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Health Care Law

The Role of Physicians in Nursing Home Litigation

By David R. Cohen

All too often in nursing home litigation, attorneys ignore one of the most important players of the interdisciplinary team — the physician. Federal regulations establish that the role of the medical director is central to resident care and the operation of the nursing home, while industry standards confirm and bolster their importance. These standards are often far afield from the truth on the ground.

In February of 2003, the Department of Health and Human Services released its "Nursing Home Medical Director's Survey." The report noted that 72 percent of all medical directors spent less than one to four hours per week at facilities and 70 percent indicated that the role of medical director constituted somewhere between 1 and 10 percent of their medical practice. Eight percent admitted that they were not licensed to practice medicine in the state in which they served as a medical director. Fewer than half responding had achieved special qualifications with regard to the care for geriatric patients. Only 39 percent of the respondents indicated that they were involved with ensuring at admission the availability of patients' prior medical records and advance directives. In fact, only 28 percent of the nursing homes even involved medical directors for that important function. There was similarly a very low rate of response with regard to the need to monitor nurse's aides and to promote training related to all staff's functional requirements.

In sum, many medical directors are by their own admission wholly or partly unaware of what is happening in the nursing home — with their hands very much not on the steering wheel of its operation — despite a regulatory responsibility for much more involvement. In the years that have transpired since this study, little has changed.

Federal Regulations

As most nursing home attorneys are aware, it is essential to obtain what is known as the Long Term Care Survey, otherwise known as the "Watermelon Book." This publication is updated quarterly and contains not only the regulations of the Omnibus Budget Reconciliation Act (OBRA), summarized as "F-tags," but additionally the very detailed Guidance to Surveyors.

F-tag 501 (F501) (42 CFR 483.75), updated in 2005, provides the simple instruction: "1) The facility must designate a physician to serve as medical director; 2) the medical director is responsible for (i) implementation of resident care policies, and (ii) the coordination of medical care in the facility."

The means by which F501 is implemented is contained within the Guidance to Surveyors:

> INTENT 483.75(i) MEDICAL DIRECTOR
> The intent of this requirement is that:
> • The facility has a licensed physician who serves as the medical director to coordinate medical care in the facility and provide clinical guidance and ... implementation of resident care policies;
> • The medical director collaborates with the facility leadership, staff, and other practitioners and consultants to help develop, implement, and evaluate resident care policies and procedures...; and
> • The medical director helps the facility identify, evaluate, and address/resolve medical and clinical concerns and issues that: [a] ffect resident care, medical care or quality of life; or [a]re related to the provision of services by physicians and other licenses health care practitioners.

OBRA's influence on physician roles in long-term care does not end with F501. CFR 42, Section 483.40, requires that a physician approves of each resident's

Cohen is a Certified Civil Trial Attorney, a shareholder with the law firm of Stark & Stark, and chairman of the Nursing Home Litigation Group of the American Association of Justice (AAJ).

admission and that the care of each resident is supervised by a physician (F385). The physician must review the resident's total program of care, including medications and treatments at each regulatory visit (F386). The totality of F-tags 385 through 390 provide a clear connection between physician's services and the entire panoply of clinical care services provided by the nursing home itself. Namely, physicians are clearly required to be involved in each aspect of the resident's care and care planning.

For years, many physicians had accepted the position of medical director without playing a very significant role in the operation of the nursing home or allowing it to play a significant role in their own practice. The 2005 changes to F501 have theoretically brought the physician more deeply into the interdisciplinary team and have made the physician a target for surveyors citing the facility for bad outcomes, yet the industry is slow in catching up with these changes.

American Medical Directors Association

Although OBRA and the attendant F-tags establish the conduct by which medical directors must adhere in order to avoid receipt of surveyor citations, the American Medical Directors Association (AMDA) has outlined the standard of care by which they must conduct themselves in the nursing home context. In fact, the 2005 revisions to F-tag 501 reflect suggestions long made by AMDA with regard to the important role these physicians play in the coordination of care for nursing home residents. F501 also makes explicit reference to AMDA, with the caveat that it does not explicitly endorse these standards.

AMDA's formal resolution and position statement regarding medical directors in nursing homes was updated in March of 2011 and may be found at: www.amda.com/governance/whitepapers/A11.cfm.

AMDA summarizes its view of the role of the medical director into four distinct areas: physician leadership, patient care/clinical leadership, quality care and education. What is clear is that the role of the medical director in the nursing home context should be much deeper and more involved than it historically has been. Buttressed by the changes to F-tag 501, AMDA has taken a leadership role for directors of these facilities in ensuring that physicians make it more than a part-time job.

As many medical directors also have patients in the nursing homes where they serve, practitioners should be familiar with the standards to which attending physicians in nursing homes must adhere and the nature of their relationship to the director. The resolution and position statement of AMDA with regard to attending physicians was updated from its 1991 format in March of 2003. AMDA provides in its introductory statement that "attending physicians should work with medical directors to address the obstacles, not cite them as a reason to avoid responsibility." The AMDA statement goes on to provide seven categories for which the attending physician is responsible: 1) resolutions and position statements; 2) introduction; 3) role and responsibilities; 4) physician leadership; 5) patient care/clinical leadership; 6) quality of care; and 7) education, information and communication.

Included in subsection 3 is the requirement that a physician "maintain progress notes that cover pertinent aspects of the patient's condition and current status and goals. Periodically, the physician's documentation should review and approve a patient's program of care." Portions of section 6 are also pertinent in the nursing home litigation context. These include: helping the facility provide a safe and caring environment; helping to promote employee health and safety; and assisting in the development and implementation of employee health policies and progress.

Finally, the attending physician is responsible for being alert to any observed or suspected violations of patient/resident rights, including abuse or neglect in accordance with facility's policies and procedures. AMDA views the attending physician as a much more central player in the provision of care to residents than is often seen in the realities of day-to-day nursing home operation. By confronting the attending physicians with these standards, interesting information can be derived from depositions and physicians can be re-sensitized as to what their role is supposed to be within the long-term care setting. Further, attending physicians have a reasonable expectation that orders for treatment and medication are followed. Failure to comply with such orders arguably constitutes a violation of F281. (See probe §483.20(k)(3)).

Frequently, nursing homes attempt to pass blame on to physicians for failing to return phone calls about critical events in a resident's life. When left unrebutted, such arguments can potentially gain traction. In fact, they are in contravention of the F389 and its interpretive guidelines (§483.40(d)), which notes that it is the responsibility of nursing home personnel to follow-up with physicians — not the other way around. Without obtaining a physician's deposition, the nursing home's attempt to pass the buck can go unchallenged.

Agency: Must the Nursing Home Answer for a Physician's Conduct?

In the state of New Jersey, the seminal case of *Arthur v. St. Peters Hospital*, 169 N.J. Super. 575, 583 (1979), and more recently, *Cordero v. Christ Hospital*, 403 NJ Super. 306 (App. Div. 2008) confirmed that under the appropriate circumstances, health care institutions may be vicariously liable for the conduct of physicians who are not otherwise in their employ. Analysis of how that applies in the long-term care setting is beyond the scope of this article, but is an issue of which the practitioner should be keenly aware.

Many observers believe that negative outcomes occur with the frequency that they do in the long-term care setting largely as a consequence of the lack of *medical* oversight over care planning and the delivery of care. Appreciation and use of the applicable standard for physicians in long-term facilities is essential in litigating the *why* of negative outcomes and their often tragic consequences. ■