The Role of the Medical Director in Long-term Care

The population admitted to nursing homes has evolved over time. Nursing-home residents are often sicker, have dementia more than ever before, and have numerous chronic diseases treated with multiple medications. This article examines the changing role of the medical director in response to this evolving patient population.

By Graeme Bethune, CCFP, FCFP, COE

The traditional role of the medical director in our nursing homes is long overdue for change. Before examining the issue further, it is important to define some of this article’s terminology.

In this article, the term “nursing homes” will be used rather than the more generic, broader term “long-term care facilities.” The latter term may include small-options homes or assisted-living facilities where the role of the medical director is often less evident. As well, the terms “medical director” and “medical advisor” may be used interchangeably, although these two terms have different connotations.

Nursing Home History

A brief summary of the history of nursing-home populations and the physicians who served them may be useful. Several decades ago, residents of nursing homes were mobile enough to visit their own doctors’ offices for routine care. When the residents became ill, there were sufficient beds in hospitals to care for them until they were well enough to return to the nursing home.

Over time, the population admitted to nursing homes has become less mobile, necessitating house calls from family physicians. Some nursing homes initiated house doctors who would look after other residents as well as their own patients.

As the number of residents and facilities increased, legislation was required to establish a standard of medical care in nursing homes. That legislation (from the mid-1970s in Nova Scotia) mandated medical direction for nursing homes, particularly those that were licensed.

The role of the medical director was to ensure that residents received medical care, to chair or be a member of the pharmacy committee and, in general, to be a liaison between those providing medical care to the residents and the administration. In time, a credentialing function was often given to the medical director. Remuneration for this administrative work was often token. Specialized education in care of the elderly was not required and job descriptions would have been unusual and likely cursory. Of course, the field of geriatrics was in its infancy in Canada in the 1970s and 1980s.
It would appear the role of the medical director will have to change in response to the growing demands placed on nursing homes. With significant increases in longevity and chronic diseases, increasing medical pressures on nursing homes have become apparent. “… It is difficult to distinguish the nursing home of today from the hospital of the 1960s.”¹

Problems Facing Modern Nursing Homes

Those who work in nursing homes appreciate that the residents entering in the 1990s and beyond are not as mobile, are often sicker, have dementia more than ever before, and often have numerous chronic diseases treated with multiple medications.

Furthermore, there is often an attitudinal and informational disconnect between nursing homes and their cousins, acute-care hospitals. For example, Emergency Department personnel may question why a late-stage Alzheimer disease (AD) resident is sent to their department for investigation of chest pain when that person could stay in their own facility and receive appropriate comfort care. In the same situation, the nursing home’s lone registered nurse (RN), trying to look after 20 to 50 residents, may not easily get a physician to come in to assess the resident. With family hovering around, demanding that everything be done, the RN feels there is no option but to send the resident to the emergency room.

The author recently visited the Netherlands and saw nursing homes with broader functions than are traditionally seen. For example, Dutch nursing homes may provide areas for stroke rehabilitation, orthopedics rehab and several separate areas for palliative care. Many homes have day centers providing rehab and/or social activities for the frail elderly.

Willging states that “this influx of higher acuity patients in nursing facilities has helped propel sub-acute care forward as the most rapidly growing segment of long-term care today.”² He defines subacute care as “…a comprehensive program designed for the individual who has had an acute event, as a result of an illness or injury, or exacerbation of a disease process and does not require intensive diagnostic or invasive procedure.”²

There will be increasing pressures for nursing homes to develop expertise in dealing with older adults who have dementias, AIDS, recent and stable strokes, recent and stable hip fractures, and those who are strictly palliative. In addition, nursing homes may be expected to care for late-stage congestive heart failure, renal disease, and COPD in its latter stages. “The acuity and diversity of these patients will make the role of the physicians and medical directors more complex and challenging.”²

The foregoing was an attempt to illustrate how nursing-home populations have changed over the past few decades. Dr. Jacob Dimant says “they [the residents] need high-acuity, post-acute, or

