LAW & MEDICINE

Gunfight at the OK Corral

Medical professionals and the people who run their institutions can have their disagreements, but they are usually resolved in a fairly low-key manner—or, in the worst case, through negotiations with lawyers. It's not often, however, that an institution tries to use the state legislature to assist in a blatant power grab. Yet that's exactly what happened in the case of *Lawnwood Medical Center vs. Seeger* (--- So. 2d ---, 2008 WL 3926860; Fla. S. Ct. 2008).

BY MILES J. ZAREMSKI, J.D.

Lawnwood Medical Center is a corporate entity that owns Lawnwood Regional Medical Center and Heart Institute. The corporation operates the hospital through a board of directors and through a delegation of duties to the corporation's officers and board of trustees. The board's bylaws, adopted in 1988, state that the board has final decision-making authority in the areas of credentialing, peer review, and quality assurance after considering the input of the medical staff. Five years later, the medical staff bylaws were adopted; they were subsequently approved by the board. The adoption of such bylaws is a requirement for accreditation through the Joint Commission. As stated in the court's decision, the purpose of the medical staff bylaws is "for the organization of the Medical Staff … to provide a framework of self-government in order to permit the Medical Staff to discharge its responsibilities in matters involving the quality of medical care and to govern the orderly resolution of those purposes."

After the bylaws went into effect, many disputes arose between the medical staff and the corporate entity empowered to operate the hospital. One such dispute concerned a peer review of two pathologists; following the peer review, the medical staff did not recommend any sanctions.

The board, however, suspended the two physicians; a court overturned that decision after the physicians appealed the board's ruling. The court suggested several options instead of the unilateral suspension of the doctors, but the board did not consider them; instead, it created and adopted new bylaws, which said that the board could unilaterally amend the medical staff bylaws after exhausting attempts to obtain medical staff approval. This newly adopted provision conflicted with a previous provision that called for at least 60% of the medical staff to approve any substantive change to its bylaws. The medical staff believed that the newly adopted provision was invalid.

This story now gets more interesting. The corporate board succeeded in getting the state legislature to enact a special law called the "St. Lucie County Hospital Governance Law" (HGL). This law, enacted by the Florida legislature, affected only two hospitals in St. Lucie County, one of which was, of course, Lawnwood Regional Medical Center. The corporation, through the board, petitioned a Florida court to declare that this special legislation was constitutional. Dr. Seeger (for whom the case is named) was the president of the medical staff; on its behalf he opposed the petition. The court found this law unconstitutional because it impaired the contract between the medical staff and the board, and provided a privilege to a private corporation in violation of the Florida Constitution.

The board appealed the decision to Florida's intermediate (appellate) court. After this second court affirmed what the lower court decided, the corporation and board appealed to the Florida Supreme Court.

Within the HGL were provisions that consolidated the board's power in the areas of medical staff, clinical privileges, discipline, and compliance with mandated peer review, risk management, and quality assurance (QA) activities. The language of the statute also provided that in the event of conflict between the board's bylaws and the medical staff's bylaws, the former will prevail as to staff privileges, QA, peer review, and contracts for hospital-based services. Another section of the Florida law would provide that the board would have the right to reject or modify a medical staff recommendation or take action independent of the medical staff in the areas of medical staff membership, clinical privileges, peer review, and QA under defined events. The HGL also provided for a "fair hearing" process if the board chose to differ with the medical staff over corrective or disciplinary action.

In the end, the statute was found unconstitutional. In its decision, the court recognized the importance of a hospital's medical staff, and consequently its bylaws, certainly in the area of executing, renewing, or modifying an exclusive contract: "… even though the Board would have final authority on decisions relating to hospital-based contractual services, the role of the medical staff is a critical element in the decision-making process and the Board must have good cause to reject the recommendations of the medical staff in this area." The court also recognized that the HGL would eliminate the medical staff's role in the areas of staff membership and quality assurance.

