

THE LIABILITY ENVIRONMENT FOR PHYSICIANS PROVIDING NURSING HOME MEDICAL CARE: DOES IT MAKE A DIFFERENCE FOR RESIDENTS?

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Virtually all current residents of nursing homes in the United States have significant physical or mental health problems requiring ongoing, competent medical attention.

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Physicians may be involved in the provision of medical care to nursing home residents in several different ways. This Article reports on a research project involving a literature review, legal review, and the conduct of more than forty-five individual telephone and in-person conversations with key informants. The author attempts to identify and analyze the anxieties that physicians have about their own legal risks associated with nursing home involvement as either medical directors or attending physicians and how those legal anxieties may affect, positively and negatively, the quality of care and quality of life experienced by nursing home residents. The findings reported here form the basis for prescriptive recommendations for improving long-term care public policy and industry practice.

I. Introduction

Nursing homes are expected to be and do many different things today,¹ but clearly one of their most important functions is to serve as medical facilities. The nursing home population is becoming increasingly older,² sicker,³ and more

1. See Marshall B. Kapp, *Making Patient Safety and a "Homelike" Environment Compatible: A Challenge for Long Term Care Regulations*, 12 WIDENER L. REV. 227 (2005) (explaining the schizophrenic and often inconsistent expectations that consumers and policy makers have regarding the proper roles of nursing homes in the contemporary United States). As used in this Article, the term *nursing home* is defined to mean a facility that has at least three beds, is certified by the federal Department of Health and Human Services Centers for Medicare and Medicaid Services as a Medicare skilled nursing facility or a Medicaid nursing facility or is licensed by a state agency as a nursing home, and provides on-site supervision by a licensed nurse twenty-four hours per day, seven days a week. Ethel L. Mitty, *Nursing Homes*, in ENCYCLOPEDIA OF AGING 749 (George L. Maddox ed., 3d ed. 2001).

2. Nearly three-quarters of nursing home residents are age seventy-five or older, with a median age of 83.2 years. U.S. CENSUS BUREAU, AMERICAN COMMUNITY SURVEY 2006, available at <http://factfinder.census.gov>.

3. Nursing home residents usually fall into two categories: either long-term (likely for the rest of one's life) or short-term (usually made up of posthospitalized individuals requiring rehabilitation prior to returning home or transfer to a non-nursing home facility such as assisted living). Members of both of these categories of residents are very medically needy. See JUDY KASPER, WHO STAYS AND WHO GOES HOME: USING NATIONAL DATA ON NURSING HOME DISCHARGES AND LONG-STAY RESIDENTS TO DRAW IMPLICATIONS FOR NURSING HOME TRANSITION PROGRAMS 8-9 (2005); see also JUDITH S. TURIEL, OUR PARENTS, OURSELVES: HOW AMERICAN HEALTH CARE IMPERILS MIDDLE AGE AND BEYOND 22 (2005) (referring to "the public's image of nursing homes, where the oldest old, the badly disabled stroke victims, sufferers of dementia, and the semiconscious wait out their last months or years"). One of the main reasons nursing home residents are older and sicker today than in the past is the growing success of the American long-term care system in assisting individuals with their activities of daily living in home- and community-based settings until they have become so disabled that a nursing home is the only viable option. Regarding that success, see, for example, Naoko Muramatsu et al., *Risk of Nursing Home Admissions Among Older Americans: Does States'*

disabled.⁴ Virtually all current residents of nursing homes in the United States have significant physical or mental problems, both chronic and acute, requiring ongoing, competent medical attention.

Physicians may be involved in providing medical care to nursing home residents as facility medical directors, a staff position required and extensively regulated by federal law for all nursing homes certified for participation in the Medicare and Medicaid programs⁵ as well as by individual state laws.⁶ Physicians also may be involved as specialist consultants or as attending physicians.⁷ Attending physicians may be either practicing privately and granted staff privileges to treat residents within the facility, or salaried or employed directly by the nursing home as part of a closed medical staff.⁸

Nursing homes have been extensively regulated as health care institutional providers by a panoply of federal and state administrative agencies⁹ and state and local prosecutors' offices, and have been

Spending on Home- and Community-Based Services Matter?, 62 J. GERONTOLOGY: SOC. SCI. S169 (2007), and CTR. MEDICARE & MEDICAID SERVS., U.S. DEP'T HEALTH & HUMAN SERVS., MONEY FOLLOWS THE PERSON GRANTS, www.cms.hhs.gov/DeficitReductionAct/20_MFP.asp. (last visited Oct. 6, 2008). There is evidence that there is even more opportunity for progress in this regard. See Vincent Mor et al., *Prospects for Transferring Nursing Home Residents to the Community*, 26 HEALTH AFF. 1762 (2007); Press Release, U.S. Dep't of Health & Human Servs., HHS Announces \$88 Million for New Nursing Home Diversion Programs (Sept. 24, 2007), available at <http://www.hhs.gov/news/press/2007pres109/pr20070924a.html>. But see *Deinstitutionalizing Long-Term Care: Making Legal Strides, Avoiding Policy Errors*, 11 ETHICS L. & AGING REV. 1 (2005) (warning about potential problems that may arise in the process of reducing the population of nursing homes).

4. See ROBYN I. STONE, LONG-TERM CARE FOR THE ELDERLY WITH DISABILITIES: CURRENT POLICY, EMERGING TRENDS, AND IMPLICATIONS FOR THE TWENTY-FIRST CENTURY 7-8 (2000), available at www.milbank.org/0008stone.

5. 42 C.F.R. § 483.5 (2007); CTR. FOR MEDICAID & STATE OPERATIONS/SURVEY & CERTIFICATION GROUP, U.S. DEP'T OF HEALTH & HUMAN SERVS., S&C-06-05, REVISED NURSING HOME MEDICAL DIRECTOR TAG AND ACCOMPANYING TRAINING MATERIALS (2005).

6. E.g., MD. CODE ANN., HEALTH-GEN. § 19-1411 (2005).

7. CARI LEVY ET AL., LITERATURE REVIEW AND SYNTHESIS OF PHYSICIAN PRACTICES IN NURSING HOMES 6-7 (2005).

8. *Id.* at 13; Jacob Dimant, *Roles and Responsibilities of Attending Physicians in Skilled Nursing Facilities*, 4 J. AM. MED. DIRECTORS ASS'N 231, 232 (2003); Cari Levy et al., *Physician Practice Patterns in Nursing Homes*, 8 J. AM. MED. DIRECTORS ASS'N 558, 559 (2007). Many medical directors also act as the attending physician for particular residents. LEVY ET AL., *supra* note 7, at 9-10. This Article does not deal with the involvement of physicians who care for nursing home residents in settings other than the nursing home, such as the physician's own office.

9. For a compilation of state regulations pertaining to nursing homes, see NH Regulations Plus, An In-Depth Look at State Nursing Home Regulations, www.hpm.umn.edu/nhregsplus/index.htm (last visited Oct. 6, 2008).

subject to potential civil malpractice litigation and liability for a number of years.¹⁰ Additionally, nursing homes routinely receive attorneys' requests for copies of residents' medical records, an occurrence that often is a precursor to the filing of a legal action.¹¹ Tort claims against facilities usually are based on allegations of resident bedsores or decubitus ulcers,¹² falls, dehydration, malnutrition and weight loss,¹³ infections, physical abuse, and wrongful death.¹⁴ However, now individual physicians, as opposed to the facilities alone, are personally at risk of potential criminal prosecution or civil malpractice litigation and liability based on allegations that the quality of care they render to nursing home residents has deviated from acceptable professional standards.¹⁵

The genesis of the research project reported on in this Article was the author's exposure to many anecdotal complaints by physicians about their perceptions that the legal environment within which they function is personally intimidating and constricting. This project set out to examine these complaints systematically, with a specific focus on the extent to which the psychological aura of legal risk apparently pervading the provision of medical care within American nursing homes at present affects, both directly and indirectly and both positively and negatively, the quality of medical care and quality of

10. AON GLOBAL RISK CONSULTING, LONG TERM CARE: 2006 GENERAL LIABILITY AND PROFESSIONAL LIABILITY ACTUARIAL ANALYSIS 17 (2007), available at www.aon.com/about/publications/issues/2006_Itc_study.jsp [hereinafter AON 2006]; Marshall B. Kapp, *Improving the Quality of Nursing Homes: Introduction to a Symposium on the Role of Regulation*, 26 J. LEGAL MED. 1, 1-8 (2005); David G. Stevenson & David M. Studdert, *The Rise of Nursing Home Litigation: Findings from a National Survey of Attorneys*, 22 HEALTH AFF. 219, 219 (2003).

11. Rebecca Elon, *The American Geri-Wars: Moving Beyond Our Encampments*, 26 J. LEGAL MED. 69, 72-73 (2005).

12. Richard G. Bennett et al., *The Increasing Medical Malpractice Risk Related to Pressure Ulcers in the United States*, 48 J. AM. GERIATRIC SOC'Y 73 (2000); Marge Meehan & W. Michael Hill, *Pressure Ulcers in Nursing Homes: Does Negligence Litigation Exceed Available Evidence?*, 48 OSTOMY WOUND MGMT. 46 (2002); Anne Coble Voss et al., *Long-Term Care Liability for Pressure Ulcers*, 53 J. AM. GERIATRIC SOC'Y 1587 (2005).

13. Stevenson & Studdert, *supra* note 10, at 222.

14. CAL. ADVOCATES FOR NURSING HOME REFORM, MUCH ADO ABOUT NOTHING: DEBUNKING THE MYTH OF FREQUENT AND FRIVOLOUS ELDER ABUSE LAWSUITS AGAINST CALIFORNIA'S NURSING HOMES 15 (2003), available at www.canhr.org/reports/2003/CANHR_Litigation_Report.pdf [hereinafter MUCH ADO].

15. Regarding the standard of due care applicable in a medical malpractice civil action, see MARCIA M. BOUMIL ET AL., MEDICAL LIABILITY IN A NUTSHELL 25-37 (2d ed. 2003).

life experienced by many individuals who become nursing home residents.¹⁶

Part II supplies background on the project, specifically the starting assumptions, research questions, and research methods. The findings emanating from these research efforts are delineated in Part III. Part IV contains prescriptive recommendations, consistent with the research findings, for improvements in long-term care public policy and industry practice.

II. Background

A. Starting Assumptions and Hypotheses

The investigation described here commenced with several initial assumptions or hypotheses. First was the assumption that nursing home residents currently are more in need of medical care than in the past,¹⁷ and that at least some of that care should be provided directly by physicians themselves. Moreover, based on anecdotal complaints by physicians, nursing home administrators, and facility attorneys, it was hypothesized that physicians hold significant legal apprehensions about their own personal liability associated with being involved as medical directors and attending physicians in nursing homes. It was hypothesized additionally that physicians' legal anxieties are fueled by a variety of factors, one of which is an accurate appraisal of their risk of being embroiled involuntarily in litigation and liability. It was also assumed that physicians' anxieties about possible legal entanglements are exacerbated by problems they have personally experienced, or stories they have heard about other physicians' experiences, regarding the unavailability or unaffordability of liability insurance coverage.

Another initial hypothesis to be tested was that physicians' legal anxieties produce certain positive consequences. These positive consequences were assumed to include mainly improvements in attention to resident safety,¹⁸ greater respect for residents' rights,¹⁹ and better

16. See Jennifer L. Troyer & Herbert G. Thompson, Jr., *The Impact of Litigation on Nursing Home Quality*, 29 J. HEALTH POL. POL'Y & L. 11 (2004).

17. See *supra* text accompanying notes 2-4.

18. Cf. *Assuring Safety in Long Term Care: Ethical Imperatives, Legal Strategies, and Practical Limitations*, 9 ETHICS L. & AGING REV. 1 (2003) (discussing safety concerns and strategies in long-term care generally).

documentation of resident care, which, in turn, is presumed to contribute to an enhancement in the quality of care actually delivered.²⁰

However, it also was assumed that physicians' legal apprehensions produce demonstrably negative consequences. Among these hypothesized detriments to the quality of residents' lives (and, not incidentally, to the quality of life for family members of nursing home residents)²¹ were: an unwillingness on the part of qualified physicians to serve in the capacity of nursing home medical director; an unwillingness of qualified physicians to care for nursing home residents in an attending role; premature and unnecessary transfers of residents from nursing homes to acute care hospitals; excessively aggressive medical treatment of some residents (overtreatment); insufficiently aggressive medical treatment of some residents (undertreatment, especially of residents' pain);²² overprotection of nursing home residents in a way that infringes their autonomous choices;²³ and increases in the price of nursing home care that might adversely affect consumers' ability to afford and therefore obtain proper care when needed.

B. Research Methods

The project reported on in this Article took the form of qualitative social science research,²⁴ with the protocol approved by the Institutional Review Board of the author's employing institution.²⁵ The au-

19. See generally 42 C.F.R. § 483.10 (2007) (regarding the rights of nursing home residents).

20. See generally RONALD W. SCOTT, LEGAL ASPECTS OF DOCUMENTING PATIENT CARE (2d ed. 2000) (discussing the importance of good documentation in the health care arena).

21. See Cynthia L. Port et al., *Resident Contact with Family and Friends Following Nursing Home Admission*, 41 GERONTOLOGIST 589 (2001) (discussing the continuing relationship and emotional investment families maintain with their loved ones after nursing home admission).

22. See, e.g., Patricia Sawyer et al., *Substantial Daily Pain Among Nursing Home Residents*, 8 J. AM. MED. DIRECTORS ASS'N 158 (2007) (discussing generally the problem of physicians undertreating nursing home residents' pain).

23. See Marshall B. Kapp, "At Least Mom Will Be Safe There": *The Role of Resident Safety in Nursing Home Quality*, 12 QUALITY & SAFETY IN HEALTH CARE 201 (2003) (discussing the problem of resident safety trumping all other considerations).

24. See, e.g., COLLECTING AND INTERPRETING QUALITATIVE MATERIALS (Norman K. Denzin & Yvanna S. Lincoln eds., 1998); IMPROVING AGING AND PUBLIC HEALTH RESEARCH: QUALITATIVE AND MIXED METHODS (Leslie Curry et al. eds., 2006); Nancy E. Schoenberg et al., *Food for Thought: Nourishing the Publication of Qualitative Research*, 26 J. APPLIED GERONTOLOGY 4 (2007).

