Marketing Implications of the Expected Role of Physicians in Family Decisions Concerning the Institutionalization of the Elderly

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ABSTRACT

This study investigates the decision to place a loved one in a nursing home, looking at the interaction between adult children and the elderly, and at the role expected to be played by physicians. Younger respondents and those without previous experience with decisions concerning the admittance of a loved one in a nursing home do not see the physician as playing an important role, whereas the elderly and those with experience do. Differences in perceptions by these two groups are explored and the marketing implications for health-care providers are discussed. ©1995 John Wiley & Sons, Inc.

The over-65 segment is expected to grow 100% in the next 50 years, and almost 50% of Americans over the age of 65 will spend some time in a nursing home (Rowland, 1990). The number of nursing-home residents in 1985 was approximately 1.3 million, and is expected to increase to 6 million by 2040. The average cost of a year's stay in a

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nursing home is about $30,000, and little of the expense, only about 1.5%, is picked up by Medicare/Medicaid. Eligibility for Medicaid varies from state to state, but generally a person is allowed only about $5,000 in assets and a minimal income in order to quality. Kovar and Harris (1988) estimate that nursing-home costs are increasing at an average annual rate of 12%.

Increased life spans due to healthier life-styles and advances in medical technology, coupled with the fact that the baby-boom generation is now reaching middle age, means that there is an increasing number of individuals who are facing the prospect of making arrangements for the care of their aging parents. As such, the complexity of these issues is getting more visibility in the popular press as well as the entertainment media. However, there is question as to how accurate these portrayals are of the actual care-giving process. For example, the movie "Dad" portrays the return of the prodigal adult son (Ted Danson) to the nest when his mother (Olympia Dukakis) has a heart attack; the father (Jack Lemmon), with the help of the son, regains his mental and physical health before succumbing to cancer. A second notable example is the moving "Driving Miss Daisy," in which an adult son is responsible for making decisions for his aging mother.

These movie portrayals are inconsistent with the pattern of care observed in the literature (as summarized later), which finds that adult daughters are more likely to care for aging parents. Thus a more common experience is described in an article in *McCall's*, "Our Parents, Growing Older" (Ciabattari, 1990), which covered the concerns surrounding a parent who had a stroke. Not only were the affects on the caretaking spouse discussed, but also the affects on the adult children, in this case the nearby daughter and the distant daughter.

The objective of this article is to ascertain the accuracy of people's perceptions of the care-giving process for the elderly (specifically, the decision to put a loved one in a nursing home and the role of the physician in that process).

NURSING-HOME DECISIONS AND CONSUMER RESEARCH

The aging process involves a slow decline in one's physical prowess, and requires that individuals continually learn to play new or altered roles and to relinquish old ones (Brim, 1966). These changes often involve the necessitated gradual disposal of one's possessions (Belk, 1988). For people aged 60–80, focus shifts from the acquisition of possessions toward *being experiences*, such as interpersonal relationships, philosophical interpretation, and a sense of connectedness with life. People in the oldest group (70–80) have a keen appreciation for the simpler things in life, such as taking a walk, watching a sunset, or having a friendly conversation (Wolfe, 1987). Thus, retirement and old

age are dramatized by the relinquishing of certain consumption categories (consumer durables, children's education expenses, etc.) and the assumption of others (health care, securities and investments, and travel) (Smith & Moschis, 1989). It is not uncommon to see a gradual shift from one's own home to a smaller home, to an apartment, and, finally, to a nursing home. With each transition the individual experiences a loss that requires some painful acclimation.

Much of our society finds the nursing home a suitable compromise for the care of the elderly. In many cultures, the elderly are a part of the nuclear family and are cared for at home by children and grandchildren when they become infirm. In the United States, the proportion of elderly co-residing with a child decreased from 1962 to 1984 from almost 1 in 3 to less than 1 in 5 (Crimmins & Ingegneri, 1990). On the other hand, in other cultures, the elderly may be allowed to die (or be helped along in that process) when they can no longer care for themselves (Shalinsky & Glascock, 1988). Our culture's nursing-home compromise is one of the necessary evil variety.