Before declaring the statute unconstitutional, the Florida supreme court additionally recognized that the medical staff's bylaws provides a framework for cooperative governance, particularly as to the areas mentioned above: medical staff appointments and credentialing, peer review, and decisions regarding contracts for hospital-based services. The hospital responded by saying that the law was created in furtherance of patient safety in light of the two pathologists who had been subject to peer review. The court noted, however, that those physicians were not on staff at the time the HGL was enacted.

In conclusion, the court said because the HGL granted the corporation nearly complete power to run the affairs of the hospital—basically without meaningful input from the medical staff—the HGL "unquestionably" granted the corporation rights, benefits, or advantages that would fall within the definition of a privilege not granted by the Florida Constitution.

On this occasion, the doctors of the medical staff dueled successfully this time at the "OK Corral"—where medicine is administered within the walls of a hospital. But there is a lesson to be learned here, and not just for hospitals. Cooperation and collegiality must prevail between a health care institution's board and its medical staff so that patient care will not be compromised by a corporate structure thinking it can run roughshod over practitioners who administer that care by going to the legislature for help. ■

MR. ZAREMSKI *is a health care attorney who has written and lectured on health care law for more than 30 years; he practices in Northbrook, Ill. Please send comments on this column to cenews@elsevier.com.*

Fight Inertia in Diabetes Care With Performance Feedback

BY JOYCE FRIEDEN
Publication Editor

WASHINGTON — Physicians and other health care providers who take care of diabetes patients can easily suffer from "clinical inertia," but performance feedback might help improve their performance, according to one diabetes expert.

Clinical inertia is defined as "failure to institute or change therapy appropriately when more intensive management is indicated," Catherine Barnes, Ph.D., said at the annual meeting of the American Association of Diabetes Educators.

This problem is usually not caused by unfamiliarity with practice guidelines or inadequate time for care, she noted. Instead, it usually occurs when providers use "soft" reasons to avoid intensifying therapy. For example, they tell the patient to "try the diet a little longer," or they say that a particular study's results don't apply to their own patients. Such providers also usually don't have systems to encourage them to step up therapy, such as flow sheets or "stepped" care protocols, said Dr. Barnes, who is with the Grady Diabetes Clinic in Atlanta.

Both patients and providers are trained not to be really aggressive with diabetes therapy, she said. "Patients don't change their diet because they're used to high-fat [food], or because they say they can't afford sugar-free items," said Dr. Barnes. "Socially, they complain about lack of family support. … Or they have trouble looking at food labels and at food exchanges."

On the caregiver side, one likely cause of inertia is that the providers have no way of knowing how their patients are doing as a group. So the clinic conducted a study to see if giving feedback to providers would result in lower HbA_{1c} readings for patients. Because the Grady clinic is run by nurses, who provide most of the care, the researchers focused on six nurses who saw a total of 1,171 patients over a 2-year period.

The patients had a mean age of 61; 64% were female, and 94% were black. The mean body mass index was 33.9, average diabetes duration was 12 years, and average HbA_{1c} was 7.35%. A total of 7% of patients were being treated with diet alone; 33% were on oral medications alone or a combination of oral medications and diet therapy; 47% were on insulin alone, and 13% were on insulin plus diet therapy.

The first year of the study served as a comparison period; no feedback was given. By the end of the first year, the patients' average HbA_{1c} rose slightly to 7.36%, an insignificant difference.

Starting in the second year, the nurses had 5-minute feedback sessions with a diabetes specialist every 3 weeks. The specialists told the nurses how their particular patients were doing as a group in terms of HbA_{1c} levels and other tests, such as blood pressure and cholesterol. Feedback sessions were scripted and included some questions to help the nurses become active learners.

At the end of the 2 years, the average HbA_{1c} had dropped to 7.24%, a significant difference. "In every case, after these report cards, the HbA_{1c} of [each nurse's patients] had come down," showing that they were more likely to intensify treatment if they were given feedback. The comments from the nurses were also positive, she added.

In addition to receiving feedback, physicians and other providers can take several steps to improve their care of diabetes patients, according to Dr. Barnes. "One thing you can do is [post] reminders of high values," she said. "You can also give those numbers to patients, so the patient can become empowered to say, 'My A_{1c} is 8.5; what can we do about this?' " ■

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