similar critical point about Foucault's view of the relationship between criminology and discipline.

[18] See Wolfensberger (1972). In the 1980s, Wolfensberger reformulated his normalization concept somewhat as "social role valorization" (Wolfensberger 1985).

regulation is a weapon used on both sides of the barricades, though the modalities of regulation favored by the two sides are very different.[19]

Furthermore, we must not forget that it is specific regulatory choices that created the conditions for a factory industry. Smallness dissolves many of the disciplinary imperatives of the chains of large institutions. Tiny English nursing homes can be justifiably criticized for sloppy record keeping and abysmal care planning. Yet, in their defense, they do not need such discipline as do American institutions managed by a remote corporate headquarters on the other side of the country. When there are only eighteen residents in the nursing home, the director of nursing knows the problems of all of them personally and intimately. She does not need a systematic information system to ensure that problems do not fall through the cracks. She does not have to worry so much about shuffling staff from A wing, where they know the residents, to F wing, where they do not, because there is only one wing. She does not need a pervasive surveillance system to cover the nursing home because she herself gets into every part of the nursing home many times every day. The more intimate knowledge of every resident's needs that can be accomplished when all staff get to know all the residents means that particularized solutions can be found to problems that more bureaucratized institutions feel they can only handle with a form of control such as restraint.

The structural imperatives of scale and bureaucratization therefore combine with a disciplinary regulatory system (that is forgiving so long as the appearance of remedial inputs is documented) to create disciplinary institutions for the elderly. A little more should be said on how the disciplinary regulatory system is created, though my colleagues and I will have a great deal more to say about this when we write a book on the subject. What we are describing is a disciplinary regress. Mrs. Smith is disciplined by the dietician onto a diet. The dietician has been in turn disciplined to do this by the existence of a state inspector, who is unlikely to understand the details of Mrs. Smith's preferences as well as the dietician and who therefore may react to the appearance of poor health care when overweight residents

[19] The battle is joined on one side by the majority in the corporatized caring sector who want to be "given the rules of the game so we can play by them" and the rulebook regulators. On the other side are the bulk of the consumer movement and the outcome-oriented regulators who are interested in a regulatory process that includes dialogue about resident rights and freedoms.

overeat. The state inspector, in turn, is disciplined by the existence of supervisors and HCFA look-behind inspectors, who are even less likely to get close to a nuanced understanding of Mrs. Smith's case but who can readily pick up a failure of an inspector to notice an unclosed loop in documentary records the inspector should have checked. A regulatory system has been created where everyone is regulated by someone else in a culture of distrust in which all are ground through the disciplinary mincer. Demands for regulatory accountability are met with ever more layers of regulation, usually heavily documented to vindicate the new discipline.

Structurally, this situation conduces to ritualism. Getting the documentation right is the way to protect yourself. The way to persuade the disciplinary actor above you is to show her that you are a credible agent for her discipline, passing it on to those below in a way that can be documented to those above. It is the documents and the disciplinary practices that are your defense, not any imaginative or dedicated things you might have done to improve the quality of life of nursing home residents. That is, ritualism is your defense—devoting your energies to institutionalized means rather than to a goal like reducing pain. The contrast is palpable at every layer of the regulatory apparatus, between the United States and England or Australia, in the proportion of the time people spend working on documentary defense rather than hands-on problem solving. Nurses in the United States spend very little of their time giving care to residents; that must be left to untrained nurses' aides because practically all of the registered nurse's time must be dedicated to the more important task of keeping documents in order.[20] Inspectors in the United States spend most of their time alone in a room poring over resident charts, whereas English and Australian inspectors spend most of their time out in the nursing home observing care and talking to staff, residents, and visitors about care. The theory of the recent OBRA reforms was that the inspection process would become more resident-centered and less document-centered. But our research team's observation is of no significant change because the new element of resident interviews has been balanced by extra documents for inspectors to check and extra pieces of paper for them to fill out.

[20] This, in turn, exacerbates the disciplinary quality of nursing homes because there is evidence that registered nurses are less "custodial" in their attitudes to residents than are licensed practical nurses and that licensed practical nurses are less custodial than nurses aides (Bagshaw and Adams 1986, p. 242). Nurses, with their more caring, patient-centered professional socialization, are sorely needed on the front line as role models of noncustodial care.

Enormous resources in the United States are dedicated to documentary accountability checks to ensure that inspectors have completed all their records in the right way; few resources are dedicated to evaluating whether they have done anything to improve quality of care or even to talking with them about how to better accomplish this.

At every level in this hierarchy of mistrust, actors have a more jaundiced view than they should of the competence and capacity for responsibility of those they wish to discipline. The social scientists who advise U.S. governments on the design of nursing home surveys, for example, almost uniformly have the view of nursing home inspectors as incompetents who are incapable of dialogic problem solving, who must be disciplined against deviating from "objective" survey protocols. These are registered nurses whom they view as incapable of the responsible exercise of discretion, some of whom have run much larger organizations than the departments in which the academics work. The social scientists typically have acquired this stereotype of the untrustworthy, incompetent inspector without ever seriously interacting with inspectors on the job about their reflections on how they achieve progress. Instead, they sit at their computer terminals designing protocols for inspectors-as-dopes, thereby increasing the prospects that inspectors will become dopes. Our truth is that it is the dopes at each level who create dopes at the next rung down on the disciplinary ladder. Hence, the inspector who does not trust nursing home management will insist on making "recommendations" that they expect to be followed instead of opening up a dialogue that encourages management to design their own solutions. At the next step down, good managers empower their staff: in the best nursing homes, one sees nurses' aides actively involved in decision making and rising to the challenge of exercising their discretion to better serve the residents who are their responsibility (Tellis-Nayak 1988). In the worst nursing homes, one finds care managers manifesting the jaundiced view of the competence and trustworthiness of aides of this Australian director of nursing: "A checklist was my way of getting it done. We have to accept that we are dealing with girls who are rote learners. So it's the way I get them to learn. It's not checked off so they say, 'Oh, I haven't done it.' "

Breaking out of the hierarchical culture of mistrust and ritualism requires advocacy of a new regulatory maturity, a radical break with the documentation-driven obsessions of the past. American social scientists and health care scholars who work in this field hold out limited hope because they are central communicators of the culture of mistrust.

