Two physicians from rural Minnesota are at the center of a lawsuit that has implications for physicians throughout the nation.

BY KIM KISER
S

teven Meister, M.D., M.B.A., remembers the day when he knew he was on to something big. Standing before a room full of physicians at the American Medical Association’s annual meeting in Chicago last June, he told the story of how he found himself at the center of a lawsuit against the leadership of the hospital in Marshall, Minnesota, where he has practiced for the last 10 years—a case that centers on whether the hospital’s administration can change the medical staff bylaws without physician approval.

The lawsuit had consumed Meister and his colleague, Jane Willett, D.O., for nearly two years, taking them away from their practices and placing them at odds with hospital leaders. He hadn’t expected that his story about a situation in a town of 13,000 in southwestern Minnesota would resonate so strongly with physicians from across the country. But it did.

“Several dozen physicians from Texas, Florida, Indiana, came up afterward and spoke to me in support,” he recalls. “They said similar things were happening in their health care systems.” Although a lawsuit over whether bylaws constitute a contract between a hospital and the physicians who see patients there sounds like fodder for legal scholars, it cloaks a larger issue: Who ultimately decides what is considered to be high-quality medical care—hospital administrators or physicians?

Unlikely litigants

Meister, who was serving as chief of staff at Avera Marshall Regional Medical Center when the suit was filed in January of 2012, and Willett, who was chief of staff-elect at the time, consider themselves unlikely litigants. Committed rural family physicians, neither thought they would find themselves at odds with the hospital—much less embroiled in a case against it that could have national repercussions.

Meister, who grew up in Cloquet, came to Marshall to practice family medicine 10 years ago. He says he “fell in love” with the community while doing a Minnesota Rural Provider Associate Program clerkship with one of the town’s doctors during his third year of medical school at the University of Minnesota. After seven years in the Navy, he joined the staff of Affiliated Community Medical Center (ACMC), which has clinics throughout southwestern Minnesota.

Willett, who is originally from Owatonna, came to Marshall 22 years ago after earning her D.O. at Kirksville College of Osteopathic Medicine in Missouri and doing a residency in Ohio. She wanted to live in a smaller town where, as a family physician, she could practice obstetrics and see patients both in the clinic and the hospital. “A lot of family physicians in larger cities just do outpatient medicine. I like being able to do inpatient care and deliver babies, too,” she says.

Both Willett and her husband, an internist, are long-time figures at the hospital. They have served as medical staff officers, playing a key role in writing the medical staff bylaws a number of years ago. Those bylaws are the rules by which physicians govern and police themselves. They define such things as who qualifies for membership on the medical staff and admitting privileges at the hospital, the responsibilities of the medical staff, its various committees (quality assurance, accreditation, infection control and executive committee, for example), and the procedures for instituting corrective action or suspension of a physician. Bylaws must be adopted by the medical staff and approved by the hospital’s governing body, according to the Joint Commission, which accredits hospitals in the United States. The fact that the hospital’s board and administration changed the bylaws on their own is what ultimately led Meister and Willett to file the lawsuit.

It started over peer review

Avera Marshall Regional Medical Center opened in 1950 as Louis Weiner Memorial Hospital. For most of its existence, the hospital was owned by the city of Marshall. For years, ACMC was the only medical group in town, and its physicians worked in a clinic attached to the hospital. After outgrowing that space, and later clinic space at a nearby mall, ACMC, which now has 18 primary care physicians, moved into a new two-story 45,000-square-foot building on the northeast side of town, about a mile from the hospital, in March of 2013.

In 2004, South Dakota-based Avera Health was hired by the city to run the 25-bed critical access hospital. The city then decided to sell the hospital to Avera in 2009. In the meantime, Avera brought in its own team of 17 primary care and specialty physicians and housed them at the hospital and a nearby clinic.

Physicians from ACMC worked alongside those who were employed by Avera as well as a few independent practitioners. “Our relationships with the physicians at the hospital have been very collegial and fun,” Willett says. The medical executive committee, which represents all physicians who practice at the hospital, was composed of equal numbers of physicians from ACMC and Avera. And the ACMC physicians’ relationship with the hospital’s administration was “not problematic,” according to Willett. But that changed after the sale closed in November of 2009.

According to court records, in 2010, ACMC sued Avera Marshall for allegedly steering patients away from their physicians and toward Avera’s employed physicians. But the issue that was what Meister describes as “the powderkeg” was peer review.

As chief of staff, Meister was charged with working with the hospital’s CEO to form a quality-improvement committee
that would conduct physician peer review. The applicable policy that had been adopted by the hospital's medical staff and board of directors indicated that the committee should consist only of physicians. It did not include any specific requirements as to a member's employment status, but it did indicate that the committee was to be made up of physicians who hold certain medical staff offices or positions and representatives from the medicine, emergency, surgery, maternal-fetal medicine and psychiatry departments. “You want fair and equal balance,” he says. Meister proposed a slate of candidates that he describes as “a 50/50 balance” of Avera and non-Avera physicians.

