In the year 2000, the Maryland State Legislature approved a package of legislation related to nursing homes. Among other things, the legislation mandated the Maryland Office of Health Care Quality (OHCQ) to create requirements for attending physicians and medical directors in Maryland nursing homes. Based on this mandate, the OHCQ drafted and then implemented in August 2001 an unprecedented set of detailed requirements.

Not surprisingly, these regulations have been controversial. Some physicians have objected to the idea of regulatory requirements for physicians or to specific portions; for example, requirements for some formal medical director training. The purpose of this article is to discuss in detail the rationale for these requirements, to consider the various concerns and objections raised by them, and to explain why they are relevant to rethinking physician accountability in nursing homes in Maryland and nationwide.

PROCESS FOR CREATING THESE REGULATIONS

The Political Foundation

These regulations arose from a political process based on public and legislative concerns about nursing home care in Maryland. A governor-appointed nursing home task force considered a broad range of testimony from many interested parties. Among the themes that arose during these hearings was concern about the consistency and quality of physician and medical director support for the care of a vulnerable population. Despite the relative scarcity of data specific to Maryland, task force members were aware of studies and reports identifying problems of physician participation in long-term care nationwide and of numerous case examples of problems related to healthcare decisions and services in Maryland nursing homes.

Ultimately, the task force recognized that nursing homes depended heavily on appropriate physician performance. They were informed of efforts for over more than two decades to identify appropriate clinical practices and physician responsibilities in the care of the elderly and medical director roles and responsibilities. They identified that the federal nursing home regulations require medical directors to play a major role in overseeing the overall quality of health care in nursing homes and in implementing clinical policies and procedures.

Even while hearing nursing homes express their frustrations about the difficulties of influencing and overseeing physicians, the task force could identify only a few fragmented efforts to evaluate or correct these problems. Thus, the task force ultimately recommended that the legislature require the OHCQ to draft explicit requirements for both attending physicians and for medical directors.

The Systems Foundation

As much as possible, those who drafted these regulations proceeded sequentially to give these regulations a rational basis. Those same steps (Table 1) are universally relevant, whether the goal is to consider similar requirements elsewhere or simply to clarify attending physician and medical director roles and responsibilities.

Analyzing the Population

A preliminary step is to review the problems and needs of the nursing home population; for example, they are often chronically ill or severely impaired functionally, most are elderly and frail, they take many medications, which alone or collectively can cause significant complications, and their physical conditions and problems often affect their function and quality of life.

Considering Basic Principles and Practices

After identifying the characteristics of the population, the next step was to consider basic geriatric principles and practices. For example, although chronic diseases cannot be cured, it is possible to identify and reduce many common risks and to try to anticipate and prevent certain complications. Also, one illness or condition may cause multiple symptoms, and a given symptom may have several simultaneous causes.

Identifying Practices and Related Care Processes

Based on the above, it was then possible to identify specific processes needed to care for this population in accordance with these principles. For example, nursing home patients need the attention of those who can properly identify symptoms and abnormalities, decide when abnormalities constitute problems requiring treatment, identify causes of those problems from among many possibilities, and select appropriate interventions. Certain systemic processes such as completing relevant documentation and evaluating patient outcomes must also occur. State and federal regulations also influence many of these processes.
• Review characteristics of the nursing home population
• Consider geriatrics and other relevant principles and practices
• Identify care processes and facility practices needed to address the problems and risks of the population in accordance with identified principles
• Identify specific physician roles and responsibilities relevant to caring for this population, based on identified principles and practices
• Identify current physician and medical director performance and practices in Maryland
• Identify known management principles and practices that affect performance and performance correction
• Identify the roles and responsibilities of a medical director relative to both physician and facility responsibilities, based on management principles and practices
• Define what attending physicians and medical directors should know and do to fulfill their roles and responsibilities
• Identify nursing home responsibilities to ensure adequate physician and medical director performance
• Draft the regulations according to the above considerations
• Send the regulations for review and comment, and then revise them
• Implement the regulations, review performance, collect data
• Give feedback to facilities about improving processes and performance
• Attempt to relate physician performance and medical director activities to patient care processes and patient outcomes

**IDENTIFYING KEY PHYSICIAN ROLES AND RESPONSIBILITIES**

Physician roles and responsibilities can be identified based on the above factors and a review of relevant literature, including recent efforts to specify physician process indicators.16 The next step was to identify, as best as possible, and compare current to desired physician performance (Table 2) and practices (Table 3). For example, effective geriatrics care depends on good problem definition (that is, distinguishing incidental symptoms or abnormalities from those reflecting a problem requiring an intervention). Physicians are supposed to be trained to analyze clinical information more thoroughly than other disciplines and to know how to make such distinctions. Therefore, it is reasonable to expect them to help nursing homes analyze the data they collect and draw appropriate conclusions and to discuss the significance of medical information with staff, patients, and families.

**IDENTIFYING KEY PHYSICIAN PERFORMANCE ISSUES**

Tables 2 and 3 also provide examples of the consequences of undesirable physician performance (Table 2, column 3) and clinical practice (Table 3, column 3), based on actual cases in Maryland familiar to the author.

**Uneven Performance in Maryland**

In Maryland, as in American society generally, physicians have a unique collective status. Our society generally holds physicians in high esteem and tends to give them the benefit of the doubt about their competence and credibility just by virtue of being a physician.17

But the physician record in nursing home care in Maryland is uneven at best. Many Maryland physicians perform admirably and do nothing to betray this trust. Others, however, abuse this trust and use these social advantages to escape accountability for poor practice and inappropriate performance. For whatever reasons, physicians may take out their frustrations and anger inappropriately on the facilities or on the patients under their care, sometimes by refusing to meet their responsibilities, by acting inappropriately toward other staff, or by refusing to change orders or attend to required documentation.

As a medical director for several decades in Maryland, I have experienced physician responses ranging from receptive to threatening and am aware of many cases where the same physicians have made the same mistakes or created problems repeatedly for years. Physicians just out of training or without any previous long-term-care experience may unknowingly provide problematic care, because they have never been trained to the contrary. But other physicians refuse advice or correction even after receiving a rationale for performance or practice expectations. Over time, many Maryland physicians in nursing homes have received little or no significant feedback about their practice or have not been held accountable for problematic performance—even when patients have suffered repeatedly from such problems.

For example, for almost four decades adverse drug reactions (ADRs) have been identified in the literature as a major issue in health care generally and the elderly in particular.18,19 Yet, many physicians in Maryland have their nursing home patients on 15 to 20 or more medications, often in large doses or without adequate indications for long-term continuous use. A common response to notification of a symptom or condition change is to add a medication instead of doing an appropriate assessment or reviewing for a possible ADR from existing medications. Probable ADRs such as falling, confusion, lethargy, and anorexia are plentiful.

Even after providing physicians with various articles in the medical literature about medication-related problems, such as falls or failure to thrive,20,21 only some of them try to identify and prevent adverse drug reactions. Some physicians have warned me “not to put my hands on” their patients, whereas others have asserted their right to prescribe whatever they please and implied that such studies may apply to others but not to them.

