TRENDS & Ideas

MEDICINE AND LAW

HMO Medical Directors Lose a Round

Sim Gellman

In what could turn out to be a landmark decision, an Arizona appellate court has ruled that a state medical board can discipline a physician for a decision he made as the medical director of a health maintenance organization (HMO).

In 1992, writes Linda O. Prager in *American Medical News*, John F. Murphy, MD, medical director of Blue Cross and Blue Shield of Arizona, vetoed gall bladder surgery for a plan member. Despite Murphy's ruling, the member's surgeon removed the gall bladder, which in fact proved to be diseased.

Although the HMO later paid the claim, the surgeon filed a complaint with the Arizona Board of Medicine, accusing Murphy of unprofessional conduct and medical incompetence. In return, the HMO filed a lawsuit, claiming that the board had no jurisdiction over Murphy because in his work for the HMO he made decisions about insurance benefits but did not practice medicine.

But, in its recent decision, the appellate court ruled that Murphy had acted for the HMO in a medical—not an insurance—capacity and in doing so had substituted his medical judgment for that of the patient's physicians. He could therefore be disciplined by the medical board, the court said.

The HMO, worried that the court's verdict might be the first trickle in a flood of complaints against plan medical directors, says such complaints could both raise administrative costs and discourage physicians from becoming medical directors. "It's in our customers' best interests to have skilled medical professionals reviewing these things," says Lyn McKay, an HMO lawyer. "But if a doctor is going to be hauled before the board all the time, we might not be able to get doctors to work in these jobs."

On the other hand, Mark Speicher, executive director of the medical board, argues that the verdict "puts the board in a position where it can protect the public from inappropriate medical decisions."

The HMO is planning to appeal the appellate court's ruling to the state supreme court.

MODERN CULTURE

Diversity Training Gains Popularity

Across the country, doctors are being coached in how to communicate better with patients from different ethnic backgrounds, reports George Anders in the *Wall Street Journal*. Health maintenance organizations (HMOs) and malpractice insurers, in particular, are promoting ethnic diversity training programs because they can boost membership and help doctors avoid costly mistakes. In Michigan last spring, a medical-malpractice insurer offered 2 percent to 5 percent premium discounts to doctors who attended a workshop about cultural differences in medicine. More than 400 doctors signed up.

Diversity training can include explaining to doctors when to seek or avoid eye contact (seek it with Latino patients, avoid it with some Asian patients) and making them aware of a Guatemalan folk belief that a person's well-being is regulated by giant worms in the belly. While some doctors feel that patients do not want to be treated differently, there is no question that such programs are cropping up all over. Kaiser Permanente, in Southern California, has on its staff a medical anthropologist who helps develop specific programs for minority members. In Seattle, the Cross-cultural Health Care program has conducted 23 workshops this year for doctors and nurses. The Baltimore-based medical-education group that conducted the Michigan workshop has also conducted workshops for New York hospitals and California HMOs.

This training boom may be due in part to the increased role of HMOs in the Medicaid program—millions of low-income blacks, Latinos, and Asians have joined Medicaid HMOs in the last five years. Gilson DaSilva, director of Medicaid programs at United Health Plan of New England, counts eight languages that 100 or more plan members speak, including Portuguese, Spanish, Laotian, Vietnamese, Russian, Hmong, Cambodian, and French. The plan, in addition to conducting doctor training, also hires interpreters to help doctors and patients communicate.

HEALTH PRACTICES

Who Has Bad Habits?

Kentuckians smoke too much. Alaskans tend to be binge drinkers. Minnesotans not only drink too much; they also drive while drinking. That, anyway, is the way residents of those states see themselves, according to Paula Mergenhagen in *American Demographics.*

These self-descriptions were among the 1995 results of a continuing survey conducted by the Centers for Disease Control and Prevention (CDC). In the survey, called the Behavioral Risk Factor Surveillance System (BRFSS), the agency makes monthly phone calls to ask about drinking, smoking, and other risky behaviors. The CDC thus learns what progress Americans are making—or failing to make—in their efforts to overcome bad health habits.

