EXCHANGE, POWER, AND COMPLIANCE: A SCOTTISH AND AMERICAN COMPARISON IN TWO INSTITUTIONS FOR THE AGED

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INTRODUCTION

Few studies of long-term care institutions have examined the social interaction between the nursing home staff and the elderly and how the nature of this interaction is related to quality of care. This report, a cross-cultural comparative study of one long-term care institution in Scotland and one in the United States, using social exchange theory as a framework, argues that there is a correlation between resources and the quality of care for the institutionalized aged. It is not suggested that resources alone determine the quality of care. Elsewhere I have presented detailed discussions of such multiple factors as the financing, organization, and delivery of health care, the demographic characteristics, physical disabilities, and functional disorders of the residents, and the differences in medical and nursing care that also account for disparity in care (Kayser-Jones 1981). The purpose of this paper is to discuss the relationship of patients' resources to the quality of care and to demonstrate that in these two institutions (similar in some respects and dissimilar in others), exchange of resources between staff and patients does occur and that these exchanges, small as they are, make a critical difference in the quality of patient care.

THE STUDY

Using anthropological field methods, I compiled data during three months of fieldwork in a 96-bed government-owned, model geriatric hospital in Scotland (Scottsdale) and four months in a similar 85-bed proprietary nursing home in the United States (Pacific Manor); both names are pseudonyms. These institutions were selected for study because they were comparable in size, types of patients, service, and provision of medical and nursing care to the aged with chronic physical disabilities. In Scotland, the government owns most health care facilities; a government facility was therefore selected as most representative. In the U.S., 5% of the institutions for the aged are government-owned, 18% are voluntary nonprofit, and 77% are proprietary (U.S. Department of Health, Education and Welfare 1979). Proprietary homes may have a high percentage of public-pay (Medicaid) or private patients, or some combination thereof. It has been found that the higher the number of Medicaid patients, the lower the quality of care; conversely, homes with a high proportion of private patients provide a higher level of care (Gottesman and Bourestom 1974). The proprietary, public-pay institution is most typical. However, not wanting to compare the best of Scotland with the worst possible analogue in the U.S., I selected for study a proprietary home (reputed to be one of the finest) which admitted only private patients, though it continued to care for those who had exhausted their personal resources and were then placed on Medicaid.

Data Collection

Participant observation and structured interviews were used to gather data. Participant observation was my primary research tool because I believed that direct observation of the elderly, going about their daily activities in interaction with staff members and others, would provide new insights into the problems of institutional care.

Initially, I obtained a broad overview of life in each institution. I spent six to eight hours a day in the facility, making observations at various hours throughout the day, during mealtime, bath time, visiting hours, and at social and recreational functions. Through informal interviews, I attempted to learn from the aged what it is like to be old, disabled, and institutionalized, and their perspective on factors that contribute to high- or low-quality care. From these interviews, I found that staff-patient interaction was of great importance to the elderly. Since nursing staff are the primary caregivers, I administered a questionnaire measuring residents' assessments of care to 25% of the aged in each facility. Residents were asked, "How do you feel about your nursing care?" or "How do you find the nurses?" Responses were ranked on a scale of 1 to 5, 1 representing complete dissatisfaction and 5 complete satisfaction with care. Subsequently, a mean was computed.

Interview Data

At Scottsdale, 88% of the respondents expressed complete satisfaction with nursing care, 12% partial satisfaction, and none dissatisfaction; the mean was 4.5. Typical responses were "The nurses are very kind; they are so understanding." Patients especially valued the nurse who was kind under adverse circumstances such as wetting the bed. "When I have accidents, I feel so ashamed, but they don't make a fuss." "They don't treat me as if I were a baby," remarked one woman.

At Pacific Manor, 35% of those interviewed expressed complete satisfaction with care, 40% partial satisfaction, and 25% complete dissatisfaction; the mean was 3.25. Many of the responses indicated unhappiness and dissatisfaction with care. Typical responses were "They don't like me." "When I ask them a question, they won't answer me." "I never know when they will get angry at me."

Observation of Patient-Staff Interaction

The interview data clearly suggested that there was a significant difference in the nature of patient-staff interaction in the two institutions; information collected through participant observation confirmed these data.