Although physicians often have legitimate concerns with some elements of nursing home practice, it is not unusual for them to simply vent their frustrations on nursing facility staff by failing to do things that the staff needs to care for the patients. For example, one physician responded to a letter detailing repeated episodes of attacking the nursing staff and failing to address certain patient issues by angrily denying all
When facilities assign patients to physicians who have not been meeting responsibilities or who have not been credentialed adequately, or to physicians who do not want them or who are unavailable, patients are left without adequate medical coverage.

When hospitals discharge patients to nursing homes, the ability to oversee appropriate care of a patient is lost, and if information, inadequate or problematic care results.

Special Article Levenson

Specific Physician Responsibilities in Long-term Care and Problems When Not Fulfilled

When a physician does not perform adequate medical evaluations, important risks are not identified and the causes of symptoms and problems are not determined.

When physicians do not respond to notification of new admissions for many hours, facilities cannot initiate treatments and medications in a timely fashion.

Physician Responsibility (As Listed in Maryland Regulations)

The attending physician shall accept responsibility for the patient’s care.

- Assess a new admission in a timely fashion, depending on the individual’s medical stability, recent history, and previous medical history, presence of significant or previously unidentified medical conditions, or problems that cannot be handled readily by phone.
- Seek, provide, and analyze needed information regarding a patient’s current status, recent history, and medications and treatments, to enable safe, effective continuing care, and appropriate regulatory compliance.
- Provide appropriate information and documentation to support a designated level of care for a new admission.
- Authorize admission orders in a timely fashion, to enable the nursing facility to provide safe, appropriate, and timely care.
- For a patient who is to be transferred to the care of another health care practitioner, continue to provide all necessary medical care and services pending transfer until another physician has accepted responsibility for the patient.

The attending physician shall support patient discharges and transfers.

- Follow-up as needed with a physician or another health care practitioner at a receiving hospital within 48 hours of the transfer of an acutely ill or unstable patient.
- Provide whatever summary or documentation may be needed at the time of transfer to enable care continuity at a receiving facility and to allow the nursing facility to meet its legal, regulatory, and clinical responsibilities for a discharged individual.

The attending physician shall provide appropriate patient care.

- Perform accurate, timely, relevant medical assessments.
- Properly define and describe patient symptoms and problems, clarify and verify diagnoses, relate diagnoses to patient problems, and help establish a realistic prognosis and care goals.
- In consultation with the facility’s staff, determine appropriate services and programs for a patient, consistent with diagnoses, condition prognosis, and patient wishes.
- In consultation with the facility staff, ensure that treatments are medically necessary and negative outcomes are medically unavoidable, in accordance with nursing facility regulatory requirements.
- Respond in an appropriate time frame to emergency and routine notification, to enable the facility to meet its clinical and regulatory obligations.

Rationale

- A physician’s knowledge of a patient’s medical conditions and treatments is pertinent to all subsequent care.
- Facilities must convey information when a patient is transferred.
- A physician is often best able to explain in detail why a patient is being transferred and what needs follow-up by another healthcare practitioner or provider.
- There are many well-established, pertinent, geriatric and medical principles that are relevant to the nursing home population.
- Physicians are trained specifically—and in more depth than any other discipline—to be able to analyze and explain the significance of most medical symptoms and test results and to determine when treatments are medically appropriate or may be problematic in many nursing facilities, few if any others can be expected to do so.
- Many other staff in a nursing facility depend on medical information and analysis to provide other aspects of care correctly.
- Physicians are legally authorized to be the ones to determine medical necessity.
- We may readily identify many clinical issues related to physician care (Table 3).

Identified Performance Problems (Based on Cases in Maryland)

- When facilities assign patients to physicians who have not been meeting responsibilities or who have not been credentialed adequately, or to physicians who do not want them or who are unavailable, patients are left without adequate medical coverage.
- When hospitals discharge patients to nursing homes with inadequate, conflicting, or incomplete information, inadequate or problematic care results.
- When physicians do not help review and explain information about a patient’s condition or problems, some facility staff do not understand what they are doing, resulting in inadequate care.
- When physicians do not respond to notification of new admissions for many hours, facilities cannot initiate treatments and medications in a timely fashion.
- When physicians do not adequately explain the reasons for transfer, the facility gets blamed for an inappropriate transfer or cannot defend itself against subsequent allegations of inadequate care.
- When a physician does not perform adequate medical evaluations, important risks are not identified and significant problems are inadequately or incorrectly managed.
- When a physician does not adequately explain the significance and the causes of symptoms and problems, clarifies and verifies diagnoses, related diagnoses to patient problems, and help establish a realistic prognosis and care goals.
- When a physician does not explain to facility staff the significance of and relationships between various problems and diagnoses, they render incorrect or inappropriate care.
- When a physician prescribes medications indiscriminately or without recognizing their risks, or does not recognize how they may cause new symptoms or condition changes, patients suffer serious adverse consequences, including delirium, falls, anorexia, weight loss, and dehydration that may result in avoidable decline, hospitalization, or death.

Table 2. Specific Physician Responsibilities in Long-term Care and Problems When Not Fulfilled