They tend to view the industry as rapacious and untrustworthy, regulatory managers as captured and feckless, and inspectors as incompetent. Managers in the industry are the least capable actors of effecting a profound change in regulatory culture, notwithstanding the conventional incantations about the power of capital. This is because they are the most mistrusted in a culture of mistrust, because they have most to gain by being untrustworthy. The federal regulators—within the Health Care Financing Administration—are in a better position to lead than the industry, though they still suffer from considerable mistrust as "captured regulators" and they have a poor record of policy entrepreneurship, probably because of their structurally weak position within a spending agency driven by the imperative to keep costs down.

The greatest hope for policy leadership toward a radical shift in the culture of U.S. nursing home regulation resides with the group who have been the policy entrepreneurs during the past decade—the National Citizens Coalition for Nursing Home Reform (NCCNHR). This consumerist coalition has as outstanding a leadership in Elma Holder and Barbara Frank as one can find in a consumer movement anywhere in the world. They enjoy a surprising degree of grudging respect from their adversaries in industry and the state. They are in touch with the grass roots of their constituency—the nursing home residents. This gives them a good grasp of the failures of U.S. nursing home regulation from a resident-centered perspective. It is this grasp that led them to campaign so vigorously and effectively for reform in the use of restraints—reform, as we have seen, that has challenged the ritualism of regulation that accepted a pile of physicians' orders as sufficient justification for restraint.

At the same time, advocacy of a radical renegotiation of the ground rules of U.S. nursing home regulation poses risks and threats to an organization like the NCCNHR. First, there is the risk that major accomplishments of their social movement would be lost in a radically redesigned regulatory order. One of these, for example, is that the United States was perhaps the only country in the world with a demonstrated capacity during the 1980s, even if an underused capacity in many states, to take tough enforcement action against nursing homes with deplorable standards. Second, there is the threat involved in conceding that the consumer movement shares with the industry, the lawyers, the regulators, and the social scientists a significant part of the blame for the disciplinary, ritualistic quality of American nursing home regulation. The consumer movement does share in this blame

because it has been at the forefront of demanding new layers of discipline, the filling out of more pieces of paper to ensure that residents are protected. The consumer movement position has not been without paradox in this regard. While it has been an advocate of more and more specific new regulations that require new pieces of paper, in the broad it has been an advocate of a more resident-centered process that is less oriented to checking documentation. The policy it has advocated as a matter of broad regulatory strategy has been at cross-purposes with the aggregation of its piecemeal advocacy of an extra bit of discipline here and there. In this, the consumer movement is no less guilty than the industry associations that call for regulatory simplification as a matter of broad regulatory strategy and scream for tighter specification (ergo, multiplication) of regulations as soon as their members complain of inconsistent application of a broader rule.

As politically difficult as it would be for them, it is perhaps only the NCCNHR who have the political respect to initiate a cooperative process with the other industry players of fundamentally rethinking the culture of American nursing home regulation. Early success with the "untie the elderly" campaign is a taste for them of what can be accomplished down this path for the people they represent. Moreover, they already have succeeded with some path-breaking reforms in the direction of an alternative accountability model to more and more layers of discipline. These involve increased empowerment of advocacy groups outside nursing homes and of residents' councils within them. Examples are the recent OBRA reforms empowering representatives of residents' councils and advocates to participate in exit conferences at the conclusion of inspections and earlier reforms to give discussions with residents' councils an important role during the inspection process and to give residents more effective access to inspection reports.

VII. Conclusion

My view would be that dialogic, local accountability based on broad outcome-oriented standards and well-resourced local advocacy is a more hopeful strategy than national accountability based on demands for detailed documentation and a myriad of inputs (see Handler 1986). This, indeed, is the path that nursing home regulation is heading down in Australia, with reasonably broad, if fragile, support from industry, the consumer movement, and the state. Out of the energetic process of nursing home reform proceeding in the United States, a somewhat different model of nursing home regulation better suited to American

realities may be developing. The American consumer movement has successfully lobbied for a new accountability model based on dialogue with consumers and advocates, though this has been allowed to grow alongside the oppressive old accountability model based on ritualized inputs and paper warfare. So there are grounds for both hope and despair about the future. A next step might be to open up a dialogue about a coherent program to effect the demise of this old accountability model. While it is hard to break out of cycles of mistrust, it should be possible to persuade consumers, workers, owners, and bureaucrats that a less disciplining industry culture would allow them all more rewarding lives. How such a process might unfold is better left for others to consider. Outsiders with comparative knowledge can occasionally glimpse a little clarity of perception in observing regulatory rituals that are taken for granted by locals. But they lack the appreciation of cultural and procedural subtleties to advise on ways of reforming local institutions. Americans must seize their own history. In the meantime, history may prove us to have also followed the wrong path in Australia.

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