At Scottsdale, on the whole, residents were treated kindly, their wishes were respected, and they were cared for with dignity. By comparison, at Pacific Manor, staff often were authoritarian toward residents, showed little concern for their dignity, and sometimes treated them unkindly and with disrespect. For example, incontinent patients were scolded as if they were children; staff, speaking in a parental voice, commanded them "Eat!" "Stay in your chair!" "Go to your place for lunch!" Sometimes, if residents did not comply, they threatened them. Frequently, staff ignored calls for help and often walked by residents without responding to their greetings. Pacific Manor residents were subjected to dehumanizing experiences that often centered on bathing and elimination. Patients' genitals were carelessly exposed, men and women were bathed simultaneously in the shower room, and, because of staff inattention, residents sometimes urinated and defecated in public places.

Theft of residents' food, clothing, money, jewelry, and other personal items was common at Pacific Manor. Their attempts to hide personal belongings from the staff were usually unsuccessful. Some of the aged, having been warned of the theft problem, gave valuables, even wedding bands, to relatives before admission. The loss of personal belongings further served to depersonalize the elderly.

Although food, activities, and medical care were also important to the aged, staff-patient interaction was found to be one of the most important variables in measuring quality of care. Many residents have few visitors; the nursing staff may be the only people with whom they interact. The elderly depend on them, not only for physical care, but for social interaction, emotional support, and maintenance of self-respect and self-esteem.

Disrespectful treatment of residents was not seen at Scottsdale, but it had a devastating effect on the Pacific Manor residents. There was a sharp contrast in the appearance and behavior of the elderly in the two institutions. At Pacific Manor, residents appeared apathetic, depressed, and withdrawn; they sat restrained in chairs, slumped forward, head bowed, eyes closed, and hands folded in their lap. By comparison, at Scottsdale, the aged looked alive and alert, had animated conversations with staff and other residents, expressed interest in themselves, others, and current events, often read books, made handicrafts, or rolled about the hallways in wheelchairs.

The quality of care was high at Scottsdale, and significantly lower at Pacific Manor; within each institution, however, there was a disparity in quality of care. This was especially evident at Pacific Manor. A few residents received preferential care; some, minimal custodial care; others were ignored and neglected. Through informal interviews with the elderly and meticulous participant observation, I learned that those with resources were able to negotiate special services, whereas those without resources had no power to bargain for better care. I therefore propose exchange theory as a vehicle to explain the differential quality of care.

MAJOR PROPOSITIONS OF EXCHANGE THEORY

Exchange refers to the transaction of labor, resources, and services within a society and plays a vital part in the social life of all societies. "Exchange is not restricted to economic markets: social exchange is ubiquitous" (Blau 1968:453). Malinowski (1922), in his description of the kula, and Mauss (1925) in his analysis of gift exchange, were the first anthropologists to observe this phenomenon, and they greatly influenced the development of exchange theory. Homans (1961), Emerson (1962, 1972), Blau (1964), and Ekeh (1974) have also made major contributions to exchange theory.

Social exchange theory posits that people enter into social relationships because they expect them to be rewarding; a person who derives benefits from another is obligated to reciprocate by supplying some benefit in return. When the person reciprocates, both parties benefit and a social bond develops. Thus, social interaction will probably continue. If the individual fails to reciprocate, he may be accused of ingratitude, and the incentive to continue the interaction is removed. In every interaction, costs (the resources one gives to the other) are inevitably incurred. If one perceives the cost to be equal to the reward, the exchange relationship is in balance. If, however, one participant values the reward more than the other, an imbalance results. That participant then loses power, and a unilateral dependence develops (Emerson 1962, 1972; Blau 1964).

Numerous investigators have discussed the relationship between resources and power, examining how control over resources contributes to the role and status of elders in various societies (Simmons 1945; Carrasco 1959; Arensberg and Kimball 1961; Goody 1962, 1976; Spencer 1965; Colson 1982). Simmons, for example, states, "Property rights have been lifesavers for the elderly" (1945:36). And Colson in describing old age in Gwembe District states, "As for today's senior elders, what influence they have derives from whatever wealth

they have managed to retain, from the belief that they possess powerful medicines, and from the mystical power of the shades of the dead that are attached to their persons" (1982:141).