<table>
<thead>
<tr>
<th>Physician Responsibility (As Listed in Maryland Regulations)</th>
<th>Rationale</th>
<th>Identified Performance Problems (Based on Cases in Maryland)</th>
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<tr>
<td>The attending physician shall accept responsibility for the patient’s care.</td>
<td>- A physician is legally and ethically responsible for overseeing appropriate care of a patient.</td>
<td>- When facilities assign patients to physicians who have not been meeting responsibilities or who have not been credentialed adequately, or to physicians who do not want them or who are unavailable, patients are left without adequate medical coverage.</td>
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<td>- Assess a new admission in a timely fashion, depending on the individual’s medical stability, recent history, and previous medical history, presence of significant or previously unidentified medical conditions, or problems that cannot be handled readily by phone.</td>
<td>- A physician should have the training and skill to gather information and analyze its significance and the causes of symptoms and problems.</td>
<td>- When hospitals discharge patients to nursing homes with inadequate, conflicting, or incomplete information, inadequate or problematic care results.</td>
</tr>
<tr>
<td>- Seek, provide, and analyze needed information regarding a patient’s current status, recent history, and medications and treatments, to enable safe, effective continuing care, and appropriate regulatory compliance.</td>
<td>- Regulations require physician verification of admission orders and care plan.</td>
<td>- When physicians do not help review and explain information about a patient’s condition or problems, some facility staff do not understand what they are doing, resulting in inadequate care.</td>
</tr>
<tr>
<td>- Provide appropriate information and documentation to support a designated level of care for a new admission.</td>
<td>- A nursing facility must have admission orders in a timely fashion.</td>
<td>- When physicians do not respond to notification of new admissions for many hours, facilities cannot initiate treatments and medications in a timely fashion.</td>
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<td>- Authorize admission orders in a timely fashion, to enable the nursing facility to provide safe, appropriate, and timely care.</td>
<td>- Once having accepted a patient, a physician who wishes to withdraw from that patient’s care must remain responsible until another physician accepts the patient.</td>
<td>- When physicians do not adequately explain the significance and the causes of symptoms and problems, clarifies and verifies diagnoses, related diagnoses to patient problems, and help establish a realistic prognosis and care goals.</td>
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<td>- For a patient who is to be transferred to the care of another health care practitioner, continue to provide all necessary medical care and services pending transfer until another physician has accepted responsibility for the patient.</td>
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<td>The attending physician shall support patient discharges and transfers.</td>
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<td>- Follow-up as needed with a physician or another health care practitioner at a receiving hospital within 48 hours of the transfer of an acutely ill or unstable patient.</td>
<td>- Facilities must convey information when a patient is transferred.</td>
<td>- When a physician does not adequately explain the significance and the causes of symptoms and problems, clarifies and verifies diagnoses, related diagnoses to patient problems, and help establish a realistic prognosis and care goals.</td>
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<td>- Provide whatever summary or documentation may be needed at the time of transfer to enable care continuity at a receiving facility and to allow the nursing facility to meet its legal, regulatory, and clinical responsibilities for a discharged individual.</td>
<td>- A physician is often best able to explain in detail why a patient is being transferred and what needs follow-up by another healthcare practitioner or provider.</td>
<td>- When a physician does not explain to facility staff the significance of and relationships between various problems and diagnoses, they render incorrect or inappropriate care.</td>
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<td>- Perform accurate, timely, relevant medical assessments.</td>
<td>- There are many well-established, pertinent, geriatric and medical principles that are relevant to the nursing home population.</td>
<td>- When a physician does not perform adequate medical evaluations, important risks are not identified and significant problems are inadequately or incorrectly managed.</td>
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<td>- Properly define and describe patient symptoms and problems, clarify and verify diagnoses, relate diagnoses to patient problems, and help establish a realistic prognosis and care goals.</td>
<td>- Physicians are trained specifically—and in more depth than any other discipline—to be able to analyze and explain the significance of most medical symptoms and test results and to determine when treatments are medically appropriate or may be problematic; in many nursing facilities, few if any others can be expected to do so.</td>
<td>- When a physician does not adequately explain the significance and the causes of symptoms and problems, clarifies and verifies diagnoses, related diagnoses to patient problems, and help establish a realistic prognosis and care goals.</td>
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<td>- In consultation with the facility’s staff, determine appropriate services and programs for a patient, consistent with diagnoses, condition prognosis, and patient wishes.</td>
<td>- Many other staff in a nursing facility depend on medical information and analysis to provide other aspects of care correctly.</td>
<td>- When a physician does not adequately explain the significance and the causes of symptoms and problems, clarifies and verifies diagnoses, related diagnoses to patient problems, and help establish a realistic prognosis and care goals.</td>
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<td>- In consultation with the facility staff, ensure that treatments are medically necessary and negative outcomes are medically unavoidable, in accordance with nursing facility regulatory requirements.</td>
<td>- Physicians are legally authorized to be the ones to determine medical necessity.</td>
<td>- When a physician does not adequately explain the significance and the causes of symptoms and problems, clarifies and verifies diagnoses, related diagnoses to patient problems, and help establish a realistic prognosis and care goals.</td>
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<td>- Respond in an appropriate time frame to emergency and routine notification, to enable the facility to meet its clinical and regulatory obligations.</td>
<td>- We may readily identify many clinical issues related to physician care (Table 3).</td>
<td>- When a physician does not adequately explain the significance and the causes of symptoms and problems, clarifies and verifies diagnoses, related diagnoses to patient problems, and help establish a realistic prognosis and care goals.</td>
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When a physician does not perform adequate medical evaluations, important risks are not identified and significant problems are inadequately or incorrectly managed.

When a physician treats symptoms without defining the problem in sufficient detail, wrong treatment is rendered, a significant problem goes untreated, or the treatment itself causes complications.

When a physician does not make visits in a timely fashion, important problems are overlooked or not managed in a timely fashion, resulting in potentially avoidable patient decline, hospitalization, or death.

When a physician does not discuss complex medical symptoms and test results and determine when treatments are medically appropriate or may be problematic; in many nursing facilities, few if any others can be expected to do so.

When a physician prescribes medications indiscriminately or without recognizing their risks, or does not recognize how they may cause new symptoms or condition changes, patients suffer serious adverse consequences, including delirium, falls, anorexia, weight loss, and dehydration that may result in avoidable decline, hospitalization, or death.

A physician must ensure that medical care is provided in a broader context of function and quality of life, which often requires an exchange of information with other disciplines.

When a physician treats symptoms without defining the problem in sufficient detail, wrong treatment is rendered, a significant problem goes untreated, or the treatment itself causes complications.

When a physician does not explain complex medical symptoms and test results in a timely fashion, based on the patient's condition and the clinical significance of the results.

When a physician does not perform adequate medical evaluations, important risks are not identified and significant problems are inadequately or incorrectly managed.

When a physician does not provide timely or legible documentation, other staff who depend on physicians information and interpretations give inadequate or inappropriate care, resulting in harm to the patient.

There are regulatory requirements for visit frequencies.

Medical episodes occurring between routine visits may require a physician's follow-up.

A physician must ensure that medical care is provided in a broader context of function and quality of life, which often requires an exchange of information with other disciplines.

When physicians do not adequately interpret the significance of lab test results, patients receive unnecessary treatments or fail to receive essential or timely interventions.
Table 2. Continued