But the hospital’s board and administration didn’t go along with it and instead set up a peer-review committee predominantly made up of Avera physicians plus one ACMC physician and several non-physician hospital board members. That was what ultimately led to the lawsuit.

“They demanded to have [non-physician] board members on the Medical Staff Quality-Improvement Committee, and we didn’t feel it was appropriate. It’s not peer review because they’re not peers, and they don’t understand when we talk about medicine. But they wouldn’t budge on that.”

JANE WILLET, D.O.

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Court records show that in January 2012, Avera Marshall sent a letter to the medical staff saying that it planned to repeal the bylaws and establish new ones. Among the proposed changes were additional requirements for eligibility to serve on the medical staff; more clearly defined work requirements for the staff, officers, departments and departmental leaders; modifications to clinical rules and regulations; and changes to the procedure for and timing of elections. The court described the changes as a “transition to a top-down, management-based approach to hospital administration.”

The records also noted that the hospital’s president and CEO indicated that the changes would not be brought before the medical staff for a vote (the existing bylaws stated that changes to the bylaws must be approved by two-thirds of the medical staff) but that individual members could submit comments to hospital administration. Avera asked that written feedback be submitted by March 1; the changes to the bylaws were scheduled to take effect April 1.

“We looked at the changes, evaluated them at the medical executive committee and got input [from the medical staff],” Meister says. Operating under the guidance of the existing bylaws, the staff voted and rejected the repeal by a margin of 18 to 10 and rejected the new bylaws by a margin of 17 to 11, according to the records. Despite the outcome of the vote, Avera went ahead and instituted the new medical staff bylaws. The hospital’s board and administration took the position that “they’re the hospital; they had the power to just make changes,” Meister says.

The physicians’ attempts to negotiate with the hospital broke down. “It got to the point where they wouldn’t even come to the table,” Meister says. “So when you’re at a point where we felt it was very important and they felt it was very important and you’ve exhausted all of your diplomatic opportunities for coming together, what’s left?”

Shortly after the hospital’s administration announced its intent to change the bylaws, Meister and Willett and the medical staff filed suit against Avera Marshall Regional Medical Center. Their contention: that the medical staff bylaws are an enforceable contract between the medical staff and the hospital and that the hospital should not be able to amend them unilaterally.

Living a lawsuit

The lawsuit, which was filed in Lyon County District Court, thrust Meister and Willett into the unfamiliar world of lawyers and judges, state and federal statutes, case law and amicus briefs.

“It was really foreign to me,” Willett says. “I don’t have a legal or business background, and I’m an eternal optimist. I thought Why can’t we all talk and get along? Why do we have to have lawyers involved? Can’t we work this out?”

As chief of staff, Meister was the most affected. “My hair is grey,” he says with a
laugh, running his hand over his salt-and-pepper head as he recalls that period in his life. At the time, he was also working toward a master’s degree in business administration at the University of St. Thomas—a factor that gave him an appreciation for the business of running a hospital. “I didn’t see my family very much,” the father of two teenagers and a four-year-old admits. He says he usually spent one day a week dealing with the case.

Physicians and nurses at both the hospital and the clinic were concerned about how this might affect patient care. “When the suit was first initiated, it was pretty contentious,” Meister says. “Some perceived this brought up barriers to quality patient care. It didn’t. But I didn’t blame them for feeling that way,” he says.

Patients and others in town wondered what it would mean as well. For Willett, who is known as “Dr. Jane” to the friends, neighbors and patients she sees both in her practice and in the grocery store, it meant answering question and assuaging concerns. “The perception in the community was that ACMC docs and the hospital were one entity because we work at the facility. They couldn’t figure out why we were fighting,” she says.

Both regret the fact that dealings with the hospital’s board and administration often became confrontational. “We used to have very open-ended discussions with them, and they had an open-door policy. Not anymore,” Willett says.

Adds Meister: “Our feeling is that the board will do what the board wants to do, physician input be darned. And they do have ultimate credentialing authority . . . When you think about going forth in a situation like that where I have to follow the bylaws and we have these meetings but our input doesn’t matter, then what’s the sense of having a meeting when they make their own rules?”

Confusing ruling
On July 6, 2012, a Lyon County District Court judge ruled that the medical staff was not an unincorporated association with the capacity to sue the hospital, although its officers could bring these claims while acting in their official capacity. In its final order issued September 24, 2012, the court ruled that the bylaws were not a contract, and that the hospital could unilaterally amend the bylaws without approval by two-thirds of the medical staff as long as they substantially complied with the procedures in the bylaws.

“The ruling was very confusing,” Meister recalls. “They said the bylaws don’t constitute a contract, yet the hospital has to follow them. It doesn’t make sense.”

Meister and Willett decided to appeal the District Court’s decision, knowing that if they didn’t take a stand, the consequences could set a precedent for physicians in other parts of the state and the country. “As the elected leadership of the medical executive committee, our job is to protect everyone—Avera docs who may not feel comfortable speaking openly because their paycheck is signed by the administration, and independent docs who don’t have the power of a group behind them,” Meister says.