Dowd (1975) sees the problem of aging as one of decreasing control over power resources. As resources decline, the aged, unable to engage in balanced exchange relationships, are forced to exchange compliance for continued sustenance.

INSTITUTIONALIZATION AND THE DECLINE OF POWER

The propositions of exchange theory are especially relevant to the care of the institutionalized aged. The elderly, obviously, cannot engage in balanced exchange relationships without resources, and the loss of resources is characteristic of nursing home residents. Typically, they are 75 to 80 years of age, single women (widows, divorcees, and never married) who have many chronic physical and mental disabilities. Many, if not indigent on admission, find their financial resources quickly depleted by the high cost of institutional care (Kane and Kane 1978; USDHEW 1979). Estes (1979) notes that over 47% of nursing home costs in the U.S. are paid by Medicaid for patients who were not initially poor (U.S. Congress 1977). These facts illustrate that in the U.S. the institutionalized aged, who are in need of many services, have few resources with which to reciprocate. Physical and mental impairment may curtail the use of previously valued skills, and if they do possess skills, they are often not acknowledged or used. Furthermore, once they enter the institution and take on the status of "nursing home patient," any social position they may have had is lost. The mere fact of becoming a "patient" entails a loss of status and prestige, a feeling of helplessness, loss of control over one's environment, loss of freedom to make decisions, and dependency on others for life-sustaining services (Becker 1962; Moore 1970; Tagliacozzo and Mauksch 1972). The caregivers, therefore, have the authority and power that is common to many professional-client relationships.

Power is the ability of persons or groups to impose their will recurrently on others—despite resistance—either by withholding regularly supplied rewards or by punishment. By supplying regularly needed services to those who cannot reciprocate, a person establishes power over them, and they are forced to comply with that person's wishes. In power-dependence relations, individuals who need services have the following options: (1) they may supply a service in return, (2) they may obtain the service elsewhere, (3) they may use coercion to obtain the service, or (4) they may do without the service. If they are unable to choose any of these alternatives, they must comply with the wishes of the one in power, since he can make the continuing supply of needed service contingent on compliance (Blau 1964).

Many Pacific Manor residents are unable to choose any of the above alternatives. For example, one woman was dependent on the staff for bathing, but she objected to being placed in the shower room with male patients. "I don't know how the men feel," she said. "I find it disgusting, but what can I do?" She was too disabled to perform a return service for the staff, could not obtain the service elsewhere, had no power of coercion, and could not manage without the service. Her only alternative was to comply with the staff's wishes. She realized that if she complained, the service could be withheld. That threat was so powerful that proud, elderly people at Pacific Manor, who would normally have protested vociferously when subjected to such dehumanizing experiences, usually acquiesced.

THE APPLICATION OF EXCHANGE THEORY TO CARE OF THE INSTITUTIONALIZED AGED

Institutions for the aged provide a microcosm for viewing aging as a process of social exchange. As mentioned above, resources are essential if people are to engage in balanced exchange relationships, and yet many of the elderly at Pacific Manor were virtually without resources. They were poor; 50% of the residents were formerly private patients who became impoverished through long-term care and were placed on Medicaid. Medicaid stipulates that they be permitted to keep $25 per month of their Social Security benefits for personal use. The likelihood of theft prevented them from keeping money in their rooms. Some residents kept a small amount of money in the business office, but there was no shop in the facility where they could purchase gifts and sundry items. Also, there was no occupational therapy that enabled them to produce items to exchange for services.

By comparison, the elderly at Scottsdale had resources that enabled them to reciprocate for services given. They made items in therapy that were valued by others. Some women, for example, knitted beautiful scarves and sweaters; others made lovely trays, padded coat hangers, and children's toys that they sold or gave to staff, family, and friends. These items provided residents with resources that they gave in exchange for services, and enabled them to engage in balanced exchange relationships. The exchanges also contributed toward the establishment of social bonds; it is unlikely that a nurse will treat a patient unkindly once a social bond has developed between them. In addition to making products for exchange, the Scottish patients had money and access to a shop where they could purchase articles to give to others. Frequently, I observed patients giving small gifts to a favorite nurse, and I too was often the recipient of small presents. The elderly valued my lengthy visits and rewarded me with gifts of chocolate bars, cookies, coat hangers, and homemade marmalade. The marmalade provides an interesting example of a successful exchange system. The minister of one of the Scottish women made delicious orange marmalade, which he sold at a small profit. Each time he came she ordered several jars, which he delivered on his next visit and which she, in turn, gave to staff members who were especially kind to her. "I am good to people who are good to me," she informed me.