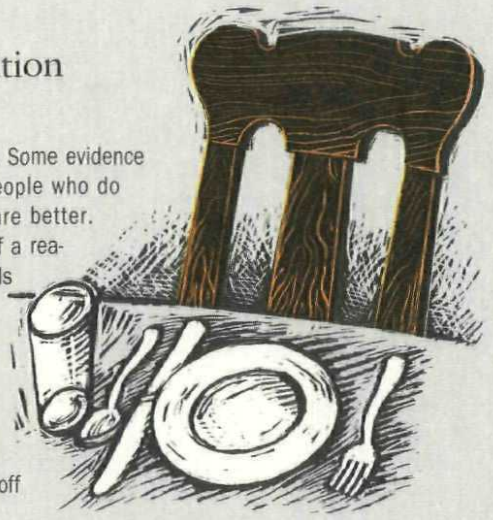
In 1995 BRFSS respondents reported the following things about themselves:

- Southerners apparently tend to feel less well than people who live in other states. More than 20 percent of residents in Mississippi, Kentucky, and West Virginia described their health as poor to middling. On the other hand, only 8 percent of Alaskans said their health was poor.
- Along with Kentuckians (28 percent), the residents of Indiana (27 percent) and Nevada, Ohio, North Carolina, Michigan, and West Virginia (all 26 percent) are apparently the nation's leading cigarette smokers. Residents of Utah said they smoked the least (13 percent), followed by Californians (16 percent).
- New Englanders led other Americans in admitting that they do not always wear seat belts. Residents of Maine (38 percent) ranked highest in this regard, followed by those of Rhode Island (34 percent), New Hampshire (33 percent), and Massachusetts (26 percent). At the other end of the scale, only 4 percent of Hawaiians said they do not buckle up every time they get in the car.
- Although 71 percent of American women aged 50 or older said they had had a mammogram in the previous two years, there was a good deal of variance among states. For example, 80 percent of Michigan and Massachusetts women reported having recent mammograms, but only 54 percent of Mississippi women did so.

CDC officials said differences in mammogram use, and in other health practices, could be partly attributed to gaps between states' economic and educational levels.

GERIATRICS

Elderly at Risk of Malnutrition



Untreated nutritional deficiencies in older people are extremely prevalent, yet are largely undetected by physicians, writes April Thompson in *Aging Today.* A recent study conducted by the Geisinger Geriatric Education Center, in Danville, PA, revealed that 90 percent of elderly individuals who met standard criteria for undernutrition were not identified as undernourished by their primary care physicians. The study involved 200 geriatric inpatients.

Such oversight can be unnecessarily costly. Malnutrition is eminently preventable, but, if doctors are unaware of it, elderly patients may need expensive acute care before the problem is addressed. Study results have shown that hospital readmission rates are higher for older patients who lose weight or do not maintain adequate protein levels after being discharged. Malnutrition can also interfere with treatment therapies. According to Ronni Chernoff, president of the American Dietetic Association, treatment for pressure ulcers (which costs the United States $1.3 billion a year) is useless unless the patients are given specific nutrients to help build new tissue.

Many factors may affect older people's nutritional status. Depression, social isolation, poverty, and disability all may play a part, as may surgeries or illnesses. Some evidence suggests that people who do not live alone fare better. "There is more of a reason to cook meals at night . . . to do a variety of lifestyle things that people who live alone do not have the motivation to do," Chernoff points out.

Physiological changes that occur with age also affect nutritional needs. Calorie needs decrease with age, for example, but protein needs generally increase. A nutritional assessment should include a physical examination and an evaluation of fluid intake. Poor teeth or ill-fitting dentures are other clues to possible malnutrition that are often overlooked by physicians.