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<td>• discipline</td>
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<td>• recruiting physicians</td>
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<td>• creating on-call schedules</td>
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<td><strong>Administrative</strong></td>
<td>• sit at senior leadership table</td>
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<td>• sit at planning, renovation table</td>
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<td>• initiate new committees (e.g., palliative care)</td>
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<td><strong>Education</strong></td>
<td>• plan workshops</td>
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<td>• put on educational lunches for staff</td>
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<td>• organize conferences</td>
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<td><strong>Facility Representation</strong></td>
<td>• attend regional, provincial and national meetings and conferences on behalf of the facility</td>
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<td><strong>Research</strong></td>
<td>• encourage facility to be involved in seniors research</td>
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<td>• initiate research within nursing homes</td>
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<td><strong>Advocacy for Long-term Care</strong></td>
<td>• lobby local and provincial health departments</td>
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<td></td>
<td>• seek increased funding from public and private sources</td>
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<td>• advocate for greater educational opportunities for all staff in areas such as dementia</td>
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end-of-life care, are increasingly frail and medically complex, and more than half suffer from dementia. But the paradigms of care have not shifted significantly in tandem with these changes. The current nursing-dominated process of care, combined with staffing shortages and competency issues, simply does not suffice.”

Furthermore, he states, “in addition to apparent and difficult-to-recognize acute or subacute problems (e.g., delirium), attention must be directed to chronic problems, functional impairments and disabilities, palliative care, risks and preventive care, psychosocial and family issues, all in the context of resident choices, preferences, or advance directives and quality-of-life concerns. In addition, all this needs to be done within a difficult regulatory, institutional and reimbursement environment, requiring teamwork and specific documentation. It is the medical director’s responsibility to educate attending physicians about these issues, as well as provide them with tools and processes that help them practice quality care.”

**The Changing Role of the Medical Director**

With the changing of the nursing-home population, not only should the attending physician’s role change, but so must that of the medical director. It is the medical director who should lead the medical staff into new paradigms of care in nursing homes in the 21st century. “The medical director’s most important role in the facility is as a leader of the medical staff. The medical director should develop a professional and educated group of MDs dedicated to the care of the residents, the environment of long-term care and the special needs of the population they serve.”

To lead this group of nursing-home physicians, the medical director should receive appropriate education. “With increasing long-term care diversification into sophisticated areas of care including subacute and specialized areas such as AD, the medical director will need clinical expertise on specific disease states and conditions such as AIDS, head injuries and dementia. [...] The director will also have to understand the impact of design and environmental factors on resident outcomes and to have a basic knowledge of government regulations and guidelines.”

There are several medical schools in Canada which offer six- to 12-month diplomas or certificates in healthcare for the elderly. The Dutch were forward-thinking 30 years ago when they began discussing the concept of nursing-home medicine, which was introduced as a new specialty. The discipline of nursing-home medicine exists as an independent two-year medical specialty with its own training. There are now over 1,000 qualified nursing-home physicians in the Netherlands.

The modern nursing-home medical director could have several useful and important roles. In addition to the traditional functions, such as credentialing, physician discipline, scheduling, and chairing the pharmacy and therapeutics committee, there are several other roles with potentially greater impact.

One valuable responsibility might include a seat at the senior leadership or management table. This role allows for significant two-way communication between the non-medical administrators and the physician leader. This allows for medical input into key strategy sessions, budget considerations, advance planning, and major staffing decisions.

Another huge potential role for the medical director is that of education. Possibly one of the
biggest shortfalls and greatest desires in nursing homes is the need for frequent, high-quality continuing education. This is true for all levels of staff, including dietary, non-licensed care workers, nursing staff, allied health staff and physician staff. A motivated medical director can urge the organization to promote education for its staff, can plan workshops, and organize conferences. He or she will often have good contacts in the broader health community that can be used for the educational benefit of the staff at the facility.

Given time, a medical director can represent the facility at various municipal, regional, provincial, national, or even international venues. This type of representation allows the director to interact with other people in the same field, thus building the all-important network for sharing innovative ideas. These ideas may then become items of discussion at the senior leadership table, which may then progress to action. This type of activity also shows the community that the medical director comes from a visible and committed nursing home, which sponsors his or her time to attend various meetings. The profile of the nursing home is thereby raised, which is helpful in attracting new high-quality staff and volunteers.