At least two factors result in the U.S. family's inability to take care of elderly loved ones: (a) a high level of mobility, which leaves adult children physically unable to monitor their elderly parents on a frequent basis; and (b) a longer life span, which results in more frequent occurrence of dementia. Though one may wish to take care of an Alzheimer patient, at some point the nearly constant monitoring of the patient exceeds the care-giver's abilities. Despite the declining number of parents being cared for by adult children in the U.S., the Biblical admonition, "Despise not thy mother when she is old" (Proverbs 23:22) would still appear to be much observed. However, physical separation and the complex nature of problems such as Alzheimer's disease leave one with few options.

The provider of long-term medical care is presented with a complicated situation, as the service being sought is one that is frequently not desired by the customer and yet is extremely costly. Baumgarten, Rao, and Ring (1976) found that 56% of the 121 nursing-home patients whom they interviewed would have preferred not to come to a nursing home at all. In general, society wants to provide the elderly with the right to age with dignity, but adult children do not have the expertise, nor, in many cases, do they want to take the responsibility for long-term care themselves. Another complexity arises because research suggests that older people may suffer from inadequate socialization into roles assumed in later life (Smith & Moschis, 1990). For example, Lambert (1980) found many older people to be ill prepared to assess correctly their medigap protection needs, and, because of this lack of socialization, older people cannot accept the fact that their new life situation calls for nursing-home care.

Further, many elderly see the admission to a nursing home as an admission to themselves that death is imminent (Baumgarten et al.,

1976). The long-term care provider thus is providing a needed service, but one that is unwanted by all parties involved. The elderly may well not want to be there, and the adult children may well experience a high level of guilt. It is therefore incumbent upon the long-term care provider to understand the dynamics of the elderly residence decision process in order to attempt to make the process as palatable as possible to all parties involved.

Smith and Moschis (1990) note that the elderly also have the ability to influence their environment. For example, the older person's desire to remain out of a nursing home, coupled with her or his increasing affluence, influences the various types of social support systems that are to be provided. For example, many traditional providers of long-term care now also provide services targeted to help the elderly stay in their own home; such services include adult day care, home health care, health-care planning, rehabilitation services, independent living, Meals on Wheels, and hospice.

ROLE OF THIRD PARTIES

The Family Care Giver

Medical and housing decisions faced by the elderly usually involve more than the provider/client dyad. Unfortunately, much research has ignored the broadened perspective. The declining health of the elderly may increase their willingness to subcontract their housing and health-care decisions to others.

Sorce, Loomis, and Tyler (1989) found that 82% of older consumers would ask the advice of their family and children when considering their next move. Similarly, Baumgarten, et al. (1976) found that 51% of the nursing-home residents they interviewed indicated that the decision to enter a nursing home was made strictly by others (predominantly family). Lipman (1961) found that older people see or speak to their child(ren) an average of once a week and prefer to remain close. However, Smith and Moschis (1990) note that individuals experience role attrition as they grow older, resulting in less involvement with others and a decrease in interaction with family and coworkers.

Mancini and Blieszner (1989) suggest that there are two separate caregiving roles: (a) instrumental support, including giving money, running errands, making repairs, and providing transportation; and (b) emotional support, including providing affection and counseling, and decreasing another's feelings of isolation. Raphael and Schlesinger (1993) found even more delineation, as recreation and entertainment activities are distinct from such aspects as personal and home-related care. The specific domain investigated in this study deals with the in-

strumental and, especially, emotional support involved in the decision to enter a nursing home.

