Mr. Chairman and Committee Members,

I am James E. Lett II, MD, CMD, Immediate Past President of the American Medical Directors Association (AMDA). AMDA represents more than 7,000 medical directors, long term care physicians and others who practice in nursing homes, as well as other venues in the long term care continuum (LTCC), which includes home health care, assisted living settings, hospice and other sites of care for the frail elderly.

AMDA focuses its work on clinical practice guidelines and best practices to improve the care for frail elders in Long Term Care (LTC). Once the right method to care for our elders is established, our mission then moves to educating long term care physicians on the unique needs of frail elders who require LTC and how to meet those needs. We are pleased that the body of physicians with specialized training and experience in long term care has been growing in recent years, but we fear that threats posed by the current liability crisis will stop that trend dead in its tracks. We now see experienced LTC physicians who are unable to renew liability coverage despite their claims history. Equaling alarming, we are now finding that physicians who wish to embark upon a nursing home practice, full time or part time, cannot obtain insurance coverage, even if they have completed advanced training programs in geriatrics. In states such as California, a further barrier is in place. Physicians treating geriatric patients, particularly those in nursing homes, are more likely to be involved in lawsuits.

To fully understand the crisis, it is necessary to describe the dual roles fulfilled by physicians in LTC. Many AMDA members perform both an administrative position as medical director within nursing facilities, which is mandated by federal law, and act as attending doctors providing direct clinical care to nursing home patients. Both activities are essential to quality care for the nation's frail elders, and both are threatened by the current legal quagmire.

Under federal statute (specifically the Nursing Home Reform provisions of the Omnibus Budget Reconciliation Act of 1987, or OBRA '87), each nursing facility must have a licensed physician to act as medical director. The medical director is charged with a wide range of clinical oversight and duties to protect the frail elders, vulnerable adults and children in long term care facilities. Those responsibilities include:

- Implementation of resident care policies.
  This portion of the job includes involvement in such wide-ranging clinical policies as how residents are admitted to and discharged from the facility; how infections are addressed and prevented; the use of medications; and determination of requirements for physician and non-physicians to practice in the nursing home, among many others. The medical director is the clinical watchdog for the manner in which policies are applied to promote overall quality of care for residents; and

- Coordination of medical care in the facility.
  This includes assuring that the facility is providing appropriate care to residents. It also includes clinical oversight and supervision of physician, non-physician and ancillary (laboratory, radiology, pharmacy, etc.) services and the medical care provided for residents by all providers.

AMDA members see the issue of medical liability as a direct threat to quality of care and access to care for frail elders. Liability issues impacts AMDA physicians in two distinct, but intertwined sectors: both as a medical director of a nursing facility and as a practicing physician.

Impact on AMDA Nursing Facility Medical Directors

Medical directors must be covered for errors and omissions which may be alleged while acting in their administrative acts for the nursing facility. This type of policy is over and above the required separate professional liability coverage for their clinical work. Since most medical directors also serve as attending physicians to patients in their facilities, and maintain private practices or practice in other settings, they need two distinct policies. Typically, the nursing facility will offer coverage for the *administrative* actions only of the medical director.

We are seeing increasing numbers of nursing homes that are losing their liability insurance or are simply no longer able to afford it, leaving them ---and their medical directors---"bare"; that is, without any liability insurance for themselves and for the medical director's administrative acts. This increasingly common circumstance leaves medical directors with three unpleasant choices: 1) find a personal administrative acts policy – now expensive ***if*** available; 2) risk personal financial ruin by maintaining no insurance: or, 3) leave the medical specialty and patients they love.

Catastrophically, more and more experienced, dedicated physician medical directors are choosing the third option. A 2002 AMDA membership survey on the liability crisis showed that 5.1% of respondents simply left their medical director role due to liability cost and access. Alarmingly, a follow up survey mailed in late 2003 revealed a continued loss of medical directors. There is no evidence that this trend is slowing, much less stopping. Since all nursing facilities who accept federal payments must have a physician medical director, there will soon be facilities forced to hire medical directors with little knowledge of LTC and frail elders, or even facing unlikely, but potential closure due to their inability to acquire any medical director, especially in rural and inner city areas.

Impact on AMDA Long-Term Care Practicing Physicians

The second major problem being encountered is the adverse impact of medical liability on coverage for the physicians' clinical work.

In the 2002 AMDA physician member survey:

- 20.5% of respondents reported problems renewing or obtaining professional liability insurance (PLI);
    - 4.6% were told this was related to working in LTC

The 2003 AMDA follow up survey then revealed:

- 21.5% or respondents reported problems renewing or obtaining PLI, but now
    - 34.2 % were now refused PLI because they work in nursing homes.