25. Southern Illinois University Institutional Review Board approval of this project is on file with the author.

thor engaged in more than forty-five telephone interviews with a purposefully selected sample²⁶ of professionals—physicians, a nurse, attorneys, nursing home resident advocates, nursing home administrators, trade association executives, insurance industry representatives, and health services researchers—drawn from practice, private organizations, and academia who are involved in some form with nursing homes and resident care. The template for these interviews consisted of the following queries:

- (a) Do you think physicians are apprehensive regarding their own personal legal exposure associated with caring for nursing home residents, either as a medical director or attending physician, or in both capacities?
- (b) To the extent such legal anxiety exists among physicians, what is its etiology or origin?
- (c) How do you think physicians' apprehensions square with the actual risks they confront?²⁷
- (d) How do you think the prevailing liability insurance situation, in terms of both availability and price (affordability), exacerbates or mollifies physicians' concerns about participating in the medical care of nursing home residents?
- (e) How do you think physicians' legal anxieties positively or negatively influence their professional conduct in ways that impact access to and affordability of nursing home care, as well as the quality of life and quality of care enjoyed by nursing home residents?
- (f) Have you given up or curtailed your nursing home practice because of litigation and liability fears? Do you know of physicians who have either curtailed or given up their nursing home practice because of these apprehensions?

Additionally, relevant websites of trade and professional associations, advocacy organizations, and government agencies were

26. See, e.g., Mary Hrywna et al., *Content Analysis and Key Informant Interviews to Examine Community Response to the Purchase, Possession, and/or Use of Tobacco by Minors*, 29 J. COMMUNITY HEALTH 209, 211 (2004) (illustrating the purposeful selection technique of identifying potential interviewees for a social science research project).

27. Cf. DAVID A. MOSS, *WHEN ALL ELSE FAILS: GOVERNMENT AS THE ULTIMATE RISK MANAGER* 41 (2003) (arguing that perception, much more than reality, is what determines human behavior).

thoroughly searched. A general Google search also was conducted. Several other potential data sources were pursued without success.²⁸

III. Findings

A. Sources and Forms of Physicians' Anxieties

This study clearly confirmed the consensus that nursing home residents today indeed are both acutely and chronically sicker and more in need of medical care than past generations of nursing home residents have been. Health services researchers have commented on:

the intractable nature of chronic health conditions and disease processes for many residents in the nursing home population. Even with the very best of care, residents may fail to improve or may decline in health status over time. Outcomes such as ADL decline, decline in range of motion, worsening incontinence, weight loss, or increasing pain may be difficult to prevent, particularly in the latter stages of Alzheimer's disease, cancer, or other progressively debilitating conditions.²⁹

In light of current demographic trends—especially the aging of the American population—and directions in public policy that enable people to avoid entry into nursing homes for longer periods of time, everyone expects the morbidity and disability levels of nursing home residents to intensify in the future.³⁰

A significant finding of the study was that physicians' legal anxieties about nursing home involvement, either as medical directors or attending physicians, appear to vary widely—mainly based on any particular physician's present geographical location—from serious concern bordering on virtual paranoia to a relaxed attitude bordering

28. One of those unfruitful pursuits was a series of requests made by the author to the California Department of Insurance for access to data collected by the Department's Policy and Planning Branch, Statistical Analysis Division pursuant to section 674.9(b) of the California Insurance Code. That statutory provision requires property and casualty insurers covering long-term health care facilities, residential care facilities for the elderly, and physicians who provide or oversee the provision of care to residents of long-term care facilities or residential care facilities for the elderly to regularly report to the Department of Insurance data on claims and losses. CAL. INS. CODE § 674.9(b) (West 2005). The Department failed to respond to a number of formal requests by the author to access this statutorily required database. E-mail correspondence is on file with the author.

29. Greg Arling et al., *Nursing Effort and Quality of Care for Nursing Home Residents*, 47 GERONTOLOGIST 672, 681 (2007).

30. See, e.g., Ashok J. Bharucha et al., *Predictors of Nursing Facility Admission: A 12-Year Epidemiological Study in the United States*, 52 J. AM. GERIATRICS SOC'Y 434, 438 (2004).

on complacency. The level of physicians' legal anxieties appears to be influenced in any specific locale by a variety of factors other than the actual number and outcome of malpractice lawsuits brought recently in that area against physicians³¹ by nursing home residents or representatives (usually family members) of nursing home residents³² who were treated by the physician³³ or who allegedly suffered injuries while residing in a nursing home for which the defendant physician served in the capacity of medical director.³⁴ The other factors influencing the level of legal anxiety include the extent to which physicians are regularly exposed to—some would say “bombarded by”—advertisements by personal injury law firms seeking out potential nursing home plaintiffs,³⁵ media coverage of untoward incidents in local nursing homes, especially if those incidents involve legal action of some type, and an incidence rate of threatened lawsuits by families

31. According to some of the resident advocates interviewed for this project, even when the physician is personally named as a defendant in a tort action brought by or on behalf of a nursing home resident (which the advocates characterize as a rare event itself), this is done as a proper matter of due diligence by the plaintiff's attorney, and the physician usually is voluntarily dropped from the lawsuit early in the litigation. Telephone Interview with Representative of Resident Advocacy Org. (Aug. 27, 2007). The plaintiffs' attorneys interviewed for this project concur with this assessment. Telephone Interview with Ill. Plaintiff's Attorney (Aug. 1, 2007). By contrast, other interviewees counter that it is not uncommon for an attending physician to be named as a defendant for the first time only after that physician has given a deposition in a tort action originally brought solely against the nursing home and perhaps the Director of Nursing. Telephone Interview with Cal. Physician (Aug. 2, 2007).

All interviews cited throughout the Article were conducted with the understanding, as required by the Southern Illinois University Institutional Review Board reviewing the research project, that interviewees would not have their identity revealed in any report or publication from the project. The author maintains personal notes of all interviews in his files.

32. See Deborah K. Hedgecock, *The Preliminary Impact of 2001 Florida Tort Reform on Nursing Facility Litigation in One County* 65 (Mar. 30, 2007) (unpublished Ph.D. dissertation, University of South Florida) (on file with author) (finding that relatives were legal representatives of residents in 74.4% of all lawsuits brought against nursing homes or their personnel).

33. See, e.g., *Miller v. Cotter*, 863 N.E.2d 537 (Mass. 2007) (providing an example of an action for negligence; willful, wanton, and reckless conduct; and failure to obtain informed consent brought on behalf of a nursing home resident against the treating physician in the nursing home).

34. Telephone Interview with Fla. Physician (Aug. 24, 2007).

35. See, e.g., Wilkesmchugh.com, *Nursing Home Abuse and Neglect*, <http://www.wilkesmchugh.com/nursing-home-abuse> (last visited Oct. 6, 2008) (law firm bragging that it has earned over \$300 million in courtroom verdicts against nursing homes).

that fosters an atmosphere of unpredictability and emotional drain even when the threats do not actually materialize.³⁶

It is imperative to understand that, in the words of one physician interviewee, “[i]n shaping perception, one case opens the floodgates of anxiety and defensive reaction, and the word is out.”³⁷ According to another physician interviewee who reported that, over the past couple of years, he has been approached without any solicitation on his part much more regularly by both plaintiff and defense attorneys to review the files of nursing home patients in anticipation of or response to legal claims against those patients’ attending physicians, “[p]eople talk [about the nursing home physician litigation situation], and legal risk is the elephant in the room all the time.”³⁸ For another physician interviewee, the possibility of being sued “is always in the back of your mind.”³⁹ Additionally, physicians’ personal legal concerns in any locale seem to vary almost directly with the degree to which the nursing homes themselves in that area are effectively unavailable as the potentially lucrative primary defendant to be sued for compensation for a resident’s injuries.⁴⁰ Nursing homes *qua* corporate entities⁴¹ have become less available as potential liability “deep pock-

36. Telephone Interview with N.Y. Physician (July 27, 2007).

37. Telephone Interview with Cal. Physician (Aug. 2, 2007).

38. Telephone Interview with Mass. Physician (Aug. 3, 2007).

39. Telephone Interview with Ill. Physician (Sept. 18, 2007).

40. Telephone Interview with Fla. Physician (Aug. 24, 2007).

41. The majority of nursing homes in the United States are for-profit, investor-owned corporations. See JULIUS B. RICHMOND & RASHI FEIN, *THE HEALTH CARE MESS: HOW WE GOT INTO IT AND WHAT IT WILL TAKE TO GET US OUT* 130 (2005).

[T]he aging of the population and the presence of Medicaid funding for long-term care led to the expansion of the nursing home sector. This expansion required the investment of capital (which was not as readily available to not-for-profits on a loan basis). In turn, this led to an increase in the proportion of for-profit nursing homes and for-profit chains . . .

Id. However, treatment of the nonprofit sector of the industry by regulatory bodies and the civil justice system has been generally indistinguishable from that of the proprietary sector, and therefore both sectors are included in this discussion. See Marshall B. Kapp, *The Nursing Home Crisis: Views from a Trustee in the Nonprofit Sector*, 4 J. HEALTH CARE L. & POL’Y 308, 317–18 (2002); cf. Nursing Home Transparency and Improvement Act of 2008, S. 2641, 110th Cong. (providing consumers with more transparency about nursing homes, including current information about facility ownership and operations); *Two House Committees Plan to Investigate Private Equity Ownership of Nursing Homes*, 16 BNA HEALTH L. REP. 1289–90 (2007) (announcing plans for a vigorous congressional investigation into the appropriateness of private equity ownership of nursing homes); Carla K. Johnson, *Illinois Lawmakers Hear About High-Stakes Nursing Home Buyout*, BLOOMINGTON PANTAGRAPH, Nov. 27, 2007, <http://www.pantagraph.com/articles/2007/11/27/>

ets” recently in many places for several different reasons. For one thing, in the last several years, in response to both national⁴² and local⁴³ concerns about a socially negative nursing home liability climate in terms of diminished quality, access, and workforce capacity,⁴⁴ a number of states have enacted legislative and judicial changes specifically intended to discourage the filing and reduce the severity of tort actions against nursing homes.⁴⁵ Many of these changes have been strongly, and sometimes quite polemically,⁴⁶ criticized by nursing home residents’ advocates on the grounds that, because the existing federal-state regulatory system for surveying and certifying nursing

news/doc474bbb9bc3da4022628300.txt (reporting on the Illinois House Committee on Aging’s investigation of the proposed sale of the Manor Care, Inc., nursing home chain to the private equity firm Carlyle Group and suggesting that nursing homes “have become popular acquisition targets for Wall Street investment companies in recent years” and that “Carlyle wants to buy Manor Care because it foresees profits driven by aging baby boomers and the success of Manor Care”).

42. See, e.g., *Medical Liability in Long Term Care: Is Escalating Litigation a Threat to Quality and Access?: Hearing Before the S. Spec. Comm. on Aging*, 108th Cong. (2004).

43. See, e.g., Marlene Piturro, *Liability Crisis Update*, <http://www.amda.com/publications/caring/march2004/liability.cfm> (last visited Oct. 6, 2008) (featuring “a historical overview of the liability debacle”).

44. See, e.g., Kendall Anderson, *Area Could Face Nursing Home Director Shortage: Preparing for Growing Geriatric Needs; Lack of Applicants Could Affect Care of N. Texas Seniors*, DALLAS MORNING NEWS, Feb. 23, 2002, at 29A (reporting on a sharp drop in the number of people becoming nursing home administrators in Texas).

45. See, e.g., Cherie Song, *States Move to Curb Nursing Home Suits: Damages, Right to Sue Are Limited*, NAT’L L.J., July 8, 2003, <http://www.law.com/jsp/article.jsp?id=90005535917> (reporting on enacted laws or pending bills in Louisiana, Texas, West Virginia, Oklahoma, and Alabama).

46. See, e.g., Michael L. Rustad, *Heart of Stone: What Is Revealed About the Attitude of Compassionate Conservatives Toward Nursing Home Practices, Tort Reform, and Noneconomic Damages*, 35 N.M. L. REV. 337 (2005).

Tort reformers regale the public with horror stories about nursing homes going bankrupt or having to forgo insurance coverage as a result of frivolous lawsuits. They want to cut off the ability of injured residents to obtain legal representation by reducing the incentives for lawyers to represent elderly victims of neglect. Tort reformers know that it is expensive for the nursing home industry to react to lawsuits by improving conditions; unfortunately, they are more concerned about saving corporate profits than about preventing an epidemic of pain and suffering. Any concept of morality or family values should include robust legal remedies to redress the consequences of disgusting nursing home conditions.

Id. at 340. But see R. Patrick Bedell, Note, *The Next Frontier in Tort Reform: Promoting the Financial Solvency of Nursing Homes*, 11 ELDER L.J. 361 (2003) (propounding the position that enacting and strengthening tort reform with regard to nursing home litigation may alleviate some of the financial difficulties facing the American nursing home industry).

homes⁴⁷ is largely ineffective as a quality control mechanism,⁴⁸ a robust tort system is necessary to compensate victims injured by nursing home neglect and to deter providers from negligence in caring for future residents.⁴⁹ Nonetheless, in several jurisdictions it appears that the litigation climate for nursing homes has stabilized to some extent—in terms of the number of malpractice claims and their outcomes—following legislative enactment of legal modifications expressly intended to produce that result.⁵⁰

However, changes in tort law constitute only one factor, perhaps not even the most important, in making the nursing home *qua* corporate entity less inviting as a deep pocket for plaintiffs to sue in those jurisdictions. Other potentially contributing explanations might include: greater attention to quality of care⁵¹ and resident safety;⁵² nurs-

47. For a good description of the present nursing home survey and certification process and some of its limitations, see *The Nursing Home Reform Act Turns Twenty: What Has Been Accomplished, and What Challenges Remain: Hearing Before the S. Spec. Comm. on Aging*, 110th Cong. 11–16 (2007) (statement of Kathryn Allen, Director of Health Care, U.S. Government Accountability Office). The results of every state survey of a Medicare- and Medicaid-certified facility are compiled and published by the Centers for Medicare and Medicaid Services through the On-Line Survey, Certification, and Reporting system. AM. HEALTH CARE ASS'N, CMS OSCAR DATA, http://www.ahca.org/research/oscar/OSCAR_readme.pdf (last visited Nov. 21, 2008).