<table>
<thead>
<tr>
<th>Physician Responsibility (As Listed in Maryland Regulations)</th>
<th>Rationale</th>
<th>Identified Performance Problems (Based on Cases in Maryland)</th>
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<td>The attending physician shall agree to provide adequate ongoing coverage.</td>
<td>• Covering physicians have responsibilities comparable to those of an attending physician during the time that they are covering.</td>
<td>• When an attending physician is unavailable and there is not another physician to provide adequate backup, patients do not have medical coverage when they need it.</td>
</tr>
<tr>
<td>• Designate an alternate physician(s) who will respond in an appropriate, timely fashion in case the attending physician is unavailable and intervene with them when informed of problems regarding such coverage.</td>
<td>• The evenings and weekends constitute 75% of the week.</td>
<td>• When a covering physician is unavailable or refuses to discuss or address significant problems or condition changes, or when they prescribe medications indiscriminately, or do not ask for or receive enough information about a patient to make appropriate medical decisions, a patient suffers potentially avoidable complications, decline, hospitalization, or death.</td>
</tr>
<tr>
<td>• Update the facility about his or her current office address, phone, fax, and pager numbers to enable appropriate, timely communications, as well as those of designated alternate physicians.</td>
<td>• Like agency nurses, covering physicians may be very helpful or may potentially cause considerable problems for patients and for the nursing home.</td>
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<tr>
<td>• Adequately inform covering physicians about patients with active acute conditions or other significant problems that may need medical follow-up during their on-call time.</td>
<td>• Physicians are only present intermittently in the nursing facility; many problems of necessity are handled by phone.</td>
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<td>• Covered physicians have responsibilities comparable to those of an attending physician during the time that they are covering.</td>
<td>• Proper conveyance of information can improve the management of most problems and condition changes and reduce unplanned hospital transfers.</td>
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<tr>
<td>The attending physician shall provide appropriate, timely medical orders.</td>
<td>• Clear, properly written medical orders can help others provide more effective care.</td>
<td>• When a physician gives orders that do not take into account patient-specific information, the patients do not receive relevant care or suffer potentially avoidable complications.</td>
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<tr>
<td>• Provide timely medical orders based on an appropriate patient assessment, review of relevant pre- and post-admission information, and age-related and other pertinent risks of various medications and treatments.</td>
<td>• It is widely recognized that some medical orders have the potential to lead to mistakes and patient complications.</td>
<td>• When a physician gives unclear orders by phone or writes illegible orders, serious or potentially harmful medication errors occur.</td>
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<tr>
<td>• Provide sufficiently clear, legible written orders to avoid misinterpretation and potential medication errors, such orders to include pertinent information such as the medication strength and formulation (if alternate forms available); route of administration; frequency and, if applicable, timing of administration; and the reason for which the medication is being given.</td>
<td>• When a physician does not verify that orders were taken and followed correctly, a patient fails to receive correct or all necessary treatments and suffers potentially avoidable complications.</td>
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<tr>
<td>• Verify the accuracy of verbal orders at the time they are given and co-sign them in a timely fashion, no later than the next patient visit.</td>
<td>• When a physician does not complete medical discharge summaries in a timely fashion or fails to provide pertinent information in the summary, a patient suffers from lack of care continuity and the facility fails to meet its legal and regulatory obligations.</td>
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</tr>
<tr>
<td>The attending physician shall provide appropriate, timely, and pertinent documentation.</td>
<td>• Physician documentation helps explain the basis for treatments and can explain why negative outcomes may have been medically unavoidable.</td>
<td>• When physicians put inappropriate or unqualified speculative diagnoses on death certificates or fail to complete their portion correctly, a facility suffers adverse regulatory and legal consequences and is blamed for causing problems that were not its fault.</td>
</tr>
<tr>
<td>• Provide documentation required to explain medical decisions, enable effective care, and allow a nursing facility to comply with relevant legal and regulatory requirements.</td>
<td>• Because laws and regulations authorize physicians to approve and certify many different things about patients, facilities depend heavily on physicians to do these things correctly and in a timely fashion.</td>
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<tr>
<td>• Provide a pertinent medical discharge summary within 30 days of discharge or transfer.</td>
<td>• When a physician does not complete medical discharge summaries in a timely fashion or fails to provide pertinent information in the summary, a patient suffers from lack of care continuity and the facility fails to meet its legal and regulatory obligations.</td>
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<tr>
<td>• Complete death certificates in a timely fashion, including all information required of a physician.</td>
<td>• When physicians put inappropriate or unqualified speculative diagnoses on death certificates or fail to complete their portion correctly, a facility suffers adverse regulatory and legal consequences and is blamed for causing problems that were not its fault.</td>
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</table>

**Rationale**

- Covering physicians have responsibilities comparable to those of an attending physician during the time that they are covering.
- The evenings and weekends constitute 75% of the week.
- Like agency nurses, covering physicians may be very helpful or may potentially cause considerable problems for patients and for the nursing home.
- Physicians are only present intermittently in the nursing facility; many problems of necessity are handled by phone.
- Proper conveyance of information can improve the management of most problems and condition changes and reduce unplanned hospital transfers.

**Identified Performance Problems (Based on Cases in Maryland)**

- When an attending physician is unavailable and there is not another physician to provide adequate backup, patients do not have medical coverage when they need it.
- When a covering physician is unavailable or refuses to discuss or address significant problems or condition changes, or when they prescribe medications indiscriminately, or do not ask for or receive enough information about a patient to make appropriate medical decisions, a patient suffers potentially avoidable complications, decline, hospitalization, or death.
- When a physician gives orders that do not take into account patient-specific information, the patients do not receive relevant care or suffer potentially avoidable complications.
- When a physician gives unclear orders by phone or writes illegible orders, serious or potentially harmful medication errors occur.
- When a physician does not verify that orders were taken and followed correctly, a patient fails to receive correct or all necessary treatments and suffers potentially avoidable complications.
### Table 3. Physician Clinical Responsibilities and Related Performance Problems in Nursing Home Care

<table>
<thead>
<tr>
<th>Physician Responsibility</th>
<th>Rationale</th>
<th>Examples of Ineffective Practice and Consequences (Based on Cases in Maryland)</th>
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<tr>
<td>Physicians should help organize and explain medical issues of care in each patient, regardless of underlying primary diagnoses or alleged primary reason for admission.</td>
<td>Regardless of the primary diagnosis or ostensible reason for admission, all patients require some organized approach to their physical, functional, and psychosocial problems, with consideration of how their various problems and conditions interact.</td>
<td>A physician abdicates the care of so-called “rehabilitation patients” to nurses and therapists and fails to get involved in managing risk factors and comorbidities, resulting in unanticipated acute crises, potentially preventable functional declines, and potentially preventable hospitalization.</td>
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<tr>
<td>Physicians should provide sufficient information about the medical aspects of care to enable others to understand condition, prognosis, and the basis for medications and treatments.</td>
<td>Physicians are often the only ones with the training and ability to unravel and explain the physical basis for functional impairment and the interactions of diseases and functional impairments.</td>
<td>A physician does not answer questions from nursing facility staff (nurses, dieticians, etc.) about the basis for decisions about treatments and medications. Inadequate or incorrect information makes effective care much more difficult and puts the patient at higher risk.</td>
</tr>
<tr>
<td>Physicians should comply with state and federal laws and regulations regarding ethics decision making and advance care planning.</td>
<td>Individuals have the right to make choices to withhold or withdraw treatments, even if those treatments could potentially correct a medical condition. There is no ethical obligation to treat medical conditions out of context. Many individuals and families depend heavily on physicians to advise them about the potential benefits of treatments and the likely impact on condition and prognosis.</td>
<td>A physician does not agree that limited medical treatment may be warranted in some situations. A physician transfers and treats patients aggressively contrary to their wishes. A physician does not disclose all relevant treatment options sufficiently to patients or families or does not disclose his/her bias toward aggressive treatment regardless of likely prognosis.</td>
</tr>
<tr>
<td>Physicians should provide patients and families with thoughtful, balanced information about their condition and a realistic assessment of prognosis.</td>
<td>Patients and/or families need such information to make important decisions about treatment choices and advance care planning.</td>
<td>A physician fails to complete important documentation required by state laws to ensure that patients receive desired treatment or do not receive undesired treatments. A physician leaves discussion of complex ethical issues and underlying clinical concerns to nurses and social workers, who are not adequately trained and often do not explain these issues to patients and families in a way to help them make effective advanced care planning decisions.</td>
</tr>
<tr>
<td>Physicians should help evaluate and manage behavior problems.</td>
<td>Aberrant behavior is a symptom, often reflecting underlying treatable causes including medical conditions and medications.</td>
<td>Patients receive treatments that they didn’t want or from which they cannot benefit. The failure to present this information or to present it accurately may lead to unrealistic expectations and blaming the facility when the results are different than expected. Potentially treatable underlying causes are not addressed adequately or in a timely fashion.</td>
</tr>
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<td>Physician Responsibility</td>
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| Physicians should help evaluate and manage falls. | • Falling is a symptom, often reflecting underlying treatable causes including medical conditions and medications.  
• A physician considers falls to be ”just a nursing problem,” or refuses to review or reconsider a current drug regimen or fails to perform an adequate patient evaluation to identify medical causes.  
• Potentially preventable falls and potentially preventable complications of falls such as fractures and subdural hematomas are not prevented.  
• Nursing facilities are blamed for causing falls in situations that are beyond their control, yet they would be helped if physicians either did things to reduce fall risks or gave an adequate explanation of their underlying causes. | • By abdicating responsibility for evaluating or managing behavior problems to psychiatrists or nursing staff, a physician never learns how to evaluate or address underlying causes.  
• Patients receive incorrect medications or inadequate treatment for major psychiatric problems, such as psychosis, resulting in potentially preventable decline or hospitalization. |
| Physicians should help evaluate and manage hydration risks. | • Hydration problems and risks are often due to underlying medical conditions, and numerous medications may directly or indirectly increase the risk.  
• Preventable dehydration and fluid and electrolyte imbalance are not detected or managed correctly or in a timely fashion.  
• Patients suffer potentially preventable decline in condition, hospitalization, or death. | |
| Physicians should help evaluate and manage urinary incontinence. | • Some cases of urinary incontinence are at least somewhat reversible.  
• A physician fails to assess or categorize incontinence adequately.  
• Patients continue to suffer unnecessarily from continued urinary incontinence, which impacts their function and quality of life.  
• A physician indiscriminately prescribes medications for incontinence that do not work or are associated with other serious complications and side effects.  
• The nursing facility is blamed for failing to improve a patient’s continence. | |
| Physicians should help evaluate and manage altered nutritional status and unplanned weight loss. | • Weight loss and undernutrition are symptoms that often reflect underlying treatable causes, including many medical illnesses and adverse drug reactions (ADRs) caused by many categories of medications.  
• A physician does not evaluate anorexia or weight loss and defers instead to dietitians and nurses, who are not sufficiently trained or experienced in the differential diagnosis of anorexia and weight loss.  
• Potentially reversible causes of anorexia and unplanned weight loss are undetected and unmanaged.  
• A physician indiscriminately prescribes medications as appetite stimulants without considering underlying causes or the risks of these medications.  
• Nursing facilities are blamed for failing to prevent or manage hydration and nutrition problems that actually have identifiable medical causes or that are medically unavoidable. |
### Table 3. Continued