Although care givers come in many forms (family, friends, neighbors, etc.), the predominant form is that of a daughter, often the closest in terms of geography and/or the eldest (Atkinson, Kivett, & Campbell, 1986; Brody, 1981; Cantor, 1983; Coward & Dwyer, 1990; Finley, 1989; Horowitz, 1985, Jones & Vetter, 1984; McFall & Miller, 1992; Stoller, 1983; Stone, Cafferata, & Sangl, 1987; Walker & Pratt, 1991; White-Means & Chang, 1991). Aronson (1992) found in her study of the elderly and care-giving daughters that respondents had integrated normative expectations of men and women in one's family: It was obvious to them that daughters would naturally step in to assist their mothers. As a possible explanation, Aronson (1992) cited research that has compared women's and men's motivations to care for an elderly dependent and found a powerful link between femininity and caring. Although women express their motives in terms of duty and obligation, men speak of love. Henry Brooks Adams, in *The Education of Henry Adams* (1970), offers an additional suggestion, "Young men have a passion for regarding their elders as senile."

The Physician

The relationship between the elderly person and her or his physician becomes closer due, in part, to the increased frequency of contact. Although the average American consults a doctor 5.4 times a year, people aged 65 to 74 average 8.2 contacts a year, and people 75 or older see or talk to doctors an average of 9.9 times per year (Staying in touch, 1991). Due to the close relationship between the elderly person's mental/physical condition and her or his housing needs, the physician is likely to play an especially important role in decisions to place someone in a nursing home. In fact, if the person's care is to be paid for by Medicaid, the physician must confirm that such care is required.

The role of the physician in the nursing-home decision is not well understood. A guidebook for choosing a nursing home (Routh, 1970) discusses only tangential roles: the physician's ability and willingness to continue to provide services at the nursing home, and her or his recommendation being needed for nursing-home admission.

Reports of the actual role of physicians are somewhat inconsistent. Goldstucker, Bellenger, and Miller (1974) surveyed 25 nursing-home patients (and their family care givers) about their admission decisions. Table 1 lists the results of their survey. Clearly the patient and family members have different perceptions as to the role that physicians play. Relatives believe that the physician plays a greater role in informing the family about nursing homes, but the patients perceive a greater likelihood that it was the physician who first concluded that a nursing

Table 1. Findings of the Goldstucker et al. (1974) Study.

	Patients' Responses	Relatives' Responses
Persons or Agencies First Advising Patient to Reside in a Nursing Home		
Physician	44%	37%
Family	31	37
Physician and family	13	25
Physician and social worker	6	—
Friend	6	—
Source Informing Participant about the Home		
Physician	19%	25%
Relatives	55	13
Friend	13	6
Church	—	13
Advertising	—	13
Other	13	31
Involvement of Physician in Choice of Nursing Home		
Gave approval after choice made	31%	19%
Not involved	44	31
Suggested several homes	6	31
Chose home	19	13
Don't know	—	6

home was necessary. In general, both groups acknowledge that physicians play a major role in the initial decision to move to a nursing home, and that they play a diminished role in the choice of a specific nursing home.

In their study of residents of three nursing homes in Lansing, Michigan, York and Calsyn (1977) found that 59% of the patients came directly to the nursing home from the hospital. Thus it was not surprising that physicians (83%) and hospital social workers (43%) were listed by the family as being important factors in the decision to place the patient in the nursing home.

On the other hand, Baumgarten, et al. (1976) found that only 4% of the nursing-home patients interviewed indicated that a doctor's recommendation was a major stimulus in the decision to enter the nursing home; however, the modal category (63%) was the catchall item, "Illness/Old Age."