48. See NAT'L CITIZENS' COAL. FOR NURSING HOME REFORM, THE FACES OF NEGLIGENCE: BEHIND THE CLOSED DOORS OF NURSING HOMES 2–3, available at <http://www.nccnhr.org/uploads/SectionI.pdf> (last visited Nov. 19, 2008) [hereinafter NCCNHR] (noting poor enforcement performance by state regulatory agencies); U.S. GEN. ACCOUNTING OFFICE, GAO/T-HEHS-98-219, CALIFORNIA NURSING HOMES: FEDERAL AND STATE OVERSIGHT INADEQUATE TO PROTECT RESIDENTS IN HOMES WITH SERIOUS CARE VIOLATIONS (1998); Troyer & Thompson, *supra* note 16 (concluding that tort claims may result from quality problems that go unmeasured during the survey process).

49. NCCNHR, *supra* note 48, at 4–5; TEX. ADVOCATES FOR NURSING HOME RESIDENTS & NAT'L CITIZENS' COAL. FOR NURSING HOME REFORM, THE FACES OF NEGLIGENCE: BEHIND THE CLOSED DOORS OF TEXAS NURSING HOMES 6–7, in *Medical Liability in Long Term Care: Is Escalating Litigation a Threat to Quality and Access?: Hearing Before the S. Spec. Comm. on Aging*, 108th Cong. 137–38 (2004); see also David M. Studdert & David G. Stevenson, *Nursing Home Litigation and Tort Reform: A Case for Exceptionalism*, 44 GERONTOLOGIST 588 (2004) (cautioning against extending conventional medical malpractice tort reforms to the nursing home industry).

50. Hedgcock, *supra* note 32, at 71 (discussing the situation in Florida following the 2001 enactment of chapter 2001-45 of the Laws of Florida). The Florida nursing home legislation and the circumstances leading to its passage are described in Larry Polivka et al., *The Nursing Home Problem in Florida*, 43 GERONTOLOGIST 7 (Special Issue II 2003).

51. See, e.g., JOSHUA M. WIENER ET AL., KAISER FAMILY FOUND., NURSING HOME CARE QUALITY: TWENTY YEARS AFTER THE OMNIBUS BUDGET RECONCILIATION ACT OF 1987 (2007); AON 2006, *supra* note 10, at 12; Jennifer L. Hilliard, *The Nursing Home Quality Initiative: Shift in Policy, Shift in Paradigm*, 26 J.

ing homes purposely reducing the amount of liability insurance coverage they purchase when, as in Florida, they are not required to carry a specific minimum amount of coverage;⁵³ nursing homes even “going bare” or without any coverage in some cases;⁵⁴ facilities exiting jurisdictions with particularly adverse legal environments altogether;⁵⁵ corporate restructuring strategies, such as the creation of limited liability companies to separate the lucrative real estate investment from the shoestring nursing home operations, designed to protect financial assets from being reached by civil judgments;⁵⁶ and a strong effort to get new consumers or their surrogates to enter into agreements to arbitrate rather than litigate their future disputes with the facility.⁵⁷ The ultimate result is that physicians in those jurisdictions in which plaintiffs do not have nursing homes readily available and desirable as primary defendants in malpractice actions fear that they, as the medical directors and attending physicians, have involuntarily, by default had thrust upon them that role of deep-pocketed liability target.

LEGAL MED. 41 (2005); Catherine Spader, *Long-Term Care Facilities Implement QI Plans for Skin Breakdown*, Nov. 19, 2007, <http://www.include.nurse.com/apps/pbcs.dll/article?AID=/20071119/IL02/711190314> (reporting on a quality improvement initiative conducted by the Illinois Quality Improvement Organization).

52. Regarding resident safety in nursing homes, see Kapp, *supra* note 1.

53. Hedgecock, *supra* note 32, at 94. Moreover, “[t]he issue of minimal or no nursing facility professional liability insurance coverage may be influencing not only the willingness of attorneys to file nursing facility related lawsuits, but also may explain overall reduced settlements.” *Id.* at 104.

54. Laurence Darmiento, *Nursing Facilities Drop Insurance as Prices Ratchet Up*, L.A. BUS. J., May 17, 2004, available at 2004 WLNR 14370548 (describing the California situation); Andrea Petersen, *Malpractice Litigation Costs Stabilize for Nursing Homes*, WALL ST. J., Apr. 27, 2005, at D5 (commenting on the Florida situation); Kathy Robertson, *Malpractice Cancellations Worry Nursing-Home Docs*, SACRAMENTO BUS. J., Oct. 11, 2002, available at <http://sacramento.bizjournals.com/sacramento/stories/2002/10/14/focus2.html> (“By some estimates, roughly half the facilities in the state [of California] are going ‘bare’—without insurance—or with coverage from companies that are not registered in the state.”).

55. AON 2006, *supra* note 10, at 73 (noting the impact of large providers leaving Florida); Petersen, *supra* note 54.

56. Joseph E. Casson & Julia McMillen, *Protecting Nursing Home Companies: Limiting Liability Through Corporate Restructuring*, 36 J. HEALTH L. 577 (2003). Some of these arrangements are beginning to be examined more closely by regulators. See Associated Press, *Nursing Home Sale Scrutinized* (Nov. 9, 2007) (on file with author) (describing how some Florida lawmakers and unions are questioning a private equity firm’s pending purchase of the nation’s largest nursing home chain, Manor Care).

57. Nathan Koppel, *Nursing Homes, in Bid to Cut Costs, Prod Patients to Forgo Lawsuits*, WALL ST. J., Apr. 11, 2008, at A1.

Consistent with those physician anxieties is the following determination by a Florida researcher:

Lawsuits filed post reform added more defendants, both corporate and individual [and including physicians as well as nursing home owners, general partners, directors of nursing, administrators, corporate officers, and board trustees], with individuals added significantly more often (26.5%), almost doubling pre reform levels (13.5%). Adding more defendants increases the likelihood that based on the combined insurance coverage of many defendants settlements will meet the maximum allowable damage amounts under the law. This practice most likely represents attorney efforts to seek damages from every possible source and may be rising due to extremely low professional liability insurance coverage by at least some facilities. Some nursing facilities base decreased liability coverage on reducing risk exposure. They are also looking for alternatives by using limited liability corporations or restructuring ownership of real estate and facility operations into single purpose entities, thereby minimizing available assets.⁵⁸

The reasonableness of physicians' legal anxieties appears to vary substantially from jurisdiction to jurisdiction.⁵⁹ Reasonableness in this context may be looked at as the fit between a physician's degree of legal apprehension and the physician's real risk of exposure to litigation and liability because of the physician's professional involvement in the nursing home context, as judged by an area's previous history with malpractice claims brought against nursing home physicians. This observation was not unexpected given that physicians' perceptions of the legal climate often are driven forcefully by factors other than, and sometimes even contradictory to, statistically valid data, such as attorney advertising for clients and other public admonitions of physicians, their own attorneys' advice,⁶⁰ media coverage, the in-

58. Hedgecock, *supra* note 32, at 97.

59. Regarding the variation among jurisdictions in medical malpractice lawsuits, see generally Kevin D. Hart & Philip G. Peters, *Cultures of Claiming: Local Variation in Malpractice Claim Frequency*, 5 J. EMPIRICAL LEGAL STUD. 77 (2008), and Leonard J. Nelson et al., *Medical Malpractice Reform in Three Southern States*, 4 J. HEALTH & BIOMEDICAL L. 69 (2008). See also John T. Nockleby, *How to Manufacture a Crisis: Evaluating Empirical Claims Behind "Tort Reform,"* 86 OR. L. REV 533, 546-52 (2007) (contending that apprehensions about malpractice liability exposure are overblown).

60. See Elon, *supra* note 11, at 72.

[A] young Baltimore internist decided to open an office and work with the nursing home down the street. An attorney reviewing his medical director contract told him the potential liability of doing nursing home work was far too great and advised him to steer clear of any nursing home involvement. He took his attorney's advice.

Id.

formal medical community grapevine, and the random nature of any particular physician's experience.⁶¹

In California, physician apprehension about potential litigation and liability exposure connected with the care of nursing home residents appears to be uniquely well-grounded. In 1975, the state legislature enacted the California Medical Injury Compensation Reform Act (MICRA) in response to a perceived medical malpractice insurance availability crisis.⁶² MICRA was aimed primarily at discouraging medical malpractice lawsuits against physicians and hospitals, but its provisions apply to nursing homes as well.⁶³ Among the components of this legislation are: a \$250,000 limit on noneconomic—that is, pain and suffering—damages; a collateral-source offset rule under which the jury is permitted to reduce damages by the amount the plaintiff is receiving from any other source, such as health or disability insurance; and allowance of damages to be paid periodically over time rather than as a lump sum.⁶⁴

Although the effects of MICRA have been controversial,⁶⁵ the legislation has been successful in reducing both the size of claim payments and malpractice insurance costs for the medical profession as a whole in California, as compared to other states.⁶⁶ However, “[i]nterestingly, MICRA has not decreased the estimated per capita medical malpractice lawsuits filed in the state nor the number of claims filed against California physicians.”⁶⁷

According to California physicians interviewed for this project and a number of media reports, the damage-recovery limitations imposed by MICRA in standard medical malpractice actions have in-

61. See, e.g., SARA C. CHARLES & EUGENE KENNEDY, DEFENDANT, A PSYCHIATRIST ON TRIAL FOR MEDICAL MALPRACTICE: AN EPISODE IN AMERICA'S HIDDEN HEALTH CARE CRISIS (1985) (a physician's very personal memoir).

62. Richard E. Anderson, *Effective Legal Reform and the Malpractice Insurance Crisis*, 5 YALE J. HEALTH POL'Y L. & ETHICS 341, 350 (2005).

63. Michael L. Rustad, *Neglecting the Neglected: The Impact of Noneconomic Damage Caps on Meritorious Nursing Home Lawsuits*, 14 ELDER L.J. 331, 370–72 (2006).

64. Anderson, *supra* note 62, at 350.

65. Compare Amanda Edwards, *Medical Malpractice Non-Economic Damages Caps*, 43 HARV. J. ON LEGIS. 213, 217–19 (2006) (contending that MICRA unfairly disadvantages injured patients), with Anderson, *supra* note 62, at 349–51 (arguing that MICRA has been a model of effective tort reform).

66. Hedgecock, *supra* note 32, at 24.

67. *Id.* at 24–25.

spired the plaintiffs' bar to seek out other avenues of recovery.⁶⁸ In the nursing home context, California's Elderly Abuse and Dependent Adult Civil Protection Act (EADACPA), enacted in 1991, has provided one such avenue.⁶⁹ Noneconomic damages awarded for violation of this law, which requires the plaintiff to prove by clear and convincing evidence that the defendant is guilty of recklessness, oppression, fraud, or malice in the commission of abuse,⁷⁰ are not subject to MICRA caps.⁷¹ Awards may include unlimited attorneys' fees, punitive damages, and premortem pain and suffering damages as well.⁷² Although consumer advocacy organizations contend that suits filed against nursing homes under the EADACPA have not been excessive or improper,⁷³ there are no reliable available data on legal claims brought against individual physicians involved in nursing home medical care for violation of this statute.

The unavailability of data aside, California physicians appear to hold a widespread perception that the state's EADACPA places them at a very high legal risk in the nursing home context.⁷⁴ They are mindful that one of the express goals of the state legislature in enacting this legislation was "to enable interested persons to engage attorneys to take up the cause of abused elderly persons and dependent adults."⁷⁵

68. Telephone Interview with Cal. Physicians (Aug. 2, 2007); Telephone Interview with Cal. Physicians (Aug. 1, 2007); Telephone Interview with Cal. Physicians (July 25, 2007); Telephone Interview with Cal. Physicians (July 24, 2007).

69. CAL. WELF. & INST. CODE §§ 15600–15657.3 (West 2008); see Seymour Moskowitz, *Golden Age in the Golden State: Contemporary Legal Developments in Elder Abuse and Neglect*, 36 LOY. L.A. L. REV. 589, 605–10 (2003).

70. *Delaney v. Baker*, 971 P.2d 986, 991 (Cal. 1999) (interpreting CAL. WELF. & INST. CODE § 15657).

71. See AON 2006, *supra* note 10, at 9 n.2 (referring to "the prevailing use of the EADACPA to circumvent the non-economic damage caps contained in MICRA"); accord Robertson, *supra* note 54.

72. CAL. WELF. & INST. CODE § 15657.

73. MUCH ADO, *supra* note 14, at 5. The authors concluded from the finding that 501 EADACPA lawsuits were filed in the California counties studied during the three-year period from January 1, 2000, through December 31, 2002—an average of 167 EADACPA claims per year for 577 nursing homes with 58,134 licensed beds, and over 50% of the nursing homes studied having no EADACPA claims brought against them during the study period—that "[t]here is an extraordinarily low level of elder abuse litigation being filed against California" nursing homes. *Id.* But see AON 2006, *supra* note 10, at 39–40 (suggesting that the steady increase in the loss-cost per occupied bed in California over the past decade may owe at least partially to plaintiffs' greater use of the EADACPA against nursing homes).

74. Telephone Interview with Cal. Physicians (Aug. 2, 2007); Telephone Interview with Cal. Physicians (Aug. 1, 2007); Telephone Interview with Cal. Physicians (July 25, 2007); Telephone Interview with Cal. Physicians (July 24, 2007)

75. CAL. WELF. & INST. CODE § 15600.

They are mindful, too, that liability insurance ordinarily does not provide financial indemnity or legal defense for elder abuse claims, which entail more than ordinary negligence errors and omissions.⁷⁶ Thus, claims brought under the EADACPA expose the physician-defendant's personal assets and, at the very least, compel an accused physician to obtain and pay for his or her own legal representation. Personal exposure also predisposes most accused physicians to settle EADACPA claims brought against them as quickly as possible on the most favorable financial terms possible, rather than to "roll the dice," as one geriatrician put it, and take the risk of having even a meritorious defense rejected by a jury or appellate court.⁷⁷ The consequences of physician anxiety in California about potential EADACPA-based civil claims against them are explored below.⁷⁸

Another significant influence on physicians' perceptions about the legal climate and their behavioral reactions to those perceptions is physicians' interpretations of the signals sent to them by the liability insurance industry.⁷⁹ "Liability insurance issues have played a key role in the medical malpractice crises of recent decades."⁸⁰ The ad-

76. BERNADETTE WRIGHT, AARP PUB. POLICY INST., *NURSING HOME LIABILITY INSURANCE: AN OVERVIEW* (2003).

77. See Ramon Coronado, *Settlement Reached in Sutter Health Elder Abuse Case*, SACRAMENTO BEE, Mar. 31, 2006, available at 2006 WLNR 5404143; Telephone Interview with Cal. Physicians (Aug. 1, 2007); Telephone Interview with Cal. Physicians (July 25, 2007); Telephone Interview with Cal. Physicians (July 24, 2007).