<table>
<thead>
<tr>
<th>Physician Responsibility</th>
<th>Rationale</th>
<th>Examples of Ineffective Practice and Consequences (Based on Cases in Maryland)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Physicians should be involved in the effective evaluation and management of pain.</td>
<td>• Pain is common in the long-term care population, may reflect various underlying causes, and can often be partially or completely relieved. • Pain management should reflect identified principles about the indications, efficacy, potential risks and problems associated with analgesics.</td>
<td>• A physician fails to perform an adequate assessment of pain or relies on inaccurate information from other staff in determining the causes and treatments for pain. • Some patients with pain are undertreated, whereas others suffer potentially preventable complications from the excessive or inappropriate use of various categories of analgesics.</td>
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<tr>
<td>• Physicians should be involved in prevention of skin breakdown and in the management of active pressure ulcers.</td>
<td>• Medical conditions and medications may directly or indirectly affect a patient’s skin condition or function and thereby influence the risk and healing of skin breakdown. • Medical research has demonstrated various more or less effective and desirable approaches to the management of various aspects of skin condition and skin breakdown.</td>
<td>• A physician fails to perform an adequate skin assessment and instead defers the entire evaluation and management of skin condition and skin breakdown to nursing staff. • A physician fails to address underlying causes that may affect appetite, function, or other situations that directly or indirectly increase the risk of skin breakdown or affect wound healing. • A physician fails to manage various aspects of pressure ulcers correctly or in accordance with accepted guidelines and practices. • A facility is blamed for failure to prevent or heal ulcers because a physician does not adequately explain why the problem is medically unavoidable.</td>
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<tr>
<td>• Physicians should be involved appropriately in evaluating and managing anemia and other hematologic problems.</td>
<td>• Anemia has various categories of causes and should be appropriately evaluated and categorized before giving various treatments.(^4)</td>
<td>• A physician fails to assess anemia correctly, thereby missing potentially correctable underlying causes. • A physician indiscriminately orders transfusions or prescribes expensive medications, such as erythropoietin, when not warranted or not likely to help.</td>
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<tr>
<td>• Physicians should do everything possible to prevent delirium and to promptly identify and manage it when present.</td>
<td>• Delirium is a significant complication in elderly individuals in the nursing facility and the hospital and a major risk factor for functional and physical decline or death. • Many medications and certain medical illnesses and treatments can cause or exacerbate delirium. • Delirium is often readily reversible by addressing the underlying causes.(^4)</td>
<td>• A physician does not recognize the presence of delirium in a timely fashion or correctly identify or treat its underlying causes, resulting in potentially preventable patient decline, hospitalization, or death.</td>
</tr>
<tr>
<td>• Physicians of all specialties should use medications judiciously in the elderly and should recognize and manage ADRs promptly and correctly when they occur.</td>
<td>• Medications remain a major source of preventable death and disability in the elderly. • Physicians are the major prescribers of medications. • The medical literature contains many studies and commentaries over many years identifying the numerous risks of medications in the elderly. • Drug manufacturers themselves specifically warn about numerous potentially serious drug-related complications in product literature and references, which are readily available to physicians, such as the PDR.</td>
<td>• A physician adds medications over time based on isolated episodes, unclear indications, and vague symptoms. • A physician will not reconsider or try to taper medications, even when an ADR is highly likely. • A physician does not recognize significant ADRs or manage them correctly. • A patient suffers serious but potentially preventable ADRs, resulting in potentially preventable functional decline, hospitalization, or death.</td>
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</table>
allegations, blaming everything on the facility and its staff, and then trying to get several of his patients to move to another facility. It is not unusual for covering physicians to refuse to authorize admission orders or to fail to evaluate or even discuss seriously ill patients with a facility’s staff. Instead, they often say, “I don’t know the patient, so you’ll have to call back when the attending physician returns,” or they insist on transferring patients to the hospital without trying to determine if the patient might be assessed or treated in the facility.

Some physicians practicing in, or employed at, local hospitals in Maryland are quick to condemn the care in local nursing homes and to turn in nursing homes to the health department for perceived inadequacies of care, often without verifying information. Yet, these same physicians may deny or fail to address problems of inadequate care or serious preventable complications that occur while local nursing home patients are hospitalized.22 For instance, many physicians in Maryland hospitals still fail to prevent or address problems that have been identified in the literature as major risk factors for delirium in hospitalized elderly, including use of physical restraints, more than three medication types added to existing medications, use of a bladder catheter, and iatrogenic events.23

Recently, a nonphysician consultant who is involved in Table 3. Continued

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</thead>
<tbody>
<tr>
<td>• Physicians should advocate for their patients and do everything they can to help preserve their dignity, improve their quality of life and function, and support them through illness and functional decline.</td>
<td>• Physicians should be trained to recognize and explain how medical conditions influence functional and psychosocial aspects of life. • Physicians are influential in the health care system and should use that influence to try to get the best for their patients and to try to address those settings that may cause problems or damage for individuals.</td>
<td>• As a result of focusing just on treating medical diagnoses, a physician renders treatments that cause complications or does not help improve quality of life or function. • A physician does not advocate effectively for a patient when another practitioner or another site providing care does something inappropriate (for example, try to insert a feeding tube in the hospital in someone who stated in the nursing home that they did not want one). • A patient receives unnecessary or inappropriate treatments or suffers possibly preventable complications and iatrogenic illnesses.</td>
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</table>
many nursing homes in Maryland reported remarkably frequent difficulties in obtaining physician cooperation in certain communities. “My experience with [various] physicians in long-term care is that they are reluctant to speak with other team members. Their answer to failure to thrive in individuals is ‘they are 84 and what do you expect.’ They are deeply insulted if anyone dares to question their medication selections. Many will not even accept a fax and must be telephoned... It is a shame that it will take government regulations and intervention to force physicians to take a more active role in the care of our elderly. While I would love to see a push toward elimination of unnecessary medications, ...many of the facilities average 17-plus medications per resident” (S. Levenson, personal communication, 2001).