Care-Giver/Physician Interface

There have been a number of studies that have investigated consumerism in medical encounters. Reeder (1972) makes a distinction between the patient as a client, who comes to the physician for advice and accepts the physician's opinion, and a health-care consumer, who

listens to the physician and then makes her or his own health-care decisions. Studies investigating the relationship between health-care consumerism and aging have reported mixed results (e.g., Haug & Lavin, 1981), with some studies indicating that the elderly are more consumer oriented and others reporting that this group is less consumer oriented. Beisecker (1988) attempted to overcome some of the potential shortcomings of prior studies that relied solely on self-report by also examining the actual behavior of patients. The results of this study indicated that there is a relationship between age and a tendency for the patient to put her- or himself completely in the hands of the physician. Older patients were less likely to challenge a doctor's authority and more likely to place the locus of authority in the doctor than in themselves. This finding suggests that self-reports are closer to wishful thinking about who actually makes medical decisions and that actual behavior indicates that the physician has a major influence on actual decisions.

Beisecker (1988) offered two explanations of why older patients may have less input in medical decisions. First, as people mature, they simply may want less responsibility. As she states, perhaps the elderly are simply tired of assuming decision-making responsibility. Alternatively, older patients were socialized in a period when the physician was seen as a traditional power figure.

There is evidence that the care-giver–physician interactions are tense ones. In the York and Calsyn (1977) study of the families of nursing-home residents, less than one third of the respondents felt that they received any help from their relative's physician in understanding psychological changes, and only half felt they received any help understanding the physical aspects of aging.

More recently, Hasselkus (1992) audiotaped 40 clinic visits, each involving a patient, physician, and care giver. The study found that care givers and physicians had very different perceptions of the care giver. Both the care givers and the physicians (and sometimes the patients) came to the clinic and promoted their own agendas for structuring the visit, thus indirectly structuring the patient's care. The amount of effort required and the high involvement with the particular illness of the elderly loved one results in many care givers accumulating some degree of expertise in the specific health domain, especially as experienced uniquely by their loved one. Thus, family care givers frequently assume traditional physician responsibilities during the visit, such as making diagnoses and interpreting symptoms. The care givers seemed to view themselves primarily as practitioners and physician colleagues. Alternatively, physicians tended to view the care givers as substitutes for the patients or as second patients.

To the care giver, the physician was viewed as a resource from whom to obtain guidance or against whom to bounce off their most recent diagnoses and treatment suggestions. The relationship between

the family care giver and the medical doctor was viewed by the care givers as one between two practitioners as was, thus, very different from a relationship between doctor and patient.

The physician, on the other hand, seemed to view the care giver largely as a substitute for the patient—substitute ears and eyes, substitute mental alertness, substitute mobility, substitute source of information. Only very rarely did the physician interact with the family care giver as a care partner with whom to negotiate and exchange knowledge.

Aronson (1992, p. 14), reporting a study of 28 in-depth interviews with women who identified themselves as relying on the support of daughters or as feeling responsible for their mothers, provided a vivid example of the conflict between care giver and physician: A 47-year-old subject felt that her mother's doctor prescribed sleeping pills carelessly and was worried about her mother's depression. After cleaning her mother's apartment and disposing of the accumulation of pills, she phoned him only to be told, "Well, mother's getting older, you know, and I can't be responsible for her behavior." The encounter confirmed the respondent's impression that doctors have little interest in old people and her sense that "I knew I was on my own." Recognizing that she was on her own prompted this subject to resolve that she would not seek the help of the family doctor again.

Hasselkus (1992) provided a general explanation of the conflict by acknowledging that the care giver must act as an independent care provider, making day-by-day decisions about the meaning of the care receiver's illness and the treatment that must be given. However, during the brief, periodic forays back into the medical setting, the family care giver must largely relinquish the practitioner role and accept instead roles as a patient substitute or a patient her- or himself. Thus, the caregiver's role in the medical setting is very different from her or his role at home.