78. See *infra* Part III.B.2.

79. See Nockleby, *supra* note 59, at 597. But see Douglas A. Kysar et al., *Medical Malpractice Myths and Realities: Why an Insurance Crisis Is Not a Lawsuit Crisis*, 39 LOY. L.A. L. REV. 785, 816-17 (2006).

80. Jonathan Todres, *Toward Healing and Restoration for All: Reframing Medical Malpractice Reform*, 39 CONN. L. REV. 667, 734 (2006); see also William M. Sage, *Medical Malpractice Insurance and the Emperor's Clothes*, 54 DEPAUL L. REV. 463, 464 (2005).

Central to the academic perspective is an observation that is simultaneously obvious and startling: solving the current malpractice crisis and avoiding future ones will require restructuring medical liability insurance. Why is this obvious? Because a malpractice crisis is defined as a period when liability insurance becomes scarce and expensive. Why is it startling? Because the battle lines in medical malpractice reform were drawn between doctors and lawyers decades ago and have not budged.

Id. Even when liability insurance is readily available to financially indemnify physicians and its purchase is inexpensive, there are many other reasons, including damage to the physician's emotional well-being, professional reputation, and future career prospects, that physicians fear being held liable in a malpractice action. See, e.g., Health Care Quality Improvement Act, 42 U.S.C. §§ 11101-11152 (2000) (establishing a National Practitioner Data Bank to which any entity, including an

verse insurance situation has come as a particular shock because, until lately, coverage of physicians for their nursing home practice was more available and less expensive than almost any other segment of the professional liability insurance market.⁸¹

In some locations, a number of physicians have directly experienced, or have heard colleagues report through the informal but enormously influential physicians' grapevine, problems regarding the affordability of liability insurance covering the physician's role as nursing home medical director or attending physician for nursing home residents. Because almost all nursing home residents have the bulk of their medical care paid for by Medicare or Medicaid rather than consumer private pay, attending physicians are unable to pass their liability insurance costs along to the residents or third-party payers in the form of higher prices for their services.⁸² In some locations, physicians have directly experienced or have heard colleagues report difficulty in obtaining liability insurance coverage for their nursing home roles at any price.⁸³ For instance, the application for a claims-made professional liability insurance policy with The Doctors Company contains as a potentially disqualifying eligibility question, immediately following inquiries about the applicant's negative legal, moral, and mental health history,⁸⁴ the following:

insurer or nursing home, must report any monetary payment made on behalf of any physician to resolve a malpractice claim).

81. See Michelle M. Mello et al., *Changes in Physical Supply and Scope of Practice During a Malpractice Crisis: Evidence from Pennsylvania*, 26 HEALTH AFF. 425, 427 (2007).

82. Cf. Leonard J. Nelson et al., *Damages Caps in Medical Malpractice Cases*, 85 MILBANK Q. 259, 273 (2007) (repeating the claim "that physicians should be concerned about their medical malpractice premiums only if they could not pass on the premiums to their patients in the form of higher prices") (citing Norman K. Thurston, *Physician Market Power—Evidence from the Allocation of Malpractice Premiums*, 39 ECON. INQUIRY 487 (2001)). By contrast, California nursing homes do have the ability to recover their liability insurance costs as a direct pass through in computing their Medicaid payment rates. CAL. WELF. & INST. CODE § 14126.023(a)(5) (West 2008).

83. See Elon, *supra* note 11, at 72.

One of the best and brightest young geriatricians recently came to Baltimore to establish a "nursing home only" medical practice. He was told by the only remaining medical malpractice insurance company in Maryland that he would be uninsurable if he established such a model of practice. It would not underwrite him, at any cost. He decided not to practice in Maryland.

Id.

84. The Doctors Company, *Claims-Made Professional Liability Insurance Application for Health Care Professionals (Physicians and Surgeons)* 12–13,

19. Do you or any ancillary personnel provide medical services at any long-term care facility, skilled nursing facility, or nursing home? If yes:
- A. How many patients do you treat per month, on average?
 - B. Are you or any ancillary personnel under contract to provide medical services at any long-term care facility, skilled nursing facility, or nursing home?
 - C. Do you serve as a medical director of any long-term care facility, skilled nursing facility, or nursing home?⁸⁵

Many physicians interviewed for this project indicated they have encountered similar inquiries when applying for liability insurance policies, sometimes being rejected outright or being forced to pay vastly inflated premiums, and have agreed to large deductible amounts based on their affirmative answers to the insurer's queries about the physician's nursing home involvement, although their experiences varied by geographic location.⁸⁶ Several others reported that companies with whom they had previously contracted for liability insurance coverage cancelled⁸⁷ or declined to renew the policies because of the physician's role as nursing home medical director or attending physician.⁸⁸ One interviewee indicated that when he inadvertently let his insurance policy lapse a few years ago his long-time

http://www.thedoctors.com/ecm/groups/public/@tdc/@web/documents/form/con_id_001186.pdf (last visited Oct. 6, 2008).

85. *Id.* at 13.

86. Telephone Interview with Cal. Physician (Aug. 11, 2007); Telephone Interview with Fla. Physician (Sept. 22, 2007); Telephone Interview with Fla. Physician (July, 24, 2007); Telephone Interview with Ill. Physician (Sept. 18, 2007); Telephone Interview with Md. Physician (Aug. 20, 2007); Telephone Interview with Md. Physician (July 23, 2007).

87. Robertson, *supra* note 54 (reporting on insurance policy cancellations for nursing home physicians in southern California); Telephone Interview with Cal. Physician (Aug. 2, 2007); Telephone Interview with Ill. Physician (Sept. 18, 2007).

88. Terry Hill, *Elder Mistreatment Feeds Liability Crisis*, SAN FRANCISCO MED., Feb. 14, 2006, available at <http://www.sfms.org/AM/Template.cfm?Section=Home&template=/CM/HTMLDisplay.cfm&ContentID=2002>.

In May 2002 one of the leading "physician-owned" carriers sent a sorry-to-announce you letter announcing nonrenewal for [California] doctors whose practice concentrates on treating elderly patients in their homes or in nursing homes. This is due to a recent trend where the application of the Elderly Abuse Law [sic] has negatively impacted health care professionalism.

Id.; cf. WRIGHT, *supra* note 76, at i (discussing problems with insurers raising premiums for nursing homes or ceasing the sale of liability insurance to nursing homes altogether); Timothy F. Noland, *A Challenging Niche: Placing Insurance for Nursing Homes*, 73 AM. AGENT & BROKER 42, 42 (2001) (lamenting the troublesome liability insurance market for nursing homes in California); Telephone Interview with Md. Physician (Aug. 23, 2007).

insurer refused to issue him a new policy because he cared for nursing home residents.⁸⁹ Still other physicians indicate they have curtailed or totally discontinued working in nursing homes in response to liability insurance affordability and availability problems.⁹⁰ A few interviewees contended that some other physicians (not the interviewees themselves) have felt the need to “fly under the insurer’s radar” by falsifying or at least shading their applications for insurance by concealing or minimizing their involvement with nursing home residents.⁹¹ Regrettably, this is an ethically dubious practice that jeopardizes both the physician and the nursing home resident in the event of a negligently inflicted injury.

It appears that casualty carriers are particularly skittish about insuring physicians for potential liability connected to the administrative duties that are part of the nursing home medical director position, even though interviewees for this project uniformly opined that malpractice actions naming a medical director personally for breach of administrative responsibilities actually have been rare,⁹² albeit carrying high severity when they do occur. The American Medical Directors Association (AMDA), the national professional organization comprised of nursing home medical directors, surveyed its membership most recently in 2005–2006 about respondents’ experiences during the preceding three years.⁹³ In response to its survey questions, AMDA found that 29% of respondents had themselves experienced problems in obtaining or renewing medical liability insurance, either because they were refused coverage based on their work in nursing homes (31%) or insurance carriers had withdrawn completely from the nursing home market in the respondent’s state or area (26%).⁹⁴

89. Telephone Interview with Ill. Physician (Sept. 18, 2007).

90. See, e.g., Robert G. Brooks et al., *Availability of Physician Services in Florida, Revisited: The Effect of the Professional Liability Insurance Market on Access to Health Care*, 165 ARCHIVES INTERNAL MED. 2136, 2138 (2005) (reporting that 42.1% of Florida physicians surveyed in 2004 had eliminated nursing home activity in response to the liability insurance situation there); Telephone Interview with Cal. Physician (Aug. 2, 2007); Telephone Interview with Cal. Physician (Aug. 1, 2007); Telephone Interview with Cal. Physician (July 24, 2007).

91. Telephone Interview with Cal. Physician (Aug. 2, 2007).

92. Telephone Interview with Cal. Physician (July 24, 2007). “Rare” certainly is not synonymous with nonexistent. See, e.g., *Satterwhite v. Reilly*, 817 So. 2d 407 (La. Ct. App. 2002) (involving an action on behalf of a nursing home resident against the medical director).

93. See Am. Med. Dirs. Ass’n, *Medical Liability and the AMDA Physician*, <http://amda.com/about/liabilityfacts.cfm> (last visited Oct. 6, 2008).

94. *Id.*

AMDA survey results from a year earlier indicated that 58% of responding physicians agreed that “[h]igh insurance premiums have reduced the financial viability of [their] practice as a nursing facility medical director,” 9% agreed that the “[i]nsurance carrier suggested [they] reduce [their] service as a medical director,” and 7% that “[they] reduced [their] malpractice insurance coverage.”⁹⁵

When malpractice coverage is available, who pays for that coverage varies a great deal. Many nursing homes, to remain competitive in recruiting and retaining competent medical directors,⁹⁶ pay to purchase liability insurance that covers their medical directors for those physicians’ administrative responsibilities.⁹⁷ Anecdotally, this occurs more frequently in the case of large corporate chains as opposed to smaller independent, often not-for-profit, facilities and in urban rather than rural areas.⁹⁸ Attending physicians who are partners in or employees of medical groups may have their nursing home activities covered by the medical group’s insurance policy or self-insured arrangement, particularly when the physician has been relegated to nursing home duties as the group’s “low person.”⁹⁹ Additionally, physicians directly employed by closed-panel capitated or managed long-term care plans such as Kaiser receive liability insurance coverage as part of their employment package.¹⁰⁰

Nevertheless, in response to its survey results and the repeated anecdotal complaints of its members, AMDA concluded there was a significant need to create new options for liability insurance coverage

95. William Simonson, *Letter, Liability Issues’ Impact on Practice: A Physician Survey*, 6 J. AM. MED. DIRECTORS ASS’N 288, 289 (2005); see also James E. Lett II, *Letter, Professional Liability in Long-Term Care: The Pressure Mounts*, 6 J. AM. MED. DIRECTORS ASS’N 426 (2005) (discussing implications of the AMDA/Simonson survey of physicians).

96. See *infra* note 137 and accompanying text for discussion of the difficulties many nursing homes experience in recruiting and retaining competent medical directors.

97. Telephone Interview with Conn. Nursing Home Adm’r (Aug. 20, 2007); Telephone Interview with Md. Physician (Aug. 20, 2007); Telephone Interview with N.Y. Physician (Aug. 6, 2007); Telephone Interview with N.Y. Physician (July 24, 2007).

98. Telephone Interview with Cal. Physician (Aug. 2, 2007).

99. See sources cited *supra* note 97.

100. Kaiser Permanente Aging Network, Professional Liability Insurance, http://physiciancareers.kp.org/ncal/benefits/other_ins.htm (last visited Oct. 6, 2008). Kaiser also is a vertically integrated organization that owns the facilities in which its employee physicians work. Kaiser Permanente Aging Network, Northern California Locations, <http://physiciancareers.kp.org/ncal/locations/locations.htm> (last visited Oct. 6, 2008).

for physicians working in the role of nursing home medical director.¹⁰¹ Although there is some strong sentiment in the medical community that carrying substantial liability insurance only serves to make the physician a more inviting “deep pocket” target for potential plaintiffs, most physicians realize their need for at least minimal coverage for both the administrative and clinical components of their professional lives.¹⁰² This need is especially true if the facility itself is uninsured or underinsured and therefore obviously not providing any coverage to its medical director.

Consequently, AMDA entered into an arrangement with Roundstone Insurance beginning in 2007 to offer through Roundstone affiliates LTC Risk Management and the Westwood Group a new insurance product, MedDirect, to fill the perceived gap.¹⁰³ The basic MedDirect policy provides coverage up to \$500,000/\$1,000,000 limits for administrative services in the physician’s medical director capacity and additional optional coverage for nursing home resident care as an attending physician and for private practice patient care.¹⁰⁴

Another major origin of legal anxiety for nursing home physicians is their apprehension that, when they are physically away from the facility—which for the vast majority of medical directors and attending physicians is most of the time¹⁰⁵—they often are receiving un-

101. See Press Release, Am. Med. Dirs. Ass’n, AMDA Predicts Quality and Access Problems as Medical Liability Issues Drive Physicians from Long Term Care (July 15, 2004), available at http://www.amda.com/news/othernews/2004/071504_liability.cfm.

102. See Brandon Goodman, *Doctors Going Without Malpractice Insurance*, MSNBC.COM, June 18, 2004, <http://www.msnbc.msn.com/id/5234637>. There are, however, anecdotal reports of some physicians—especially in Florida—“going bare” in terms of liability insurance coverage and transferring their assets offshore or to family members. Telephone Interview with Fla. Physician (Aug. 22, 2007). Research revealed no data about how well this strategy has worked either to dissuade plaintiffs from suing those physicians or to protect the physicians’ assets over the long haul.