In fact, such problems are not uncommon throughout Maryland or the United States generally. Some physicians have turned intimidation into an art. For instance, poor physician practices and weak cooperation helped move one central Maryland facility to the brink of severe regulatory sanctions. When the facility finally retained a new medical director, numerous staff reported that—no matter what happened—the previous medical director always supported the physicians and blamed the facility, even when nursing staff clearly documented that a physician had failed to respond or to act appropriately. Thus, many of these physicians became markedly belligerent or irresponsible and felt justified in resisting attempted interventions.

**Review of Systemic Approaches to Physician Accountability**

A review of prior and current attempts to substantially influence physician performance and practice throughout Maryland found some significant efforts and a lot of benign neglect or active resistance. There were few substantial or enduring efforts by Maryland medical societies or physician organizations, the state university medical system, or the state’s administrator, hospital, nursing facility associations, boards, or commissions to identify and address these physician problems statewide, nor was there any indication of substantial plans to do so.

Furthermore, organized medicine in Maryland and throughout the United States has a spotty record at best in aggressively ensuring physician accountability.24 And, for various reasons, many nursing homes have tolerated inadequate physician performance or inappropriate conduct. But inconsistent expectations and accountability in the community make it harder for facilities that wish to hold physicians accountable, and it encourages physicians to resist or to threaten them. Other physicians may try to cover their own mistakes and inattention by blaming a facility for poor patient outcomes, knowing that the public and the survey agencies may be more likely to blame the facility than to recognize the physician’s role.

Table 4 lists some of the common objections of some nursing homes and physicians to strengthen accountability or to the proposed requirements. But despite these concerns and objections, there is much to suggest that the problems are more serious and widespread than is commonly believed. Situations tend not to be investigated adequately when they are not recognized as problematic or when those who are to be studied resist bringing issues into the open.

**Other Factors Affecting Performance and Accountability**

The overall physician presence in nursing homes also differs markedly from that in other inpatient settings, primarily the hospital. Historically, many physicians have needed their hospital practices for economic and clinical reasons. But studies and commentaries over several decades have documented that only a small minority of physicians will take care of nursing home patients.25

Medical directors in nursing homes have considerable responsibility but often have little authority. Hospitals invariably have formal medical staffs with rules, privileges, officers, department heads, and medical executive committees. But many nursing homes have lacked these structures and any significant procedural requirements, and a medical director must perform all of these executive and oversight functions.11

Physicians are often also angered by problems of nursing home care systems, staff performance, or care requirements.26,27 Many are turned off by low reimbursement and too many perceived “hassles.” For instance, physicians may receive numerous phone calls and faxes from inadequately prepared nurses who may fail to provide enough accurate information. Some physicians feel pressured to authorize treatments and services that they may not understand or agree with, arising from fears of regulatory consequences or from financial pressures.

The result of all this is often an uneasy truce between many physicians and nursing homes. Although many nursing homes have tried unsuccessfully to get greater physician participation, others have largely ignored physician concerns or have blocked medical director efforts to improve care processes and support systems. Many medical directors still have little say in nursing home operations or clinical practices—despite being granted considerable authority under the federal OBRA regulations12 to oversee all aspects of a nursing home’s clinical policies.

**IDENTIFYING RELEVANT MANAGEMENT PRINCIPLES AND PRACTICES**

Because the consequences for inadequate physician performance are severe for both patients and nursing facilities, haphazard accountability is inadequate. Ultimately, these regulations are based on the realistic premise that—even in this imperfect world—physician performance can be improved by consistently applying simple management principles and practices, that is, by helping them know what to do, why it needs to be done in certain ways, and how to do it right, and then reviewing their performance and giving them appropriate feedback.28,29

In conjunction with the nursing home, a medical director must give physicians the right preparation (policies, procedures, continuing medical education [CME] instruction, articles from the medical literature about managing various conditions, etc.) and offer them feedback such as communication...
Table 4. Concerns and Objections to the Medical Director and Attending Physician Requirements

<table>
<thead>
<tr>
<th>Objection</th>
<th>Response</th>
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| Physicians do not need regulations to function adequately.                | • Some individual physicians perform admirably, but many others practicing in long-term care have demonstrated problematic performance and practices.  
• Like other human beings, physician span the spectrum of personalities and performance and often use similar tactics of denial, rationalization, and projection.  
• There is no valid reason not to hold physicians accountable.  
• Alternative approaches to accountability have not worked sufficiently.  
• Many forces continue to excuse physician irresponsibility and obstruct efforts at accountability. |
| Practicing physicians will leave the nursing home.                       | • Most physicians who are already practicing appropriately should have no trouble complying.  
• Physicians who do not meet these expectations are probably creating problems for the patients and the facilities, which needs correction.  
• Problematic physicians need to stop practicing in nursing homes if their problematic performance is harming patients. |
| This is just another example of inappropriately telling physicians how to practice medicine. | • There are numerous instances of inappropriate practice in nursing homes; there is no reason why ignorance of proper practice should be allowed to cause harm.  
• Patients are not the personal possession of physicians; there is no reason why they should be able to refuse input no matter how inappropriate their actions.  
• Some physicians confuse practice decisions with process requirements; they claim erroneously that their right to make treatment choices also includes the right to arbitrarily refuse to follow processes or protocols necessary for effective care in a complex system.  
• The option to make decisions at certain steps is not the same as refusing to follow important steps. |
| Physicians claim that many of these problems are the fault of facilities. | • These regulations provide a balanced expectation for facility support.  
• Physicians and facilities should work out the problems, not hold the patients hostage to their mutual animosity. |
| Medical directors are going to refuse to do these things.                | • Some physicians will refuse, but many others have already been doing them or recognize that they need to do more.  
• Allowing a medical director to refuse to cooperate only reinforces poor performance.  
• The role of nursing homes has changed dramatically over the years.  
• Much of the care is technically complex and requires adequate physician input. |
| These are nursing homes, not medical care centers, so physicians should not have too prominent of a role. | • Most patients come to long-term care facilities out of necessity, and physicians have relatively little influence today on who goes where.  
• Uniform standards should help improve the care and prevent physicians from “shopping around” to find facilities that will overlook their performance problems.  
• Physicians who threaten facilities because they are asked to be accountable should be confronted and dealt with, not allowed to browbeat the facility into submission.  
• Responsible medical director presence and management in nursing homes is essential to providing appropriate care.  
• Medical directors have often been underpaid and underutilized in nursing homes.  
• The money spent on competent medical direction pays for itself many times over in improved care, fewer unplanned hospital discharges, improved patient outcomes, family satisfaction, and improved regulatory compliance.  
• It’s time to recognize competent physicians and compensate them appropriately for their important contributions to successful long-term care. |
| Trying to hold physicians to these regulations will cost the facility patient referrals. | • Being human, physician performance can be influenced by applying simple management tactics and respecting common psychological principles.  
• Failure to hold physicians accountable reflects inadequate understanding and use of proven management approaches, not some inherent physician attribute making them uncontrollable.  
• Nursing homes can do many things to improve care systems and the performance of other disciplines that influence physician behavior and practices.  
• It may be true that only peers can adequately review the appropriateness of clinical decisions and treatment choices but that is different from establishing performance expectations and reviewing behavior and procedural compliance.  
• A physician manager (medical director) should oversee physician performance, but when the medical director cannot or will not do the job, someone else must step in.  
• Society has an important role in ensuring that physicians perform appropriately in nursing homes and in the overall care of vulnerable elderly patients.  
• We cannot simply assume the competence, good intentions, or adequate performance of physicians as a group.  
• Medical direction is a complex job requiring many skills not taught in medical school or any aspect of physician training; there is no evidence that being a physician, having an MD degree, or being a skilled clinician automatically confers any special ability to understand management principles or perform effectively as a manager.  
• Even nursing assistants must take 60 hours or more of formal training before they work, so why shouldn’t we expect some formal training for a physician with a critical job like that of medical director? |
about specific cases or situations, periodic peer review, privilege renewals based on performance evaluation, and so on. 30 For example, there are many ways to use management techniques to improve physician performance in managing end-of-life care. 31–33