A variety of roles may be played by the physician in decisions concerning the institutionalization of the elderly, varying from no role whatsoever to actually making the decision. In between we may see such roles as the physician reducing tension and dissonance after the decision to institutionalize the elderly person is made (Baumgarten et al., 1976), the adult children shifting the parent's blame from themselves to the doctor, or the doctor's authoritarian role as being one that helps all parties accept the realities of the situation. If Medicaid is involved in the decision, the physician must play a gatekeeper role. Hill, Cacia, and Shamsey (1992) found that physicians participating in managed care organizations were perturbed by the increasing likelihood of their playing gatekeeping roles. For instance, one physician in the Hill et al. (1992, p. 559) study commented, "You end up being the 'gatekeeper' and you wind up fighting with the patients, which is the last thing you want to do. You're painted as the evil one!" Thus, the possible

roles played by the physician can be quite varied and all can have an important impact on elderly health-care decision making.

HYPOTHESES

The study will investigate the perceived role of the physician in housing-related health-care decisions faced by the elderly. Following the findings of Beisecker (1988), we expect that older consumers will perceive the physician's role to be a more influential one than will younger consumers. Further, we expect that those with previous experience with such decisions will also perceive physicians to play a stronger role. Implicit in these hypotheses is the assumption that physicians do play a major role in health-care decisions for the elderly. The limited literature available on the physician's role in nursing-home decision processes (Goldstucker, Bellenger, & Miller, 1974; York & Calsyn, 1977) supports this assumption.

METHOD

Census data for a large midwestern city were used to identify those tracts with high percentages of elderly residents, which were oversampled, and those tracts with large numbers of residents under the age of 35, which were undersampled. The survey instrument went through three pretest stages, with the last one involving personal interviews with elderly respondents. Questionnaires were distributed using the drop-off and call-back approach, with the starting points for the distribution being selected randomly within the census tracts. Respondents were identified as being over 35 years of age, and then asked to complete the questionnaire in the short run. The surveys were picked up an hour or so after being left. In those cases where the respondent was busy but willing to complete the survey later, a postage-paid envelope was left so that the questionnaire could be mailed. Approximately 20 personal interviews were conducted with elderly respondents who were unable to complete the survey without help; these respondents either had visual or physical problems that limited their ability to complete the questionnaire on their own. Fewer than 50% of the households contacted refused to complete the survey; however, only one attempt was made to reach each household. Most of the surveys were distributed during the early evenings or on weekend days in an attempt to reduce nonresponse. In total, 587 surveys were completed.

The data-collection approach allowed us to investigate perceptions of the nursing-home admittance decision across a broad continuum from young to old. However, the approach did not allow us to compare the views of adult children with those of their elderly loved ones in

nursing homes. Such a data-collection approach would be difficult due to the fact that, given our mobile society, many adult children are separated geographically from their elderly parents and due to the frequency of dementia among nursing home residents.

Measures of the Physician's Role

As mentioned earlier, respondents were asked "Who is likely to make health-care decisions for you when you can no longer take care of yourself?" Those selecting the physician were contrasted with those who did not.

A second question dealt with one's reaction to a doctor's recommendation to place a loved one in a nursing home: Seek a second opinion, follow the doctor's recommendation, or ignore the doctor.

Finally, the respondents were asked whether they agreed with the following roles that a doctor might play: primary decision maker, formal consent needed to qualify for financial support, reducing your uncertainty about what is correct to do, reducing the loved one's uncertainty, and/or virtually none at all. As Baumgarten, et al. (1976) indicated, an important role played by doctors is to reduce tension and dissonance after the decision is made.

RESULTS

The final sample size was 587. Of the respondents, 66% were under 55, 16% were between 55 and 64, 12% were between 65 and 74, and 5% were 75 or older.

Table 2 shows the responses of the younger adult versus the responses of the elderly to the role of the physician in the decision to place a loved one in a nursing home. The age used to separate the two groups was 55, as it is commonly used to delineate the mature market (Lazer, 1985; Leventhal, 1991; Moschis, 1992). Further, sample-size concerns were relevant in our selection of 55 as the break point. However, analyses done with 65 and over as the break point yielded a similar pattern of results.