103. Press Release, Am. Med. Dirs. Ass’n, MedDirect Professional Liability Insurance Is First to Provide Comprehensive Coverage for Medical Directors (Jan. 12, 2007), available at <http://www.amda.com/news/releases/2007/011207.cfm>.

104. MedDirect, Products, <http://www.meddirectcoverage.com/products/index.htm> (last visited Oct. 6, 2008).

105. DEP’T OF HEALTH & HUMAN SERVS., OFFICE OF INSPECTOR GEN., OEI-06-99-00300, NURSING HOME MEDICAL DIRECTORS SURVEY 16 (2003) [hereinafter MEDICAL DIRECTORS SURVEY] (reporting that 86% of surveyed nursing home medical directors spend eight hours or less per week at the nursing home for which they serve as medical director); INST. OF MED., IMPROVING THE QUALITY OF LONG-TERM CARE 199 (Gooloo S. Wunderlich & Peter O. Kohler eds., 2001) (“Medical services are relatively unavailable in day-to-day nursing home care. Medical practitioners have less of a presence except in rehabilitation and other fa-

reliable information about particular residents' medical conditions by telephone¹⁰⁶ from nursing facility staffs, chiefly nurses and nurse aides, who are chronically deficient in both numbers and professional training for their positions.¹⁰⁷ These fears are especially exacerbated when the staff member providing resident information to the physician works for a temporary agency and is not very familiar with the specific facility and its residents.¹⁰⁸ A related source of nursing home physicians' legal anxiety is their apprehension about how dependably the physician's treatment orders for residents will be carried out by staffs who are inadequate in both quantity and professional preparation.¹⁰⁹

cilities that provide more intensive medical services and supervision.”); LEVY ET AL., *supra* note 7, at 7 (“[T]he majority of physicians who care for nursing home residents are community physicians with both an office and hospital-based practice as opposed to practicing in one of those settings exclusively.”); Paul R. Katz & Jurgis Karuza, *Physician Practice in the Nursing Home: Missing in Action or Misunderstood*, 53 J. AM. GERIATRICS SOC'Y 1826 (2005).

106. MEDICAL DIRECTORS SURVEY, *supra* note 105, at 17–18.

Telephone calls may serve as a primary method of communication between medical directors and nursing staff [M]uch of the medical care delivered in nursing homes occurs as a result of telephone calls These calls serve as a method for managing communication between the staff, the physicians, and the directors of nursing.

Id.; see also S. Nicole Hastings et al., *After-Hours Calls from Long-Term Care Facilities in a Geriatric Medicine Training Program*, 55 J. AM. GERIATRICS SOC'Y 1989 (2007) (documenting the prevalence of after-hours telephone calls to physicians from long-term care facilities).

107. Patricia A. Parmelee, *Quality Improvement in Nursing Homes: The Elephants in the Room*, 52 J. AM. GERIATRICS SOC'Y 2138, 2138 (2004).

The nursing shortage has hit [nursing homes] especially hard. On any given day in the average [nursing home], 8.5% of nursing assistant positions and as many as 15% of professional nursing slots are unfilled. Similarly, turnover among registered nurses and licensed practical nurses approaches 50% annually and is much higher for unlicensed personnel. What this means is that, on any given day, there may not be enough “hands on the deck” to meet residents' most basic care needs.

Id. (citations omitted); see also Nicholas G. Castle et al., *Nursing Home Staff Turnover: Impact on Nursing Home Compare Quality Measures*, 47 GERONTOLOGIST 650 (2007) (finding, in general, that higher staff turnover is associated with poorer quality care in nursing homes); Telephone Interview with Cal. Physician (Aug. 2, 2007); Telephone Interview with Conn. Nursing Home Adm'r (Aug. 20, 2007); Telephone Interview with Fla. Physician (July 24, 2007).

108. Nicholas G. Castle & John Engberg, *The Influence of Staffing Characteristics on Quality of Care in Nursing Homes*, 42 HEALTH SERVS. RESEARCH 1822, 1822 (2007).

109. Telephone Interview with Cal. Physician (Aug. 2, 2007); Telephone Interview with Conn. Nursing Home Adm'r (Aug. 20, 2007); Telephone Interview with Fla. Physician (July 24, 2007).

Both sets of physician fears probably are solidly grounded.¹¹⁰ As described by one interviewee, “[t]he nursing home system is a formula for failure. We put the sickest, frailest people needing the most care in low-tech environments with poorly trained and paid staff. Physicians fear disaster because they are completely dependent on staff who are unprepared for the challenges.”¹¹¹ In the words of another interviewee, “[i]n the nursing home, physicians have responsibility without control.”¹¹² Staffing-related concerns extend to the anxiety shared by conscientious medical directors regarding their own potential liability exposure for the errors and omissions of negligent attending physicians in the facility.¹¹³ These concerns are heightened by federal Tag F501, effective November 18, 2005, which makes the medical director responsible for coordinating all the medical care within a facility.¹¹⁴

There appears to be virtually unanimous agreement that physicians are less apprehensive about their personal liability exposure when their own nursing home enjoys the ongoing physical presence of credentialed physician extenders or midlevel professionals, particularly geriatric nurse practitioners (GNPs).¹¹⁵ Midlevel professionals are most likely to be placed full-time in a nursing home when they are employed by a capitated, therefore managed, long-term care plan that has a high concentration of enrollees residing in the facility.¹¹⁶ Physicians indicate much greater confidence in the accuracy of information transmitted to them by GNPs and in the ability of GNPs to oversee the

110. Charlene Harrington et al., *Nursing Home Staffing and Its Relationship to Deficiencies*, 55B J. GERONTOLOGY: SOC. SCI. 5278 (2000) (concluding that insufficient staffing places nursing homes at higher risk of regulatory deficiencies related to quality of care). *But see* Arling et al., *supra* note 29, at 680–81 (expressing “uncertainty about cause and effect in relationships between nursing effort and outcomes,” and suggesting that factors other than amount of nursing resources available may be more important in determining quality of care).

111. Telephone Interview with Cal. Physician (Aug. 2, 2007).

112. Telephone Interview with Cal. Physician (July 25, 2007).

113. Telephone Interview with Cal. Physician (Aug. 2, 2007).

114. CTR. FOR MEDICAID & STATE OPERATIONS/SURVEY & CERTIFICATION GROUP, *supra* note 5.

115. LEVY ET AL., *supra* note 7, at 11 (describing the use of physician extenders in nursing homes); Telephone Interview with Cal. Managed Care Org. Official (Sept. 11, 2007); Telephone Interview with Conn. Managed Care Org. Official (Aug. 13, 2007); Telephone Interview with Conn. Nursing Home Adm’r (Aug. 20, 2007).

116. *See, e.g.*, LEVY ET AL., *supra* note 7, at 12–13 (discussing the Evercare demonstration project); Evercare, About Evercare, http://evercarehealthplans.com/about_evercare.jsp (last visited Oct. 6, 2008).

proper implementation in the nursing home of the physician's orders.¹¹⁷ Therefore, there is less fear that preventable care-related injuries that could legally endanger the physician are likely to happen.¹¹⁸ Consequently, physicians are more willing to serve as a medical director or attending physician in nursing homes characterized by a strong, ongoing presence of these specially trained midlevel professionals.¹¹⁹

B. Consequences of Physicians' Anxieties

1. POSITIVE CONSEQUENCES

As originally hypothesized and confirmed by informants interviewed for this project, the legal anxieties of nursing home physicians can produce a number of positive consequences.¹²⁰ These include mainly improvements in attention to resident safety, greater respect for residents' rights, and better documentation of resident care, which, in turn, is believed to contribute to an enhancement in the quality of care actually delivered.¹²¹ For example, one interviewee opined that medical directors now are "tougher" on attending physicians for whose care the medical director has coordination responsibilities and that this development is likely to redound to the benefit of residents.¹²² Another interviewee cited better communication between physicians and nurses as a quality-improvement result of a climate in which physicians have become more litigation conscious and therefore more attentive to managing risks.¹²³ A different interviewee suggested that, given the perceived threatening legal climate, more nursing home physicians are seeking second opinions and specialty consultations to spread their legal risk.¹²⁴ The same interviewee also noted that such behavior can contribute positively to the quality of resident care—

117. Telephone Interview with Cal. Physician (Oct. 1, 2007); Telephone Interview with Cal. Physician (Aug. 2, 2007).

118. Telephone Interview with Cal. Physician (Oct. 1, 2007); Telephone Interview with Cal. Physician (Aug. 2, 2007).

119. Several interviewees representing resident advocacy groups went so far as to question whether such facilities even needed physicians to be involved in overseeing resident care at all. Telephone Interview with Representative of Local Advocacy Org. (Sept. 18, 2007); Telephone Interview with Representative of Nat'l Advocacy Org. (Aug. 27, 2007); Telephone Interview with Representative of State Advocacy Org. (Aug. 27, 2007).

120. See *supra* notes 18–20 and accompanying text.

121. See sources cited *infra* notes 122–24.

122. Telephone Interview with Conn. Physician (July 26, 2007).

123. Telephone Interview with Ga. Physician (Aug. 1, 2007).

124. Telephone Interview with Mass. Physician (Aug. 3, 2007).

unless it is undertaken in a mistaken attempt to completely abdicate responsibility by “dumping” the resident on another provider rather than for the purpose of sharing information and expertise in a manner beneficial to the resident.¹²⁵

2. NEGATIVE CONSEQUENCES

Interviewees for this project and other information sources also largely confirmed the original hypothesis that physicians’ legal apprehensions regarding nursing home activity may produce, or at least be a contributing factor toward, negative consequences in terms of resident quality of care and quality of life.¹²⁶ “[A] focus on risk management . . . will not necessarily lead to improvements in care”¹²⁷ The adverse effects of these legal apprehensions’ influence on physician behavior, and therefore on resident well-being, may take several forms.

Nursing home residents need access to the services of good physicians, but physicians’ legal anxieties may—at least in some geographic regions and to a greater or lesser extent—significantly impair such access. Some physicians have discontinued their previous involvement in nursing home resident care as medical directors¹²⁸ or in an attending capacity¹²⁹ primarily because of anxiety about personal liability exposure.¹³⁰ Others have substantially curtailed, but not totally withdrawn from, their nursing home involvement mainly for the same reason.¹³¹

Moreover, for an indeterminate but probably significant number of excellent physicians, legal anxieties act to deter them from engaging

125. *Id.*

126. See *supra* note 21–23 and accompanying text.

127. Todres, *supra* note 80, at 720 n.260.

128. According to the most recent AMDA survey, 28% of respondents indicated they had stopped working as a medical director. Am. Med. Dirs. Ass’n, *supra* note 93; see also Karl E. Steinberg, *Sounding Off on the Liability Crisis*, 8 CARING FOR THE AGES 5, 5 (2007) (“Some physicians have left long-term care, at least in part because of concerns of medicolegal liability.”).

129. According to the most recent AMDA survey, 7% of respondents indicated they had during the preceding three years stopped working as attending physicians in nursing homes. Am. Med. Dirs. Ass’n, *supra* note 93.

130. Thirty-nine percent of respondents replied that they had to modify their practices as a result of liability pressures or concerns. *Id.*

131. According to the most recent AMDA survey, 56% of respondents claimed they had during the preceding three years limited their work as medical director, 18% replied they had reduced their resident care hours, and 36% replied they had referred complex cases. *Id.*

in nursing home activities in the first place. This legally inspired nursing home avoidance behavior can be especially disadvantageous for nursing home residents who enter the facility from their community residence or a hospital and whose primary care physicians refuse to continue to care for them after the individual has gone from medical patient to nursing home resident status.¹³² Interviewees described private practitioners who still, as a “social obligation,” follow their patients into the nursing home as “a rapidly dying breed,” because nursing home practice is financially viable only for physicians who care for a large number of residents residing in the same facility.¹³³

Besides creating possible physician-access problems for some residents, the physician depopulation of nursing homes threatens to impair the continued professionalization of nursing home care generally. For example, a former officer of the California Association for Long Term Care interviewed for this project estimated that his organization presently has fewer than half the number of active members that it boasted five years earlier.¹³⁴ Many nursing homes report experiencing a great deal of difficulty attracting and retaining high quality, conscientious medical directors and attending physicians at least in part because of the personal legal anxieties of physicians in their area regarding nursing home risks.¹³⁵ The degree and persistence of such difficulties varies substantially by geographical location, with rural nursing homes ordinarily encountering the most problems in recruitment and retention.¹³⁶ A significant number of nursing home administrators and physicians interviewed for this project suggested that recruitment and retention problems, coupled with nursing homes’ regulatory obligation to have a medical director under contract, not infrequently result in such undesirable outcomes as inadequately trained or outright unfit medical directors being hired and re-

132. LEVY ET AL., *supra* note 7, at 8 (“[D]ata suggest that once patients are admitted to nursing homes, they are unlikely to be followed by their physicians who had been treating them in office practices.”).

133. Telephone Interview with Cal. Physician (Aug. 2, 2007); Telephone Interview with Cal. Physician (Aug. 1, 2007); Telephone Interview with Ga. Physician (Aug. 1, 2007).

134. Telephone Interview with Cal. Physician (Aug. 2, 2007).

135. Telephone Interview with Ill. Nursing Home Adm’r (Aug. 1, 2007); Telephone Interview with Representative of State Nursing Home Trade Ass’n (July 25, 2007).