Despite their lack of resources, some elderly at Pacific Manor managed, through ingenuity, to develop balanced social relationships with certain staff members, and these few received a higher quality of care. One woman, for example, had a skill that she exchanged for services; she altered and mended clothes for a nurse aide who, in turn, did personal shopping for her. Another woman had an attentive daughter and numerous friends who visited frequently and provided her with money and gifts of food that she managed to hide and later used to purchase favors. For example, she negotiated with a nurse aide to wash her hair and she, in turn, paid $1 for the service.

Patients devoid of such resources, however, could not engage in balanced relationships, did not establish social bonds; their care was of lower quality, and staff had power over them. Mrs. Arny, for example, was a widow; her only son was mentally retarded and lived with her brother in a city 300 miles away; she saw them once a year. She was paralyzed from the waist down, was poor (on Medicaid), and had no visitors. She had virtually no resources with which to reciprocate for the many services she needed. The staff, consequently, did only what they had to do for her. They got her up in a chair, sat her beside a window (which she could not see out of, as the chair was too low), and there she remained all day. "The nurse aides never bother to put her in the lounge," said one nurse. "It is easier for them to just leave her in her chair beside the bed." When her urinary catheter leaked and her bed became wet, the staff refused to change the linens. She could do nothing to negotiate for dry bed linens. Obviously, she was not responsible for the leaking catheter, but the staff reacted to the incident as if she were. "You just lay in it now," they told her. "It is best not to get angry with the nurses," Mrs. Arny said. "I just keep it inside."

Some may ask why the aged need to "purchase" care with small gifts when their care is paid for by the government or through personal funds. Individuals, however, value noneconomic as well as economic rewards, and people seek psychic as well as material gratification (Maddox and Wiley 1976). Resources are essentially anything perceived by the exchange partner as rewarding; it may be a skill, money, or food—anything that someone has and the other values or wants (Blau 1964). For example, although health care workers receive payment for services they give, it is especially rewarding to care for the person who shows some expression of appreciation. The patient who says "Thank you" or gives some overt indication of approval of care is providing a psychic reward in exchange for service, and thus may ensure continuing, attentive care.

One woman at Pacific Manor had few material resources, and yet she was clearly given preferential treatment. She was always taken to the table of her choice for meals, was permitted to stay up as late as she wished (most patients were put to bed between 4 and 6 p.m.); she was treated with respect and not subjected to dehumanizing experiences. From observation and on questioning the staff, I learned she was indeed a gracious and charming woman who never failed to express appreciation for even the smallest service. "We all like to take care of her." Clearly, even small psychic rewards can be considered a fair exchange. But the person who has neither material resources nor personal charm is devoid of bargaining power.

NEGATIVE EXCHANGE

Although social exchange by and large concerns a reciprocal giving and receiving of goods and services, some theorists have included negative exchange as an element of social exchange. Homans (1961) speaks of exchanging punishment, Blau (1964) and Kiefer (1968) refer to offenses that call for retaliation, and Sahlins (1965) and Price (1978) discuss "negative reciprocity." Negative exchange may partially explain the mistreatment of the residents at Pacific Manor. As noted above, many Pacific Manor residents have few resources but require long-term care. In our culture, they are seen by the productive members of society as useless, dependent, and nonproductive—as a burden and a nuisance. Clark (1972) discusses how one who becomes a burden is seen as having nothing of value to exchange; his is a nonreciprocal role. If individuals are arbitrarily defined as having nothing of value to exchange, they are expecting something for nothing, and, in our culture, with its emphasis on self-reliance, negative sanctions are usually brought against them. The dehumanization and victimization I have described illustrate the negative sanctions brought to bear against those in nonreciprocal roles.