Respondents were initially asked, "Have you, a parent, or any other loved one ever experienced any care from a nursing home?," and 70% of the sample indicated that they had. Responses to the question "Who is likely to make health-care decisions for you when you are no longer able to take care of yourself?" were "Children" (75%), "Spouse" (71%), "Yourself" (32%), and "Physician" (23%). "Physician" was several times more likely than responses such as "Friend," "Clergy," and "Other Relatives." Those over 65 years of age were much more likely to list the physician as a decision maker (chi-square=13.1,6 *df*, $p<.05$). The two age groups most likely to list "Yourself" as the person making health-

Table 2. Responses to the Role of the Physician in the Decision to Place a Loved One in a Nursing Home.

Variable	Respondent Group Younger Adult (Younger than 55) n = 378	Elderly Older than 54) n = 195	*p* value
Selected physician as someone likely to make a health-care decision for the respondent	21%	26%	ns
Reaction to doctor's recommendation to place a loved one in a home.			
Seek second opinion	65%	50%	
Follow it	30%	49%	.001
Ignore it	5%	1%	
What should the doctor's role be:			
Primary decision maker	7%	15%	.01
Formal consent needed	33%	30%	ns
Reduce your uncertainty	65%	64%	ns
Reduce loved one's uncertainty	14%	8%	.05

care decisions were from 35 to 44 and the group over 75 years of age (chi-square=19.4, 6 *df*, p=.003). (We found the oldest respondents, all of whom were not living in a nursing home, to be very independent in their thinking and very intense in their desire to remain independent.)

In terms of their reactions to a doctor's recommendation to place a loved one in a nursing home, 59% indicated that they would seek a second opinion, 37% that they would follow the recommendation, and 4% that they would ignore it. One's age was strongly related to the perception of the correct role for the doctor's recommendation (chi-square=45.7, 12 *df*, p=.000). Younger respondents were more likely to ignore it; however, none of the respondents over 75 would ignore it. The majority of those in all age groups, except those between 65 and 74, would seek a second opinion; the majority of those between 65 and 74 would follow the recommendation. This pattern of results indicates that younger respondents have little awareness of the aging process and the increasing importance that physicians play in one's life. Further, those elderly over 75 who are still independent apparently resist threats to that independence, but are not willing to ignore the advice of doctors.

Most respondents (64%) perceived that the correct role of the physician was to reduce their uncertainty about what is correct to do. Those who have experiences with nursing homes were significantly more likely to select this response (chi-square=4.2, 1 *df*, $p<.05$). Approximately 35% perceived that the physician should reduce the loved one's uncertainty, whereas only 12% said that the physician should have virtually no role in the decision. Approximately 25% of the

respondents over 75 indicated that the doctor should have no role, which was significantly higher than the younger age group (chi-square=16.1, 6 *df*, $p<.03$). Only 10% said that the physician should have the primary role; those over 65 were significantly more likely to indicate that the doctor should play the primary role (chi-square=14.7, 6 *df*, $p<.03$). Finally, 32% said that the physician's role should be one of providing formal consent to the admission process.

Logistic regressions were run with the physician role perception variables as the dependent variables and age and experience with nursing homes as the independent variables. The significant logistic regression results are reported in Table 3.

In general, the conclusions reached when discussing the cross-tabulation results are consistent with the findings here. Older respondents are more likely to select the doctor as a decision maker, are more likely to accept the doctor's recommendation of going to a nursing home (without getting a second opinion), and are more likely to see the physician as having the primary role in the nursing-home decision. Those with past experiences with loved ones in nursing homes were less likely to select themselves as a decision maker in the nursing-home decision, and more likely to accept the doctor's recommendation to go to a nursing home and to see the doctor's role as reducing one's uncertainty about what is correct to do.

CONCLUSIONS AND IMPLICATIONS

The decision to place a family member into a nursing home is a very traumatic one for families. The role of the doctor in this process has

Table 3. Significant Logistic Regression Results.