“Peer review, in my opinion, is about quality. It’s about looking out for patients. But it can be horrible for a physician if it’s misused. If you want to use it as a witch hunt to run a doctor out, what better venue to do it?”

STEVEN MEISTER, M.D., M.B.A.

As the case moved to the Court of Appeals, Meister and Willett gained support from the Minnesota Medical Association, American Medical Association, American Academy of Family Physicians, American Osteopathic Association, Minnesota Academy of Family Physicians and Minnesota Academy of Pediatrics, which filed a joint amicus (friend of the court) brief on their behalf.

But on July 23, 2013, the Court of Appeals upheld the lower court’s ruling. In his opinion, Judge Michael Kirk wrote that “both sides raise persuasive policy arguments.” He also noted that there was no clear case law that could be applied in this situation.

Meister and Willett were both disheartened and perplexed by the ruling’s contradictory message. Not willing to give up, they took the case to the Minnesota Supreme Court. “Some people think this is about power,” Willett says. “It’s not. It’s about autonomy of physicians and being able to care for our patients and if our opinions make a difference.”

Back to business
The two physicians have pretty much resumed life as it was before they became embroiled in the lawsuit. They continue to see patients at the clinic and at the hospital, although relations with the administration continue to be strained. They mentor medical students, schooling them in the good and the bad of practicing rural family medicine. And they have gone back to being active in the community. Meister, who can be seen driving around town in his GEM electric car, attends Bible study sessions at church; his older children’s cross-country meets, marching band and dance team performances; and his youngest son’s preschool activities. Willett, whose three children are grown, serves as vice chair of the local sports commission and spends time reading, gardening, quilting and traveling.

In mid-October, they received news that made them optimistic: The Supreme Court agreed to hear the case. “It gives obvious credence to the fact that this is a serious issue,” Meister says. “They feel it’s important enough and has a great deal of bearing on physicians and the way they’re able to deal with patients and ensure quality care. It’s a real live issue.”

Kim Kiser is an editor of Minnesota Medicine.
One of those images was of a young and, I imagined, pretty teenaged girl. I didn’t know for sure because I never saw her face, at least not in the way God had made it.

The neighboring state had a legal drinking age of 18 years. Naturally, younger kids would drive with older ones across the state line to buy beer and party. It never entered their minds what could happen. Certainly not to them. It never entered our minds either. At least not yet.

I imagine the fun they had. A warm, bright summer day fading into dusk. Carefree, laughing, free from parents’ rules and reminders and with unspoken dreams. They drank heavily, but soon it was time to return home. She was to leave with her family the next day to see Grandma and Grandpa. She liked them. Even though they were old, she thought they were pretty cool. Anyway, the car windows were open, the radio was blasting and everyone was laughing.

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We got broken first
On healing the healers
BY GREGORY A. POLAND, M.D.

W e were full and, we thought, complete. Full of ourselves and of the naïve “heal the world” optimism that comes with acceptance into what we were told was a noble profession. What we didn’t know then, and never suspected, was who would need healing. And absent understanding this punishing reality, we would suffer. Some of us would die from the wounds inflicted by our calling. As the ancients knew and tried to warn us across the centuries, our organs would cry the tears that our eyes would not.

It was never OK to cry. Not in front of a patient, and absolutely never in front of the chief resident or attending. Unless you were weak. Then you could cry ... but at a price. A price we didn’t believe was worth paying. Because, if you did, you were labeled as “the weak one,” “probably not cut out for clinical medicine,” “lacking the necessary professionalism to be effective.” At least, that’s what we believed and what the culture of medicine insistently and callously whispered to us every day.

You see, we were going to be doctors—healers, armed with the shields of science and reason, our stethoscopes and our sincerity. Later, we would learn the truth—the kind of truth that only comes unsuspected and uninvited in the middle of the night in the form of nightmares, deep anguish and maybe, if you were lucky, insight.

We started, 76 of us, in the hot and heavy mugginess of the summer of 1977. Perhaps the oppressive atmosphere was an omen. By the end of the first year, one of us would leave school and one of us would be dead. The rest of us didn’t know it, but we would all be wounded. Only later, much later, did the toll of broken relationships, divorces, lonely lives, drug and alcohol abuse, and the unfulfilled dreams that come from living with an invisible kind of chronic pain, let us know we were wounded. Were we, who were trained to be observant, really that unobservant of ourselves and our colleagues? We didn’t know the risks, and no one told us. If the senior healers, our tribal elders, didn’t know, how should we have known or ever given a thought to the cost of healing and what lay before us?

Like soldiers in combat, we were exposed to an endless parade of brutality. Of damages to the human body that are not imaginable and cannot be described—an onslaught of blood, desperation, smells, fear, screaming and pain rushing at us, causing us to think what might have been if not for this. High-definition images that puncture the mind and never leave. Not ever. Not even 30 years later.

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