136. Telephone Interview with Conn. Nursing Home Adm’r (Aug. 20, 2007); Telephone Interview with Ill. Nursing Home Adm’r (Sept. 12, 2007).

tained,¹³⁷ medical directors taking on the attending role for more residents than they can reasonably—let alone optimally—serve, and physicians (described disparagingly by interviewees as “drive-by docs,” “patient-brokers,” or “mega-rounders”) being “spread too thin” among multiple facilities to effectively serve their residents as either medical director or attending physician.¹³⁸ Furthermore, interviewees maintained that physicians working in a “mega-rounder” corporate model under which they may be responsible for covering nursing homes distributed throughout a large geographic area usually are not sufficiently knowledgeable about local community resources relevant to the care of their geriatric patients.¹³⁹ Some interviewees, particularly in northern California, surmised that inadequacies in residents’ medical care were contributing to increased nursing home lengths of stay in their geographic area.¹⁴⁰

The immediately foregoing discussion notwithstanding, it is imperative to note the consensus among interviewees, as well as in the limited discussion of this topic in other venues, that the reason an indeterminate but likely significant number of physicians have decided not to embark upon any nursing home involvement or have greatly

137. See, e.g., Dana B. Mukamel et al., *Nursing Homes’ Response to the Nursing Home Compare Report Card*, 62B J. GERONTOLOGY: SOC. SCI. S218, S223 (2007) (discovering that, even when a state survey finds multiple deficiencies, nursing homes change their medical directors less than 1% of the time). One interviewee for this project observed that many nursing homes can retain their medical directors only by imposing minimal demands on them and “letting them do their own inadequate thing.” Telephone Interview with Mass. Physician (Aug. 3, 2007). Another interviewee asserted that many nursing homes prefer medical directors who do not raise too many questions or make too many demands about the facility’s quality of care and reward medical directors who do not make trouble by assigning to them a large number of fee-generating residents within the facility. Telephone Interview with Cal. Physician (Aug. 2, 2007). This may explain why, according to another interviewee, nursing homes generally do a mediocre job of educating their medical directors about their administrative responsibilities. Telephone Interview with Cal. Physician (Aug. 2, 2007); Telephone Interview with Ill. Nursing Home Adm’r (Sept. 12, 2007). This arrangement, in turn, incentivizes medical directors to go along uncritically with a lucrative status quo for themselves that may not always be in their residents’ best interest. Moreover, according to a medical director informant, even if a medical director wanted to exercise meaningful control over resident care, there frequently is a concern about upsetting the community-based attending physicians who may direct their future nursing home referrals to other, less demanding facilities. Telephone Interview with Mass. Physician (Aug. 3, 2007).

138. Telephone Interview with Cal. Physician (Aug. 1, 2007); Telephone Interview with Fla. Physician (July 24, 2007); Telephone Interview with Ill. Nursing Home Adm’r (Aug. 1, 2007).

139. Telephone Interview with Fla. Physician (July 24, 2007).

140. Telephone Interview with Cal. Physician (July 24, 2007).

scaled down or eliminated their nursing home activities is the *cumulative effect* of legal anxieties *added to* the many other powerful financial, organizational, and professional disincentives that make caring medically for nursing home residents such an uninviting proposition.¹⁴¹ Put bluntly, there is substantial evidence that legal anxieties are the “straw that breaks the camel’s back”¹⁴²—that is, extremely important but not singularly determinative in terms of discouraging many physicians from getting or remaining involved with nursing homes and their residents. The “back” is rather weak, though, in the first place. In this regard, interviewees consistently described the nursing home as a “scary, isolated, foreign setting over which physicians feel they have very little control and where compensation for medical services is very poor.”¹⁴³ Legal anxieties make an already bad situation worse. Phrased colorfully by one interviewed geriatrician:

There are a thousand reasons besides malpractice worries keeping physicians out of nursing homes: it’s the lowest prestige thing you can do in medicine. There is a stigma that you cannot be a very good physician if you are spending a lot of time in nursing homes. Someone is always looking over your shoulder. There is bad publicity when there are bad outcomes, and bad outcomes are inevitable in this setting even when care is conscientious. For medical directors, there is the additional administrative burden (paperwork, phone calls every time a resident’s condition changes), with minimal compensation.¹⁴⁴

In the more vernacular terms of another interviewee, “[nursing home care] doesn’t pay anyway, so who needs the legal hassles if you have any other career options? Nursing homes are a lot of work.”¹⁴⁵ For another interviewee, “[t]he outcome of lawsuits doesn’t even matter. Why should [physicians] put up with legal uncertainty on top of everything else bad about nursing homes?”¹⁴⁶ As one idealistic but disil-

141. Telephone Interview with Conn. Physician (July 26, 2007); Telephone Interview with Fla. Physician (July 24, 2007); Telephone Interview with Ill. Nursing Home Adm’r (Aug. 1, 2007); Telephone Interview with Ill. Physician (Sept. 18, 2007); Telephone Interview with Md. Physician (Aug. 20, 2007); Telephone Interview with State Advocacy Org. (Aug. 27, 2007).

142. This is defined as “the last in a series of unpleasant events which finally makes you feel that you cannot continue to accept a bad situation.” TheFreeDictionary.com, Idioms, <http://idioms.thefreedictionary.com/straw+that+breaks+the+camel’s+back> (last visited Oct. 6, 2008).

143. Telephone Interview with Representative of Cal. Managed Care Org. (Sept. 11, 2007).

144. Telephone Interview with Conn. Physician (July 26, 2007).

145. Telephone Interview with Fla. Physician (July 24, 2007).

146. Telephone Interview with Cal. Physician (July 25, 2007).

lusioned geriatrics educator commenting on “the combined poisonous regulatory environment and powerful anxiety about litigation” queried, “[w]ho would go into this field willingly? A doc devoting herself to nursing home practice doesn’t make any rational sense.”¹⁴⁷

Another starting hypothesis confirmed in this project concerned the role that physicians’ legal anxieties play in motivating many premature and even completely unnecessary transfers of nursing home residents to hospital emergency departments.¹⁴⁸ Feared regulatory repercussions and potential lawsuits often cause even mildly acutely ill residents, not to mention residents for whom the natural dying process is progressing as expected,¹⁴⁹ to be viewed as possible enemies to be dumped on another provider.¹⁵⁰ These transfers frequently are antitherapeutic for the resident who is rushed out of a familiar, supportive environment to a strange, technologically aggressive setting where the resident and family have little control and iatrogenic and nosocomial risks abound.¹⁵¹ Such premature and unnecessary resident transfers, conferring little value¹⁵² other than for the possible¹⁵³

147. Telephone Interview with Mass. Physician (Aug. 3, 2007).

148. LEVY ET AL., *supra* note 7, at 25. Although legal anxieties often play a significant role, the decision to hospitalize a nursing home resident usually is a complicated, multifactorial one. See Jiska Cohen-Mansfield & Steven Lipson, *To Hospitalize or Not to Hospitalize? That Is the Question: An Analysis of Decision Making in the Nursing Home*, 32 BEHAV. MED. 64 (2006); R. Tamara Konezka et al., *Reducing Hospitalizations from Long-Term Care Settings*, 65 MED. CARE RES. & REV. 40 (2008) (arguing that interventions for reducing hospitalizations include more skilled staffing in nursing homes, especially physician assistants and nurse practitioners).

149. See Marshall B. Kapp, *Legal Anxieties and End-of-Life Care in Nursing Homes*, 19 ISSUES L. & MED. 111, 119 (2003).

150. According to one geriatrician interviewee, “[e]very resident with a fever gets sent to the ER [and] every resident who falls gets referred for a scan.” Telephone Interview with Cal. Physician (Oct. 1, 2007). Another made the same remark about residents with wounds such as decubitus ulcers who could be better attended to in the nursing home but who routinely are packed away to be treated at hospitals by medical and nursing staffs with little training in geriatrics. Telephone Interview with Md. Physician (July 23, 2007).

151. See LEVY ET AL., *supra* note 7, at 25; David C. Grabowski et al., *The Costs and Potential Savings Associated with Nursing Home Hospitalizations*, 26 HEALTH AFF. 1753, 1753 (2007) (“Approximately 40 percent of nursing home-hospital transfers have been deemed inappropriate, meaning that the resident could have been cared for safely at a lower level of care.”).

152. See Grabowski et al., *supra* note 151, at 1753.

153. It is not clear that nursing home physicians even obtain much legal peace of mind by shunting residents to hospitals. Interviewees commented on the “adversarial relationship” between hospitals and nursing homes, citing how emergency department physicians constantly criticize the patient’s nursing home care (asking, for instance, “How did this patient get so dehydrated?”) in front of families, setting off a cascade of accusations and antagonism. Telephone Interview with N.Y. Physician (July 27, 2007).

legal peace of mind of the physician and nursing home administration and the facility's financial bottom line,¹⁵⁴ are also very wasteful of scarce health care resources.¹⁵⁵

Other negative consequences of nursing home residents' medical care being driven in a defensive direction (or at least a direction presumed to be legally prophylactic by physicians) by a desire to avoid litigation and liability paradoxically include, as originally surmised, two kinds of mistakes. First, defensiveness sometimes takes the form of overtreatment of residents at the urging of families who have unreasonable expectations about the survival and recovery of their loved ones, especially regarding the use of life-prolonging medical treatments for inevitably dying residents.¹⁵⁶ For example, according to an interviewee, the first hint of patient dehydration, even in a dying person for whom malnutrition is an expected element of the natural history of a fatal disease, means a rush to insert artificial feeding tubes.¹⁵⁷ Another interviewee alluded to batteries of invasive, or at the least uncomfortable, and expensive diagnostic tests being conducted even when the physician knows the test results will not beneficially influence the treatment plan, as well as drugs being prescribed to placate families even when those drugs are clinically inappropriate and actually place the resident at risk for adverse polypharmacy reactions.¹⁵⁸

Physicians are wary because, according to interviewees, many families come into nursing homes primed to be antagonists as a result of media coverage, including law firm advertisements, leading them to believe nursing homes are horrible places and that families must behave like vigilantes to protect the resident from harm.¹⁵⁹ Interview-

154. An interviewee suggested that physicians may, without clinical justification, "feed" nursing home patients to a hospital that then admits the patient for three days, thereby making the patient eligible for Medicare skilled nursing care—a "cash cow" for the nursing home—upon the patient's return to the facility. Telephone Interview with Cal. Physician (Aug. 2, 2007); see 42 U.S.C. § 1395d(a)(4) (2000).

155. Grabowski et al., *supra* note 151 (reporting data from New York suggesting that reducing unnecessary hospitalizations could generate major savings for Medicare).

156. Kapp, *supra* note 149, at 119.

157. Telephone Interview with Conn. Physician (July 26, 2007).

158. Telephone Interview with Ga. Physician (Aug. 1, 2007).

159. Telephone Interview with Cal. Physician (Oct. 1, 2007); Telephone Interview with Conn. Physician (Aug. 13, 2007); cf. KAISER FAMILY FOUND., CHARTPACK: VIEWS ABOUT THE QUALITY OF LONG-TERM CARE SERVICES IN THE UNITED STATES Chart 2 (2007) (reporting on a survey that found only 50% of the public agreed that "nursing homes provide high-quality services for people who need them" and only 46% of the public agreed that "nursing homes are a decent

ees uniformly chastised hospitals and community physicians for doing a poor job of dispelling family members' unrealistic expectations about the nature of nursing home care ("Why isn't the physician seeing my mother every day like in the hospital?") and not attempting to diminish families' inclination to find an adversary to blame for the plight of their loved one.¹⁶⁰ In the words of one geriatrician interviewee, "[t]he lack of coordination between the acute and long-term care systems is a setup for failure, confrontation, and bad medicine."¹⁶¹

Nursing home physicians worry about families particularly when—as is increasingly the situation—the physician and patient/family have had no relationship prior to the patient's admission to the nursing home and insufficient time to build a relationship before medical problems begin to emerge or worsen after admission.¹⁶² Several interviewees noted that "everything happens very quickly" and residents are most vulnerable to "things going wrong medically" during the first few days after admission.¹⁶³ One interviewee summarized the dynamic: "[i]t's always easier to sue the new guy."¹⁶⁴ The vicious circle is exacerbated, as explained by another interviewee, when nursing home physicians assume families will be suspicious of their competence precisely because others have led these families to believe that the only physicians who are relegated to nursing home practice are those who lack the ability to pursue other options.¹⁶⁵

Family demands for excessive medical intervention are particularly likely to be acceded to when they coincide with what physicians believe to be the pressures exerted by applicable regulations¹⁶⁶ and

place to stay"); Cory K. Chen et al., *The Importance of Family Relationships with Nursing Facility Staff for Family Caregiver Burden and Depression*, 62B J. GERONTOLOGY: PSYCHOL. SCI. P253 (2007) (analyzing the often strained dynamics of family-nursing home staff relationships).

160. Telephone Interview with N.Y. Physician (July 27, 2007); cf. Nancy Foner, *Relatives as Trouble: Nursing Home Aides and Patients' Families*, in *THE CULTURE OF LONG TERM CARE* 165 (J. Neil Henderson & Maria D. Vesperi eds., 1995).

161. Telephone Interview with Cal. Physician (Oct. 1, 2007).

162. Telephone Interview with Cal. Physician (Aug. 2, 2007).

163. Telephone Interview with Conn. Physician (Aug. 13, 2007).

164. Telephone Interview with Md. Physician (Aug. 20, 2007).

165. Telephone Interview with Fla. Physician (July 24, 2007).

166. U.S. DEP'T HEALTH & HUMAN SERVS., CTR. FOR MEDICARE & MEDICAID SERVS., PUB. NO. 100-07, STATE OPERATION MANUAL, app. PP at 275 (2008), http://cms.hhs.gov/manuals/Downloads/som107ap_pp_guidelines_ltcf.pdf.

clinical practice guidelines or parameters¹⁶⁷ that encourage more rather than less treatment.¹⁶⁸ At the same time, however, legally defensive nursing home care also may take a second undesirable form, namely undertreatment, especially of residents' pain, mainly because physicians worry about criminal prosecutions or licensing board sanctions for overprescribing narcotics.¹⁶⁹

Additionally, overprotectiveness (or, again, at least conduct believed—accurately or erroneously—by physicians to protect residents from injury) in the sense of physician- and facility-imposed restrictions on residents often has the effect of infringing resident autonomy and, therefore, the quality of life enjoyed by residents. One geriatrician interviewee volunteered the mundane but poignant¹⁷⁰ example of physicians who forbid nursing home staff from serving residents desired kinds of foods, such as frankfurters, because the treats pose a small danger of aspiration.¹⁷¹ A consumer advocate spoke about nursing homes insisting that residents who like to leave the facility wear an electronic tracking device even when the resident is not demented.¹⁷²

IV. Recommendations

The findings of this project confirm that there exists an array of serious policy and practice challenges regarding the involvement of physicians in the medical care of nursing home residents. The explanation for current shortcomings is multifactorial and recommendations for addressing them must accordingly be made from a variety of disparate, but coordinated, directions.