Selection of the physician as a decision maker	
Selection of doctor = −2.16 + 0.019 age + 0.15 experience	
$p = .01$	$p > .1$
Selection of yourself as a decision maker	
Selection of yourself = 0.40 − 0.0051 age − 0.40 experience	
$p > .1$	$p < .06$
Acceptance of doctor's recommendation (don't seek second opinion)	
Acceptance = −1.83 + 0.027 age + 0.36 experience	
$p < .001$	$p < .1$
Doctor should play primary role	
Primary role −3.35 + 0.022 age + 0.19 experience	
$p < .03$	$p > .1$
Doctor should reduce your uncertainty	
Reduce uncertainty −0.89 + 0.0037 age + 0.37 experience	
$p > .1$	$p < .06$

received little investigation. Respondents with experience with placing a loved one in a nursing home do indicate a somewhat stronger role for the physician than do those without such experience. This study indicates that the perception of that role varies with age; as one ages, the necessary role of the physician becomes clearer. To some extent, the results support the contention that people do not face the reality of age-related health problems unless they have no choice. Health-care providers have to deal with the illusions held by adult children as to the feasibility of care giving, as well as the more justifiable determination on the part of the elderly to maintain their independence. The health-care provider must, therefore, understand the dynamics of the elderly residence decision process, which includes guilt on the part of the adult children and fear on the part of the elderly. With this knowledge, the provider can attempt to make the elderly residence decision as acceptable as possible to all parties concerned.

Further, the discrepancy in perception between the elderly and adult children may mean that promotional materials accurately dealing with the decision process may not be well received by adult children. Adult children may require educational materials that help them to understand better the transition that their parents are facing, whereas materials for the elderly themselves might focus on how the trauma faced during the transition will be reduced to the extent possible.

Nursing homes need to focus much attention on marketing their services to third parties as opposed to marketing directly to families. York and Calsyn (1977, p. 502) concluded

> Physicians and hospital personnel are the largest single source of referrals to nursing homes. Since physicians and hospital social workers seem to be the most influential people in the decision to place a relative in a nursing home, any information and a referral service that ignores this infuence process is probably doomed to failure. A majority of the families in the present study were unaware of the existence of information and referral services and went directly to the physician or hospital social worker for advice.

Our results indicate that the role of the physician may be even more important for the very old, who constitute the bulk of the nursing-home residents. The current cohort of elderly do listen to doctors; this is not a new finding. However, our results indicate that, although respondents over 75 are likely to resist advice from family and friends concerning nursing homes, they do take advice from physicians seriously (even though they may seek a second opinion). The results also indicate that physicians may need to help increase the adult children's awareness of the situation faced by their parents and of the various health-care services available to them. The fierce desire to remain independent on the part of many elderly may be supported by even dis-

tant adult children through the use of a growing array of services. The results also indicate that physicians may need to help increase the adult children's awareness of the situation faced by their parents and of the various health-care services available to them.

Although family physicians have expertise in a broad range of health issues, it may be that they need to acknowledge more the expertise of the care giver in the specific health domain confronting the elderly loved one. Even if the care giver has not educated her- or himself as to the specifics of the disease, she or he still may be able to provide insights as to the nature of the problem that the patient cannot. Physicians who distance themselves from care givers may miss the opportunity to tap their expertise or, more likely, miss the possible use of a very valuable information source. Further, alienation of the care giver may well stimulate negative word of mouth that can greatly damage the physician's reputation. The physician's role in the residence decision for the elderly may well change over time, due to a variety of reasons. First, the education level of the elderly is increasing rapidly as new cohorts age, and the acceptance of medical advice may be less of an automatic decision for those with higher educational levels. Second, physicians themselves may be seeking to play a less significant role, as malpractice suits are becoming a more serious issue (Kaufman, 1988). Nonetheless, providers of long-term health care must acknowledge the physician's role in health-care decisions and should promote their services to physicians as well as to the elderly and their adult children.

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