And what about research? “Research in the nursing home must increase in order to obtain adequate sample sizes, especially for clinical studies addressing issues important to typical community-based, long-term care facilities such as nutrition, pressure ulcers, incontinence or end-of-life issues.” The medical director is uniquely positioned to encourage research within the nursing home. The staff and residents will often feel privileged to take part in relevant, appropriate research, which may help those coming after them. The teaching nursing home is very much in evidence in the Netherlands, as these facilities are extensively utilized by the three Dutch universities who train nursing-home physicians.

Another crucial role for the medical director of a nursing home is that of advocacy for long-term care, especially within the nursing-home sector. For many years, the increasing complexity and acuity of illness within nursing-home residents has been unrecognized by departments of health. While busily enforcing regulations spawned by legislation in the 1970s, health departments have overlooked the larger picture of more frail residents with more complex diseases entering our nursing homes. The average GP doing primary care in a nursing home does not have the time or breadth of knowledge to be a lobbyist or advocate for the home. On the other hand, the medical director will, over time, become well acquainted with the issues facing nursing homes and will be in a position to speak about them. Examples might include writing to provincial or municipal politicians to argue for improvements in this sector, making the case that physicians be remunerated for attendance at team meetings, or speaking out in public forums on behalf of long-term care. The director may join the Long Term Care Medical Directors Association of Canada formed in July 2003 (visit www.cmda.ca). This organization advocates for improvements in the quality of long-term care.

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through development and integration of the medical director in the management, education, and service delivery of comprehensive long-term patient care.

Finally, the medical director can facilitate communication between nursing homes and acute-care hospitals. Staff in nursing homes are often critical of the care that their residents receive while in acute-care hospitals. They complain that hospital staff do not fully understand how to deal with a resident who has dementia, for example. Nutrition problems and pressure sores are often blamed on hospital care. This is a reflection of the critical frailty of many of our nursing-home residents so that if the balance beam of health/disease on which they are perched is tilted toward disease they become very complex and require time-consuming care. Acute-care hospitals are not generally set up to provide this multifaceted care and, unfortunately, nursing homes are not adequately resourced to care for many of their ill residents on site. Over the past several years, there has been a growing lack of communication and understanding of the limits under which acute-care hospitals and nursing homes must operate.

In order to fulfill an expanded role of medical director, he or she should have adequate office space, secretarial assistance, report to the CEO, meet the board regularly and chair or co-chair such committees as quality assurance, pharmacy and therapeutics, infection control, and ethics. The medical director should be an integral part of the planning process when remodeling or renovating, and be involved in changes which occur in leadership of nursing, social services, pastoral care, and physiotherapy and occupational therapy.¹

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**Conclusion**

The author recently conducted a brief survey of the 74 nursing homes in Nova Scotia to examine the role of the medical director in these facilities. Seventy-four questionnaires were mailed out in April, 2004 and 52 were returned. The average number of beds per facility was 93, with a range of 10 to 420. Forty-seven out of 52 facilities (90.3%) had a medical advisor. Of these facilities, 13 (25%) had a written job description for their director. Twenty-one (44.7%) of the medical directors sat at the senior leadership table or its equivalent. Thirty-three (70%) of the medical directors received remuneration for their administrative work. No medical directors had a budget and in no cases did any facility have a specific budget for the medical director to represent the facility at...
conferences/workshops. Five facilities, however, added a footnote to this question suggesting that if asked, some monies would likely be found to support attendance at a conference.

This represents data from only one province, so Canadian generalizations cannot be made. However, taken together with the fact that the American Medical Directors Association is almost twenty years old and that its Canadian equivalent is just celebrating its third birthday, one might be tempted to conclude that it is indeed time to examine the role of the medical director in our nursing homes. Given the likelihood that our nursing homes will undergo a transformation to institutions which have broader roles in our communities, it follows that medical direction will need to be more inclusive, more expert and better supported.

References:

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