167. See generally Am. Med. Dir. Ass'n, Clinical Practice Guidelines, <http://www.amda.com/tools/guidelines.cfm> (last visited Oct. 6, 2008) (discussing Clinical Practice Guidelines specifically for use in long-term care).

168. Telephone Interview with Ga. Physician (Aug. 1, 2007).

169. Diane E. Hoffmann & Anita J. Tarzian, *Dying in America—An Examination of Policies that Deter Adequate End-of-Life Care in Nursing Homes*, 33 J. L. MED. & ETHICS 294 (2005).

170. See generally EVERYDAY ETHICS: RESOLVING DILEMMAS IN NURSING HOME LIFE (Rosalie A. Kane & Arthur L. Caplan eds., 1990) (discussing routine but ethically significant situations arising within nursing homes).

171. Telephone Interview with Md. Physician (July 23, 2007).

172. Telephone Interview with Local Advocacy Org. Representative (Sept. 18, 2007).

A. Legal Reform

This project began with the assumption that its eventual key recommendations would center clearly around changes in the civil justice system pertaining specifically to tort actions against nursing home physicians. The findings, however, lead to a conclusion that legal reform is only one small part of the program needed to productively address the problems confronting the contemporary American nursing home industry regarding the availability of high quality medical care to residents.

Care must be taken not to overstate this unanticipated conclusion. Although legal reform is not the complete solution, nonetheless it must be a vital part of the discussion. The legal “straw” may be only one contributor to the “broken back,” but it is an essential one. Unless the cynicism bordering on fatalism¹⁷³ among physicians about the arbitrariness and unfairness of the legal system as it applies to the nursing home context—described by more than one physician interviewee as “a deep-in-the-gut nausea”¹⁷⁴—is admitted and addressed, little progress can be expected. More particularly, physicians, especially those numerous interviewees who have served as expert witnesses in nursing home malpractice litigation, appear leery of the idea that good quality resident care is their best protection against being sued personally and possibly found liable, supposing instead “a disconnect between quality and litigation” and a system in which “the parasites”—that is, plaintiffs and their attorneys—“are busily killing off the host.”¹⁷⁵

Interviewees consistently lamented what they perceive as the civil justice system’s lack of both sensitivity (ability to identify all cases of medical negligence) and specificity (ability to identify only the true positives).¹⁷⁶ Put differently, physicians overwhelmingly criticize the civil justice system for missing too many meritorious cases, leaving legitimate injured victims with no legal redress, while including too many false positives and thereby heaping burdensome

173. An interviewee who directs a geriatric fellowship program at a major university teaches the fellows that “[i]t is not a matter of *if* you will be sued, it is a matter of *when*.” Telephone Interview with Mass. Physician (Aug. 3, 2007).

174. Telephone Interview with N.Y. Physician (July 27, 2007).

175. Telephone Interview with Cal. Physician (Aug. 1, 2007).

176. Telephone Interview with Ill. Nursing Home Adm’r (Aug. 1, 2007); Telephone Interview with Md. Physician (Aug. 20, 2007); Telephone Interview with Md. Physician (July 23, 2007); Telephone Interview with N.Y. Physician (July 27, 2007).

expense, embarrassment, inconvenience, and emotional distress on innocent defendants.¹⁷⁷

Thus, although it is far from clear what form they ultimately should take,¹⁷⁸ consideration of changes in the civil justice system affecting the attitudes of nursing home medical directors and attending physicians about their own tort exposure and the fairness of the substantive rules and procedural mechanisms for resolving that exposure must be part of a comprehensive quality-of-care and quality-of-life strategy. So, too, there must be creative thinking about more productive ways to regulate medical direction in nursing homes. Although much attention has been devoted to the proper role of government regulation of nursing homes *qua* institutions,¹⁷⁹ the regulation of medical directors, as that regulation impacts the individuals serving in that role, has received much less serious scrutiny.

B. Medical Education

There is universal agreement that the specific problem of too few qualified physicians being willing and available to care for nursing home residents, administratively or clinically, cannot be addressed seriously until reformers first tackle the larger dilemma of too few qualified physicians being willing to specialize, or at least achieve meaningful competence, in geriatric medicine.¹⁸⁰ The present insufficiency of the medical talent pool in geriatrics—in academia, clinical practice, and the educational pipeline—in the United States has been well

177. See sources cited *supra* note 176.

178. See, e.g., Steinberg, *supra* note 128 (“It is unclear whether AMDA should support tort reform, although the association welcomes member input on the subject.”). Policy makers would be prudent to heed the admonition that “law must rely not only on factual data and interpretation, but on overarching principles of effectiveness, impact on the social fabric, administrative simplicity and efficiency in the setting of operative decision-making.” LOLA ROMANUCCI-ROSS & LAURENCE TANCREDI, *WHEN LAW AND MEDICINE MEET: A CULTURAL VIEW* 22 (2004).

179. See, e.g., Kapp, *supra* note 10; Marshall B. Kapp, *Resident Safety and Medical Errors in Nursing Homes: Reporting and Disclosure in a Culture of Mutual Distrust*, 24 J. LEGAL MED. 51 (2003).

180. See Shannon J. Voogt et al., *Attitudes, Experiences, and Interest in Geriatrics of First-Year Allopathic and Osteopathic Medical Students*, 56 J. AM. GERIATRICS SOC’Y 339 (2008) (finding that medical students generally had a low interest in geriatric medicine, but those with positive attitudes were more likely to consider geriatrics as a career); Niall J. Hughes et al., *Medical Student Attitudes Toward Older People and Willingness to Consider a Career in Geriatric Medicine*, 56 J. AM. GERIATRICS SOC’Y 334 (2008) (same).

documented.¹⁸¹ This fundamental deficiency merits noting in this context as a vital adjunct to discussion of other recommendations, but need not be elaborated on further here.¹⁸²

It is unclear whether medical educators and others ought to encourage the production of more “SNFists,” physicians who dedicate their clinical practices exclusively to the care of nursing home residents.¹⁸³ Many interviewees noted that in a number of areas, SNFists are beginning to take the place of community physicians who have been shunning the nursing home environment for a combination of the financial, legal, and cultural reasons discussed previously.¹⁸⁴ Potential advantages of this development could include more involvement of physicians with specific geriatric expertise and who actually spend more time directly caring for residents. Those advantages would only be realized, though, if the SNFist’s time and attention were not spread too thin among too many residents in multiple, geographically dispersed facilities and the SNFist indeed had specific, pertinent, and up-to-date training and experience. Additionally, consumer advocate interviewees indicated a preference that residents be cared for by their community physicians because those providers should be (although there is no proof that they are) less reluctant to complain to regulators about a facility’s staffing deficiencies and other performance problems than a medical director or SNFist who has a financial stake in the nursing home.¹⁸⁵

181. See, e.g., INST. OF MED. OF THE NAT’L ACADEMIES, *RETOOLING FOR AN AGING AMERICA: BUILDING THE HEALTHCARE WORKFORCE 1–2* (2008); Annette Medina-Walpole et al., *The Current State of Geriatric Medicine: A National Survey of Fellowship-Trained Geriatricians, 1990 to 1998*, 50 J. AM. GERIATRICS SOC’Y 949 (2002); Jane Gross, *Geriatrics Lags in Age of High-Tech Medicine*, N.Y. TIMES, Oct. 18, 2006, at A1; see also Ass’n of Dirs. of Geriatric Academic Programs, *Status of Geriatrics Workforce Study*, www.americangeriatrics.org/adgap (last visited Oct. 6, 2008).

182. For a positive note, see Gregg A. Warshaw et al., *The Development of Academic Geriatric Medicine: Progress Toward Preparing the Nation’s Physicians to Care for an Aging Population*, 55 J. AM. GERIATRICS SOC’Y 2075 (2007).

183. See Mercedes Bern-Klug et al., “I Get to Spend My Time with My Patients”: *Nursing Home Physicians Discuss Their Role*, 4 J. AM. MED. DIRECTORS ASS’N 145, 150 (2003). This may be seen as a parallel to the growing hospitalist movement. See John Maa et al., *The Surgical Hospitalist: A New Model for Emergency Surgical Care*, 205 J. AM. SURGEONS 704 (2007); Robert M. Wachter, *Hospitalists in the United States: Mission Accomplished or Work in Progress?*, 350 N. ENG. J. MED. 1935 (2004).

184. Telephone Interview with Cal. Physician (Aug. 2, 2007); Telephone Interview with Cal. Representative of Managed Care Org. (Sept. 11, 2007); Telephone Interview with Ga. Physician (Aug. 1, 2007).

185. Telephone Interview with Nat’l Consumer Advocacy Org. Representative (Aug. 27, 2007).

A needed component of medical education identified by several physician interviewees is risk-management training for physicians, both generically and concerning the care of nursing home residents specifically.¹⁸⁶ In a related vein, administrators of a few nursing homes with visible, proactive risk-management programs report using this supportive operational element as an effective recruitment tool in attracting physicians to treat their residents or work as medical directors for them.¹⁸⁷ Among other things, such programs—properly conducted—are useful in putting physicians' legal risks into a realistic perspective without minimizing physicians' valid concerns.¹⁸⁸

C. Liability Insurance Changes

It is imperative for all concerned parties, not least of all the residents who are at risk of negligently caused medical injuries, that physicians who work in nursing homes have adequate liability insurance coverage. As explained above, the availability and affordability of liability insurance for physicians working as nursing home medical directors or attending physicians sends important signals to physicians about the state of their world, and physicians respond behaviorally to those signals.¹⁸⁹ In many instances, physicians' coping behaviors in response to those signals do not promote the residents' best interests.¹⁹⁰ Therefore, it is imperative that insurers' signals be changed to encourage more positive physician responses.

As noted earlier, a significant percentage of nursing homes—as a matter of practical necessity in a climate in which physicians willing to serve as medical directors are scarce but necessary commodities—provide liability insurance coverage for the administrative roles of their medical directors.¹⁹¹ Also as noted, some physicians receive coverage for their clinical and administrative duties in nursing homes under the insurance policies of the medical groups of which they are partners or employees.¹⁹² Continuation and expansion of these prac-

186. Telephone Interview with Cal. Physician (Sept. 11, 2007); Telephone Interview with Ins. Indus. Representative (Aug. 29, 2007). For a general discussion regarding risk management in nursing homes, see *Liability Issues and Risk Management in Caring for Older Persons*, 7 ETHICS L. & AGING REV. 1 (2001).

187. Telephone Interview with Conn. Nursing Home Adm'r (Aug. 20, 2007).

188. *Id.*

189. See *supra* notes 18–20, 101 and accompanying text.

190. See *supra* notes 21–23, 148–50 and accompanying text.

191. See *supra* text accompanying notes 96–97.

192. See *supra* text accompanying note 99.

tices must be encouraged and facilitated, perhaps through adjustment of facility and physician payment or other financial incentives.

However, some physicians who practice, or otherwise would practice, in nursing homes remain, in the words of one interviewee, “insurance babes in the woods” on their own.¹⁹³ An additional policy tack, therefore, might be direct regulation of the casualty insurance industry. For instance, insurers might be prohibited from discriminating in selling or pricing their professional liability products based on a physician’s practice setting or be required to underwrite their products on an individual-experience basis rather than a community basis.¹⁹⁴ The potential unintended consequence to be guarded against, though, would be professional liability insurers choosing to exit the market altogether in a jurisdiction with such legislation, rather than enduring risks the insurer deems too economically disadvantageous.

A number of physicians interviewed for this project expressed frustration that insurance industry data regarding malpractice lawsuits against physicians emanating from nursing home resident care ordinarily are very hard to obtain.¹⁹⁵ The general unavailability of data on who is being sued, how often, why, and with what result forces physicians and others, including policy makers, attorneys, and consumer advocates, to function based chiefly on anecdotes about the legal environment, resulting in lost opportunities for accurate professional education about risks and their management, more appropriate practice behavior, and evidence-predicated policy formulation. States could require liability insurers to make claims data publicly accessible, with adequate safeguards to protect legitimate confidentiality interests. As indicated earlier, California already has enacted such a requirement, but this author was unsuccessful in efforts to obtain compliance with the law’s provisions by the state bureaucracy that maintains the data collected from the insurance industry.¹⁹⁶ Addition-

193. Telephone Interview with Md. Physician (July 23, 2007).

194. See Mark Geistfeld, *Malpractice Insurance and the (Il)legitimate Interests of the Medical Profession in Tort Reform*, 54 DEPAUL L. REV. 439, 452–53 (2005).

This problem [of unfair insurance premium pricing] could be solved without tort reform. The unfairness could be eliminated by the adoption of insurance regulations banning the use of specialty and geographic location in the setting of individual malpractice premiums. These regulations could be promulgated by insurance regulators in virtually every state.

Id.

195. Telephone Interview with Md. Physician (Aug. 20, 2007).

196. See *supra* note 28.

ally, states could require more transparency from insurers regarding “how risk is calculated, how premium income is invested, and what is actually paid out in claims.”¹⁹⁷

Another possibility would be for all states to require nursing homes to carry a certain minimum amount of liability insurance coverage as a condition of initial and renewed licensure.¹⁹⁸ Such a requirement would reverse the Florida situation of physicians believing themselves to be particularly exposed as the only “deep pocket” available in the nursing home context,¹⁹⁹ and hence might encourage more physician involvement in the care of residents. However, the danger is that nursing homes, especially those owned by proprietary chains, might move or exit the market completely if forced to purchase specific amounts of insurance coverage without the ability to directly pass through that expense.

A different, nonregulatory approach would be the private development and dissemination of new insurance products. The AMDA venture with MedDirect is an example of one form that such an approach might take. If that venture conveys the appearance of success within the next few years, the emergence of competitors for the nursing home physician clientele may be anticipated.

Another nonregulatory strategy would be for insurers to require physicians, as a condition of being offered a contract for a liability policy, to undergo periodic risk-management education. Some carriers already impose this requirement, and fulfillment ranges from the physician independently doing directed readings to regular attendance at

197. James E. Lett II, *The Professional Liability Crisis: Is There Any Way Out?*, 5 J. AM. MED. DIRECTORS ASS'N 127, 128 (2004). Requirements regarding insurance industry transparency are distinguishable from direct interference with the insurance underwriting operation. See Tom Baker, *Medical Malpractice and the Insurance Underwriting Cycle*, 54 DEPAUL L. REV. 393, 429–35 (2005) (arguing against direct interference to try to moderate the underwriting cycle on the grounds that medical malpractice insurance crises lead medical providers to improve patient safety).