The inevitable result by many physicians was a decision to reduce or quit LTC involvement entirely.

- In 2002, 8.7% reduced LTC patient hours.
- In 2003, 18.4% of respondents reported changing their practices. Of those, 25% reported reducing LTC patient hours, 28% began referring complex cases to other physicians, and another 10% completely left LTC.

The numbers above were current as of January, 2004. Ongoing communications to AMDA from around the country since then indicate the situation is worsening. Each reduction in patient contact hours and departure from LTC further denies quality and access to frail elders in ever growing numbers. Given the fact that AMDA membership represents the physicians most dedicated to LTC, we expect that the exodus of less LTC-focused doctors far exceeds the percentages noted above.

The threat to quality and patient access, combined with higher costs, is the inevitable price of the liability crisis, borne out by the actions of AMDA members. This is a pattern we believe is present throughout the medical community, based upon observations and conversations.

The current long term care patient population is not just unique; medicine and society have never encountered such a challenge. These patients are older, have greater numbers of co-existing illnesses and take more medications than any we have ever treated. By the time they have reached nursing facilities, these elders are no longer sustainable at home despite every new surgery, new medical innovation and community-based support that science and society can boast. And the numbers in this group are growing rapidly. This population needs an expanding group of equally unique and committed physicians to care for them. While some medical training programs are incorporating focused geriatric skills, no medical school, no residency, no fellowship focuses on the frail long term care elder alone. Instead, physicians more often learn about the special needs of long term care patients through training such as AMDA offers, and through experience. Once they are gone, such physicians cannot be replaced. The average age of the AMDA physician is 51 years of age. As frustrated,

experienced LTC doctors leave the scene due to liability concerns, the supply of younger physicians willing to enter the long term care continuum has abruptly declined. We are seeing that more and more often, physicians feel that the costs, liability and hassle of practice in this environment have overwhelmed their desire to see this increasingly fragile population.

Expansion of capacity of the remaining doctors and the use of mid-level practitioners can only extend the time before the numbers of LTC elders completely overwhelm available care resources. The drain of talent from long term care highlighted above can only result in a decline in the quality of care for patients, and inevitably to access problems. Well-trained and dedicated physicians continue to leave long term care because they cannot obtain or afford liability coverage for their actions as medical directors and physicians. Furthermore, the intimidation of the specter of years of hassle and financial exhaustion to prove oneself innocent in such a litigious climate hasten the exodus of current doctors and inhibit any desire the enter the arena.

Recommendations

Emergency action is needed now to remedy liability problems in long term care. AMDA would like to recommend some short-term and long-term steps to solve this problem.

- The hemorrhage of experienced physicians and resources from LTC must be halted. The best single remedy available now is the Help Efficient, Low-Cost, Timely Health Care (HEALTH) Act of 2004 ((HR 4280). Although not the ultimate answer, this bill would go a long way to control wasteful liability costs by limiting non-economic (pain and suffering) damages and limiting attorney fees until more permanent answers are in place. This will again allow patient access to more physician services where they live.

- We need more careful examination of, and acceptance of, the credentials of “experts” in litigation. Each trial is a series of allegations by “experts”. Based upon the jury verdict, each trial creates a new, and possibly contradictory, “standard of practice.” One trial of a nursing facility in which I participated included a prosecution “expert” who expounded upon the quality of care in a nursing facility. He was a retired plastic surgeon who, under cross-examination, admitted he had never been in a long term care facility.

- Furthermore, there is a dearth of evidence-based outcome data in the care of frail elders. Development of and adherence to evidence-based standards of care is necessary. Once uniformly accepted, they can allow care to be judged objectively. AMDA has taken the lead in developing such a series of evidence-based clinical practice guidelines for long-term care. A partial list includes guidelines for osteoporosis; pain management;

depression; falls and fall risk; medication management; chronic obstructive pulmonary disease; and acute change of condition. Much more is necessary.

- Finally we also must recognize that in long term care, untoward outcomes are not necessarily the result of bad care. They may also be the inevitable result of the natural progression of degenerative diseases suffered by many patients.

Thank you for your consideration of this serious problem. The optimal pathway to quality care for frail elders is access to committed, knowledgeable, available physicians who compete to provide the best care. I urge your immediate action to maintain access to quality physician medical direction and physician services for nursing home patients. AMDA is ready to work with you in any way possible to deal with this crisis before it becomes a catastrophe.