IDENTIFYING MEDICAL DIRECTOR ROLES AND RESPONSIBILITIES

The next step in creating relevant regulations was to identify medical director roles and responsibilities in relation to physician and facility responsibilities, based on management principles and practices (Table 5).

Defining Fulfillment of Roles and Responsibilities

Some additional considerations in creating these regulations were to identify relevant qualifications and appropriate measures for medical directors to demonstrate compliance with these requirements. For example, it was decided that physicians should complete basic training in core topics (or demonstrate that they had obtained comparable training) within 3 years of the implementation of the regulations or of becoming a facility's medical director.

Some physicians vehemently opposed these portions of the regulations, arguing—among other things—that the state should not tell physicians what kinds of training they should obtain. However, it was concluded that (1) the medical director's job is very important, (2) some minimum education is advisable, (3) clinical expertise does not necessarily qualify a physician to perform management functions, and (4) most physicians get little or no information or training about management, systems, and regulatory issues from traditional medical education, residency, and CME programs. Additionally, for comparison, it is noteworthy that even certified nursing assistants must get at least 75 hours of formal training before they provide care in a nursing home.

IDENTIFYING FACILITY RESPONSIBILITIES

Nursing homes influence physician and medical director performance in many ways. 11 Therefore, facility support is needed to improve that performance (Table 6). This includes giving physicians and medical directors clearly defined expectations, improving internal care systems, and providing the medical director with feedback about his or her job performance. Thus, these regulations require nursing homes to help ensure that physicians and medical directors identify and fulfill their roles and responsibilities adequately.

Yet many administrators in Maryland have little formal training in critical management techniques and principles or in the details of an effective care delivery system. As a result, they may base approaches to clarifying expectations and upholding accountability more on personal preferences, beliefs, and habits than on effective management tactics.

Many nursing homes have struggled to get medical directors to perform their duties, whereas others have resisted formal physician accountability systems and significant medical director authority. As one medical director put it, “When I came back from a medical director meeting and told my administrator that I needed to implement some physician rules and regulations, he said, ‘You’ve got to be joking’ and then told me I could not do it.”

Some Maryland nursing facilities have made the same mistakes with physicians that they have made with agency nursing staff. They have exacerbated the problem by being afraid of the potential consequences of accountability; for example, some physicians will refuse to cooperate and may therefore leave. But inconsistent expectations and accountability tend to reinforce undesirable physician behavior. It was felt that uniform standards were needed to control the problem of physicians simply “shopping around” to find facilities that let them off the hook.

SUMMARY AND CONCLUSIONS

Issues related to nursing home attending physician and medical director performance and practice in Maryland seem to mirror the situation nationally. Competent, caring physicians should be respected and supported. But there is no legitimate reason to allow incompetent, bullying, or problematic physicians to harm patients or nursing homes. Physician and facility accountability are related.

Legislation and regulations were enacted because the efforts of competent, dedicated clinicians and medical directors were often overshadowed by problematic practitioners and facilities. Instead of any significant organized statewide effort to correct these physician problems, there was often denial, resistance, or even a “conspiracy of silence.” It was concluded that the current situation could be improved but had previously often been tolerated, condoned, and reinforced. Because good physician practice and performance is an identified route to improving nursing home care, the Maryland Legislature decided to try to accelerate improvement by (1) specifying physician and medical director responsibilities, and (2) requiring nursing facilities to implement systems to improve physician performance.

Additional Measures

Any efforts to improve physician performance in nursing homes, such as those in Maryland, should be part of a bigger plan. Many other factors, disciplines, organizations, and agencies influence physician performance or successful nursing home care. Other initiatives underway in Maryland include physician efforts to help the state survey agency better understand and interpret clinical issues, an initiative to expand the use of clinical practice guidelines (CPGs) as a basis for care provision in nursing homes, requirements to improve quality assurance systems and practices in nursing homes, formation of a coalition to create model job descriptions and promote improved management training for key long-term-care managers, and efforts to get more constructive support and involvement from legislators, academicians, and various state boards and commissions.

Anticipated Results

As discussed herein, these regulations were formulated with certain anticipated consequences. Identifying physician responsibilities provides a more uniform statewide foundation for physician accountability. Facilities can then clarify physi-
Table 5. Summary of Medical Director Requirements

Qualifications
- A current license as a physician in the State of Maryland
- At least 2 years of experience or specialized training in the medical care of geriatric or chronically ill and impaired residents
- Successful completion of a curriculum in physician management or administration
- Privileges at a hospital in this state or some alternative formal credentialing

Responsibilities

General
- Overall coordination, execution, and monitoring of physician services
- Monitoring and evaluating the outcomes of the health care, including clinical and physician services provided to the facility's residents
- Designating an alternate medical director with sufficient training and experience to perform the responsibilities of the medical director

Practitioner Oversight
- Oversee all physicians and other licensed or certified professional health care practitioners who provide health care to the facility's residents
- Ensure that there is a procedure for the review of the practitioners' credentials and the granting of privileges for licensed health care practitioners who treat residents of the nursing facility
- Recommend rules governing the performance of physicians and other licensed or certified professional health care practitioners who admit residents to the facility

Define Scope of Medical Services
- In collaboration with the facility, recommend written policies and procedures delineating scope of physician services and medical care

Ensure Physician Accountability
- Recommend policies and procedures that cover essential physician responsibilities to the residents and the facility, including:
  - Accepting responsibility for the care of residents
  - Supporting resident discharges and transfers
  - Making periodic, pertinent resident visits in the facility
  - Providing adequate ongoing medical coverage
  - Providing appropriate resident care
  - Providing appropriate, timely medical orders
  - Providing appropriate, timely, and pertinent documentation
  - Advising residents and families about formulating advance directive
- Any other responsibilities as determined by the facility and its medical director