198. See *Dent v. West Virginia*, 129 U.S. 114, 122 (1889) (upholding the licensing authority of the state as part of its inherent police power to promote the general health, safety, welfare, and morals of the public).

199. Telephone Interview with Fla. Def. Attorney (Aug. 31, 2007); Telephone Interview with Fla. Health Servs. Researcher (Aug. 2, 2007); Telephone Interview with Fla. Nursing Home Trade Ass'n Representative (Aug. 1, 2007); Telephone Interview with Fla. Physicians (Aug. 22, 2007); Telephone Interview with Fla. Physicians (July 24, 2007).

formal, live training events.²⁰⁰ State legislation should encourage and support this insurance industry practice.

D. Expanded Use of Midlevel Professionals in Nursing Homes

The clinical benefits of the presence of midlevel professionals, primarily GNP's and to a lesser extent physician assistants, in nursing homes have been recorded amply in the professional literature.²⁰¹ The Evercare and Kaiser models of capitated long-term care, both of which rely heavily on the placement of midlevel professionals in nursing homes with a high concentration of plan enrollees,²⁰² were virtually universally praised and recommended for wider emulation by interviewees.²⁰³ As discussed earlier, physician interviewees expressed much higher levels of confidence in the accuracy and timeliness of the resident care information they received and the likelihood their orders would be implemented competently when qualified midlevel professionals were physically present in the facility.²⁰⁴

Some resident advocates interviewed for this project indicated they would be comfortable with a large-scale substitution of well-trained, continually physically present midlevel professionals in place of the current deficient level of physician involvement in many nursing homes.²⁰⁵ The overwhelming weight of opinion, on the other hand, seems to be in favor of expanding the use of midlevel professionals to supplement, rather than substitute for, physician involve-

200. See Michael Parrish, *Malpractice Premium Discounts: They Don't Come Easy Now*, MED. ECON., Aug. 23, 1999, <http://medicaleconomics.modernmedicine.com/memag/article/articleDetail.jsp?id=124025>.

201. See, e.g., Orna Intrator et al., *The Employment of Nurse Practitioners and Physician Assistants in U.S. Nursing Homes*, 45 GERONTOLOGIST 486 (2005); Mathy Mezey et al., *Experts Recommend Strategies for Strengthening the Use of Advanced Practice Nurses in Nursing Homes*, 53 J. AM. GERIATRICS SOC'Y 1790 (2005).

202. See Robert L. Kane et al., *Effect of an Innovative Medicare Managed Care Program on the Quality of Care for Nursing Home Residents*, 44 GERONTOLOGIST 95 (2004) (presenting a positive evaluation of the Evercare Medicare+Choice demonstration program); *supra* notes 101 & 116 and accompanying text; *infra* note 220 and accompanying text.

203. Telephone Interview with Cal. Physician (Oct. 1, 2007); Telephone Interview with Cal. Physician (Aug. 1, 2007); Telephone Interview with N.Y. Nurse (July 25, 2007); Telephone Interview with State Advocacy Org. Representative (Aug. 27, 2007).

204. See *supra* notes 115–19 and accompanying text.

205. See *supra* note 120; see also sources cited *supra* note 119.

ment, with the understanding that the quality and character of physician involvement leaves much room for improvement.²⁰⁶

E. Systemic Changes to Make Nursing Home Practice More Attractive

As noted in several places above, numerous aspects of the current system (or perhaps more accurately, nonsystem)²⁰⁷ of nursing home care in the United States conspire to interfere with optimal medical care for many nursing home residents. According to a nursing home administrator interviewed for this project, echoing the sentiments of many others, “[n]ursing homes are the stepchild of the whole health care enterprise.”²⁰⁸ As phrased by another interviewee, “[g]oing to the nursing home today is, for many reasons, a losing proposition for the physician.”²⁰⁹ Per another, “[physicians] can’t do the job [they] want to do for [their] patients.” Systemic changes are needed to make nursing home practice more attractive to excellent, dedicated physicians.²¹⁰

There appears to be almost unanimity of opinion (with a small number of exceptions, primarily in California where the legal climate is foremost for some physicians) that inadequate payment under the government programs of Medicare and Medicaid for physicians’ services to nursing home residents, as both medical directors and attendings, is the most important factor discouraging physician involvement

206. See, e.g., Robyn I. Stone, *Physician Involvement in Long-Term Care: Bridging the Medical and Social Models*, 7 J. AM. MED. DIRECTORS ASS’N 460 (2006) (reporting on the recommendations of a consensus conference on the evolving function of physicians in long-term care); Telephone Interview with Cal. Managed Care Org. Representative (Sept. 11, 2007); Telephone Interview with Cal. Physician (Oct. 1, 2007); Telephone Interview with Conn. Managed Care Org. Representative (Aug. 13, 2007).

207. Regarding the contemporary “culture change” movement in nursing homes in the United States, see generally Commonwealth Fund, *Culture Change in Nursing Homes*, IN THE SPOTLIGHT, Mar. 2005, www.commonwealthfund.org/spotlights/spotlights_show.htm?doc_id=265189 (interviewing Stephen Shields about a culture-change grant project). It appears the American nursing home culture-change movement has included at best quite limited physician involvement thus far. See INST. OF MED., *supra* note 105, at 199–201.

208. Telephone Interview with Ill. Nursing Home Adm’r (Aug. 1, 2007).

209. Telephone Interview with State Nursing Home Trade Ass’n Representative (July 25, 2007).

210. Telephone Interview with Conn. Health Servs. Researcher (July 26, 2007); Telephone Interview with Nat’l Consumer Advocacy Org. (Aug. 29, 2007).

in nursing homes in any capacity.²¹¹ Regardless of what changes are made to the prevailing legal environment, as important a secondary factor as this may be, it appears no significant improvements regarding medical care of nursing home residents are likely to be realized absent a fundamental restructuring and recalculation of physician payment in this setting.

The financial incentives presented by existing capitated long-term care models appear to play a hugely helpful part in physician recruitment and retention. Many interviewees indicated their belief that by changing the financial incentives, these models have achieved significant success in encouraging the positive involvement of good physicians in the care of nursing home residents enrolled in those plans.²¹² This appears to be true even for physicians participating in open-model plans, who are private-practitioner independent contractors left “on their own” in terms of liability insurance coverage.²¹³

As an example of the positive behavioral changes encouraged by capitated models’ different physician payment structure, there is evidence that residents are visited by their own physicians and nurse practitioners more often under capitated models than under traditional fee-for-service models.²¹⁴ The immediate financial benefit for the capitated managed-care plan, according to interviewees, is a reduction in resident hospitalizations, emergency department visits, and antitherapeutically aggressive medical interventions and their associ-

211. See INST. OF MED., *supra* note 105, at 201 (“Medicare reimbursement policies could also help strengthen the quality of medical services provided to nursing home residents.”). Anecdotally, poor Medicaid payment appears in many places to pose an even larger disincentive to the involvement of dentists in caring for nursing home residents. Telephone Interview with Nat’l Advocacy Org. Representative (Aug. 27, 2007); Telephone Interview with N.Y. Physician (July 27, 2007); Telephone Interview with State Nursing Home Ass’n Representative (July 25, 2007).

212. Telephone Interview with Cal. Managed Care Org. Representative (Sept. 11, 2007); Telephone Interview with Cal. Physician (Oct. 1, 2007); Telephone Interview with Cal. Physician (Aug. 2, 2007); Telephone Interview with Conn. Managed Care Org. Representative (Aug. 13, 2007); Telephone Interview with N.Y. Managed Care Org. Nurse (July 25, 2007).

213. Telephone Interview with Conn. Managed Care Org. Representative (Aug. 13, 2007); see Dana Gelb Safran et al., *Organizational and Financial Characteristics of Health Plans*, 160 ARCHIVES INTERNAL MED. 69, 72 (2000). Evercare is an example of an open-panel managed long-term care plan, in which participating physicians are independent contractors who must secure their own liability insurance. Evercare, Physicians Network, <http://evercarehealthplans.com/physicians.jsp> (last visited Oct. 6, 2008).

214. LEVY ET AL., *supra* note 7, at 24.

ated costs.²¹⁵ Additionally, physicians entering into a contractual arrangement with a managed-care plan are required to subscribe to a philosophy of collaboration and consultation with residents' families, chiefly regarding care goals for the resident, and with that plan's employed midlevel practitioners.²¹⁶ Failure to abide by that philosophy can lead to a "separation" of the physician from the plan.²¹⁷ Anecdotal evidence suggests high levels of satisfaction by all involved parties with the enhanced communication and collaboration achieved under these plans.²¹⁸

The Medicare Advantage (Part C) program offers eligible beneficiaries the opportunity to enroll in capitated long-term care plans if they are available in the beneficiary's geographic area.²¹⁹ Moreover, according to the AARP Public Policy Institute, "as federal and state budget pressures challenge Medicaid programs, a number of states now are taking a second look at risk-based Medicaid managed long-term care (MMLTC)."²²⁰ For all of the reasons enunciated above, this policy direction should be encouraged.

Short of substantially increasing the market penetration of managed long-term care plans, which even the strongest proponents of such penetration deem unlikely to happen anytime soon because of the inertia exerted by the current dysfunctional system,²²¹ one specific systemic change likely to pay quality-of-care and quality-of-life dividends is amendment of the physician payment methodology under Medicare to allow and encourage physicians to spend more time talking with residents and families about realistic care goals and expectations. Many interviewees regret the current economic disincentives to enter into time-consuming conversations of this nature today, believing that more sustained and ongoing physician-resident-family com-

215. Telephone Interview with Cal. Physician (Oct. 1, 2007); Telephone Interview with Managed Care Org. Representative (Sept. 11, 2007).

216. See WILBURTA Q. LINDH ET AL., DELMAR'S COMPREHENSIVE MEDICAL ASSISTING 287-88 (Cathy L. Esperti ed., Cengage Learning 2002) (1998); David Mechanic, *The Managed Care Backlash: Perceptions and Rhetoric in Health Care Policy and the Potential for Health Care Reform*, 79 MILBANK Q. 39 (2001).

217. Mechanic, *supra* note 216.

218. Telephone Interview with Cal. Managed Care Org. Representative (Sept. 11, 2007); Telephone Interview with Cal. Physician (Oct. 1, 2007); Telephone Interview with Conn. Managed Care Org. Representative (Aug. 13, 2007).

219. See, e.g., SOC. SEC. ADMIN., MEDICARE 8 (2008), available at <http://www.ssa.gov/Pubs/100H3.pdf>.

220. PAUL SAUCIER & WENDY FOX-GRACE, AARP PUB. POL'Y INST., ISSUE BRIEF NO. 79, MEDICAID MANAGED LONG-TERM CARE 1 (2005).

221. Telephone Interview with Cal. Physician (Sept. 11, 2007).

munication would improve the ultimate nursing home experience for the resident and family and promote legal risk management by reducing the shock and dismay that many unprepared families now endure in response to the natural deterioration of their sick, frail loved ones despite good but insufficiently explained care.²²²

Among the numerous other types of systemic changes repeatedly advocated by interviewees was greater financial support to nursing homes for the hiring and training of additional nursing and other direct-care staff (and regulatory measures to assure that any additional financial support is really used for its intended purpose).²²³ There also ought to be exploration of other initiatives to address the dire present and future workforce-shortage issues threatening nursing home residents by, among other things, dissuading physicians from nursing home involvement. Better involvement of physicians in the general “culture change” movement²²⁴ was also mentioned, as was the need for initiatives to enhance the social and professional status of nursing home physicians.²²⁵

One of the most frequently made recommendations was the need for public (including family) education about the capabilities and limitations of nursing homes, the natural course of human frailty, and the progression of disease at life’s end.²²⁶ The goal of such public education would not be to diminish families’ legitimate expectations of quality care for their vulnerable loved ones, but rather to enable families to understand more realistically what kinds of conduct they should be able to reasonably expect, demand, and enforce from nursing homes and their physicians.²²⁷

222. Telephone Interview with Cal. Managed Care Org. Representative (Sept. 11, 2007); Telephone Interview with Conn. Managed Care Org. Representative (Aug. 13, 2007).

223. Telephone Interview with Conn. Health Servs. Researcher (Aug. 26, 2007); Telephone Interview with Fla. Health Servs. Researcher (Aug. 2, 2007); Telephone Interview with Ill. Plaintiffs’ Attorney (Aug. 1, 2007); Telephone Interview with Md. Physician (Aug. 20, 2007).

224. See Commonwealth Fund, *supra* note 207.

225. Telephone Interview with Conn. Physician (July 26, 2007).

226. Telephone Interview with Md. Physician (July 20, 2007); Telephone Interview with N.Y. Physician (July 27, 2007).

227. See Hedgecock, *supra* note 32, at 100 (“Public education and familiarization with long-term care and local nursing facilities would be a valuable addition to tort reform.”).

V. Conclusion

Unfortunately, neither tort system overhaul nor any other initiative is, by itself, the answer to the problem of inadequacies in the medical care available to many nursing home patients in the United States at present. But the absence of a “silver bullet” does not mean we are altogether without important weapons to address this challenge. Legal reforms must play a vital role in instilling confidence among physicians in the basic fairness of the civil justice system as an instrument to compensate injured victims and enforce and enhance medical standards and in encouraging confidence-inspiring behaviors likely to contribute to, rather than detract from, quality of care and quality of life for residents. Designing, debating, implementing, coordinating, evaluating, and continually improving the various pieces of a comprehensive strategy will require the active participation not only of legislators and the courts, but also of physicians, medical educators, nursing home owners and administrators, the casualty insurance industry, governmental and private long-term care payers (including the sellers of managed long-term care insurance products), consumer advocates, regulators, and families.²²⁸

228. See Lett, *supra* note 197, at 127 (calling for the convening of “mandatory assemblies of the stakeholders in [long-term care] liability” for the purpose of enhancing “the quality of care for America’s vulnerable elders”).