Sahlins (1965:148) defines negative reciprocity as "an attempt to get something for nothing with impunity." Haggling, gambling, chicanery, and theft are various means used by some to profit at another's expense. Negative reciprocity helps explain the thefts that occurred at Pacific Manor. The staff have few social bonds with the aged and therefore victimize them for personal gain; punishment is highly unlikely. The elderly cannot retaliate; their families may complain, but their complaints are ignored, and the administration sees theft as an unsolvable problem. It is advantageous, therefore, for the staff to steal from patients; they can do so without recrimination.

Although this paper emphasizes the relationship of resources to quality of care, I am not suggesting that the aged must negotiate for every aspect of care, nor am I suggesting that the establishment of exchange networks will resolve the complex issue of nursing home care. Staff do receive salaries in exchange for services, but the informal process of gift and service exchange occurs in many institutions where health care is provided. In acute-care hospitals, patients often give gifts of candy, fruit, and other items to the medical and nursing staff. Such exchange is ubiquitous and is so much a part of the social structure that when it is no longer possible, people either disengage or withdraw from social interaction (Dowd 1980). Reciprocity is fundamental to most forms of social interaction (Simon 1980), and is especially important to

the elderly in nursing homes because they are institutionalized for extended periods of time and require many services.

The provision of quality care to the institutionalized aged is a complex problem, which necessitates a multidimensional approach (Penning and Chappell 1980). Social exchange theory is one approach to use in examining the problem. Perhaps other models could be used to explore the issue. Marshall's (1973) work, utilizing game theory, and Goffman's (1961) concept of total institutions could provide alternative interpretations. These perspectives, however, are not separate from but rather related to exchange theory. Exchange theory, for example, is fundamental to the concept of total institutions. Residents of total institutions have few resources; their life is characterized by oppressive controls, poor living conditions, and physical assault; and they are among the most powerless in society (Parenti 1978).

CONCLUSION

In comparing the care of the aged in an American and a Scottish institution, a relationship between the quality of care and the resources of the elderly was found. In Scotland, the elderly have resources and are able to engage in balanced social relationships; they are, therefore, not as subject to the power of the staff. In the American nursing home the elderly have relatively few resources, are more dependent, and staff have power over them; patients must exchange compliance for essential services.

In a society that values self-reliance and independence, it is critical that the elderly not be impoverished through long-term care. Penning and Chappell (1980) emphasize the importance of autonomy and independence for the institutionalized aged; Brody (1973) observes that some sense of power and degree of control is essential to the integrity of the personality. People who are poor and disabled have little power to negotiate for care, and structures that will provide the elderly with negotiating power need to be instituted. On a broad scale, this would require changing the Medicare and Medicaid system so that the aged are not impoverished through long-term care. Such reform, however, may not be realized for years. Nevertheless, we have seen that access to meager resources can have a positive effect; the evidence that even in a restricted environment, some elderly attempt to negotiate for care emphasizes the importance of resources. An effort should be made, therefore, to create a milieu in nursing homes that will increase the availability of resources and thereby give the aged some independence and autonomy. A locked cupboard, for example, would provide a safe place for money and personal belongings. The elderly should be encouraged and enabled to use their skills to produce items of value that they could exchange for services, and small shops within nursing homes could provide them with additional items for exchange.

This research illustrates that exchange of resources between staff and residents does occur and can have a positive effect on patient care. Further research is needed to determine if such exchanges occur in other nursing homes and if the aged voluntarily offer resources in exchange for services, or if they feel compelled to do so.

To understand further the dynamics of nursing home care, studies are needed that will focus on staff-patient interaction with an aim toward analyzing the inhumane treatment of the elderly in nursing homes. The problems of old age are magnified for the institutionalized aged; many are very old, disabled, and poor, and some are without family or friends. Social exchange theory explains why some nursing home residents receive better care than others and offers insight into why the elderly fear dependence. Dependency leaves them vulnerable to the power of others.

NOTE

This research was supported by U.S. Public Health Service Training Grant GN-1224. A shorter version of this paper was published in 1983 as a "Brief Communication" in *Human Organization* 42:55-57. A book-length report of this research, entitled *Old, Alone, and Neglected: Care of the Aged in Scotland and the United States,* was published by the University of California Press in 1981.

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