Quality Assurance
- Actively participate in the facility's quality improvement process, including:
  - Regular attendance at, and reporting to, facility's quality improvement committee meetings
  - Routine participation in ongoing facility efforts to improve the overall quality of the clinical care, including facility efforts to evaluate and address the causes of various care-related problems and deficiencies cited by the Office of Health Care Quality

Employee Health Oversight
- Advise on development and execution of employee health program
- Ensure that facility plans and implements required immunization programs

Other Related Duties
- Advise administrator and director of nursing on clinical issues, including the criteria for residents to be admitted, transferred or discharged from the nursing facility
- Work with nursing facility to establish appropriate relationships with area hospitals and other pertinent institutions to improve care of the residents
- Advise and consult with the nursing facility staff regarding communicable diseases, infection control, and isolation procedures and serve as a liaison with relevant local health officials and public health agencies
- Provide or arrange for temporary physician services as needed to ensure that each resident has continuous physician coverage
- Participate as appropriate in facility committee projects and meetings concerning clinical care and quality improvement that require physician input
- Educate or oversee education of and inform all attending physicians about their roles, responsibilities, and applicable rules and regulations

Medical Director Oversight Plan
- Based upon physician and medical director responsibilities in nursing facilities, as described herein, develop and implement a plan describing how he or she will carry out his or her responsibilities for the overall monitoring, coordination, and execution of physician services and medical care to residents of the nursing facility and for the systematic review of the quality of health care, including medical and physician services, provided to the facility's residents

Documentation Regarding Medical Director Activities
- Keep documentation regarding activities in relation to these responsibilities, such as notes, minutes, or copies of faxes, letters, or telephone communications with attending physicians, other facility staff and departments, the administration, governing body, and others regarding concerns, inquiries, and interventions, including evidence of medical director's interventions and follow-up of the effectiveness of those interventions
- Facility's Quality Assurance Committee minutes shall reflect monthly input from medical director regarding physician issues and general facility clinical care issues

Facility's Responsibilities in Relation to its Medical Director

The nursing facility shall:
- Work with medical director to ensure adequate resident care and practitioner performance
- Inform physician of explicit requirements as a medical director and help medical director gain the necessary information and tools to properly execute those responsibilities
- Ensure that medical director has necessary support and authority to perform his or her duties effectively and to hold practitioners accountable
- Explain in quality assurance minutes why physician-recommended protocols or treatments cannot be rendered in the facility

Evaluation of Medical Director's Performance
- Facility shall have mechanism to evaluate medical director's performance and give medical director feedback about that performance, based on explicit medical director responsibilities
- Facility shall facilitate medical director's improvement and performance of functions and duties
<table>
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<tr>
<th>Area of Oversight</th>
<th>Examples of Helpful Facility Support for Medical Director Activities</th>
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| Establishing general physician responsibilities                                  | • Send rules and regulations to each physician  
• Support the requirement that each physician agree to the rules and regulations as a condition of practice  
• Establish policies and procedures for medical director notification, and give the other departments a list of areas for which notification should occur                                                                                                                                                                                                     |
| Assuring that physicians accept responsibility for the patients under their care  | • Inform the admissions coordinator explicitly about who can take new admissions  
• As recommended by the medical director, authorize the admissions coordinator to withhold new admissions from physicians who do not agree with, or who have been found by the medical director to be out of compliance with, the rules and regulations  
• Ensure that staff know to notify the medical director if a physician does not respond as needed, for example, to discuss a new admission and authorize admission orders                                                                                                                                 |
| Assuring adequate backup coverage                                               | • Keep lists of physician backup coverage updated  
• Help the medical director communicate as needed with physicians when backup coverage problems are persistent, problematic, or may be contributing to undesired care outcomes                                                                                                                                                                                                                       |
| Appropriate, timely visits                                                      | • Notify the medical director of physicians who do not make timely visits  
• Include discussions of physician concerns within ongoing facility meetings, such as admissions meeting, department head meetings, etc.  
• Establish policies and procedures regarding timeliness of visits in various situations                                                                                                                                                                                                                      |
| Oversee appropriate physician practice                                           | • Ensure that the nursing and other staff prepare adequate information for the medical director to allow for a relevant review of problems and concerns (eg, provide details of interactions with medical director, identify clearly issues or concerns, provide written information ahead of time, etc.)  
• Provide the medical director with quality assurance data regarding clinical issues, care policies, and other items that the medical director should review, comment on, or advise about  
• Ensure that all staff recognize the medical director’s authority, regulatory responsibility in overseeing care-related policies  
• Establish a stringent procedure for when and how the medical director’s instructions, protocols, etc. can be overridden  
• Help give physicians information, feedback about specific responsibilities in specific conditions  
• Ensure that all staff recognize the medical director’s authority and regulatory responsibility in overseeing care-related policies  
• Get the medical director’s input (not just signature) into care policies and clinical practices  
• Establish a stringent procedure for when and how the medical director’s advice, instructions, protocols, etc. can be overridden  
• Establish the medical director’s role in reviewing and changing existing clinical practices  
• Involve the medical director in reviewing care issues cited during the survey, identifying root causes, and developing corrective actions  
• Involve the medical director in basic review of employee health policies and procedures  
• As part of the quality assurance program, document review with the medical director of the implementation and effectiveness of immunization programs  
• Provide the medical director with infection control reports and statistics and incorporate medical director advice on related clinical practices such as antibiotic use into facility practices  
• Consult with medical director when there is a possible or confirmed infectious outbreak  
• Keep some records of the major areas of communication and discussions with the medical director  
• Train and reinforce effective care delivery process, other medical and gerontologic topics  
• Ensure that medical director periodically reviews key care areas with other departments  
• Document medical director participation in quality assurance process and quality assurance meetings |
cian expectations, monitor their performance, and give them appropriate feedback. The effective use of basic management approaches should improve overall physician performance or identify those who cannot or will not improve and who should simply depart the setting.

Clearer support and guidance from nursing homes can help facilitate a medical director’s job performance so that they hold physicians accountable and help improve critical care processes and support systems in their facilities. Improved physician performance and facility practices and processes should have a significant impact on patient outcomes—either improving them or at least making it easier to justify unavoidable negative outcomes, such as falls, weight loss, or medical complications.

As facility processes improve and patient outcomes become more rational, nursing homes should be viewed in a better light by the public and survey results should improve. This, in turn, should help improve the industry’s financial performance. In the course of public policy deliberations, it is uncommon to find such a relatively small action that can potentially produce so many positive consequences.

Regulations are not necessarily the ideal solution to healthcare performance and practice issues. But the concerns and performance problems that led to this initiative in Maryland are very real and probably much more widespread nationally than either physicians or the public realize or will acknowledge. So, as physicians we must take the problems seriously, study them carefully, and propose workable solutions. We cannot simply rely on traditional arguments that only physicians know best or can police themselves. Unfortunately, regarding the care of the elderly, there is simply not enough compelling evidence to support that argument. We should clean our own house even while contesting other factors that we believe are unfair or a hindrance.

REFERENCES