
Faith Regional Health Services

Medical Staff Leadership Program – Focus on Peer Review

February 20, 2025

LeeAnne Mitchell

Horty, Springer & Mattern, P.C.

Jointly sponsored by the University of Pittsburgh School of Medicine
Center for continuing education in the health and science and HortySpringer Seminars

AGENDA

- 8:00 to 9:15 a.m. **PEER REVIEW PRACTICES IN ACTION (Case Study – Meet Dr. Dewy)**
- When and how to notify a practitioner that clinical concerns have been raised through the peer review process
 - Deciding if precautionary suspension is appropriate – and acting on that decision
 - Planning a collegial meeting to discuss clinical concerns
 - Formulating performance improvement plans for clinical performance issues
- 9:15 to 10:00 a.m. **PEER REVIEW WRAP-UP: TIPS FOR NAVIGATING THE PROGRESSIVE STEPS OF PEER REVIEW**
- When and how to notify a practitioner that clinical concerns have been raised through the peer review (professional practice evaluation) process
 - Obtaining practitioner input
 - Formulating a performance improvement plan for a colleague with clinical performance issues
 - Addressing conflicts of interest in credentialing and peer review matters
- 10:00 to 10:15 a.m. **BREAK**
- 10:15 to 10:30 a.m. **MEET DR. DOS-RUPTIVE – UNDERSTANDING WHY A ROBUST PROFESSIONALISM POLICY IS AN ESSENTIAL TOOL!**
- 10:30 to 11:15 a.m. **PLANNING A COLLEGIAL MEETING TO DISCUSS A BEHAVIORAL CONCERN – A VARIATION ON A FAMILIAR THEME! (Case Study – Meet Dr. Rattler)**
- How to conduct an effective collegial intervention session when behavior is at issue – without losing your mind!
 - Documentation – tone and content, and where is it kept?
- 11:15 a.m. to Noon **TIPS FOR NAVIGATING THE PROGRESSIVE STEPS OF PEER REVIEW WHEN UNPROFESSIONAL CONDUCT IS AT ISSUE**
- Heading off retaliation
 - When to consider a psychiatric evaluation
 - Managing avoidance tactics swiftly, administratively, and without breaking a sweat
 - Stay on track! How to avoid distractions, deflections, and threats raised by the practitioner
 - Drafting – and monitoring – performance improvement plans for a colleague with conduct issues

Accreditation Statement

In support of improving patient care, this activity has been planned and implemented by the University of Pittsburgh and Harty Springer Seminars. The University of Pittsburgh is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

This activity is approved for the following credit: AMA PRA Category 1 Credit™. Other health care professionals will receive a certificate of attendance confirming the number of contact hours commensurate with the extent of participation in this activity.

The University of Pittsburgh designates this live activity for a maximum of 3.75 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Educational Intent

This program is designed for physicians who serve in Medical Staff leadership positions in hospitals. Upon completion of this program, participants should be able to identify common credentialing issues and develop best practices relating to initial appointment, reappointment, and clinical privileges. They should also be able to identify and manage the variety of peer review issues that confront them in their roles as physician leaders. Finally, participants should be able to define the legal responsibilities of Medical Staff leaders and the legal protections available to them.

Target Audience

- Medical Staff Officers
- Department Chiefs
- Credentials Committee Members
- MEC Members
- Bylaws Committee Members
- VPMAs, CMOs, and Medical Directors
- Medical Staff Services Professionals
- Quality/Performance Improvement Directors
- Hospital Management

LEEANNE M. MITCHELL**LMitchell@hortyspringer.com**

LEEANNE M. MITCHELL is a partner with the law firm of Horty, Springer & Mattern, P.C. in Pittsburgh, Pennsylvania. She has worked extensively on medical staff matters, including working with hospitals and their medical staffs on the development of new Medical Staff Bylaws, credentials policies, and other medical staff related policies and procedures, advising on practitioner-specific credentialing, privileging, and peer review matters, and working with medical staff leaders involved in formal investigations and medical staff due process hearings. She also works with hospitals on matters related to institutional review boards and research-related compliance issues. She has served as a faculty member on the HortySpringer seminars *Strategies for Managing Physician Health and Disruptive Conduct*, *The Credentialing Clinic*, and, along with Rachel Remaley, she currently leads *The Complete Course for Medical Staff Leaders*.

LeeAnne earned her J.D. from the University of Pittsburgh School of Law. While in law school, she also completed the coursework toward a master's degree in bioethics and was the recipient of the CALI Award for Excellence in Health Care Fraud and Abuse.

LeeAnne has served as a Community Member of the University of Pittsburgh Institutional Review Board since 2000 and is a member of the Board of Directors of the Carlynton School District. She is also a member of the American Health Lawyers Association, as well as the Allegheny County, Pennsylvania and American Bar Associations.

Conflict of Interest Disclosure

No members of the planning committee, speakers, presenters, authors, content reviewers and/or anyone else in a position to control the content of this education activity have relevant financial relationships with any proprietary entity producing, marketing, re-selling, or distributing health care goods or services, used on, or consumed by, patients to disclose.

Disclaimer Statement

The information presented at this activity represents the views and opinions of the individual presenters, and does not constitute the opinion or endorsement of, or promotion by, the UPMC Center for Continuing Education in the Health Sciences, UPMC/University of Pittsburgh Medical Center or Affiliates and University of Pittsburgh School of Medicine. Reasonable efforts have been taken intending for educational subject matter to be presented in a balanced, unbiased fashion and in compliance with regulatory requirements. However, each program attendee must always use his/her own personal and professional judgment when considering further application of this information, particularly as it may relate to patient diagnostic or treatment decisions including, without limitation, FDA-approved uses and any off-label uses.

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Medical Staff Leadership Program

Focus on Peer Review

February 20, 2025

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Meet Dr. Dewy

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**Sharing Peer Review Info. w/
Employers:**

- General rule: NO

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6.H **Confidentiality.** Maintaining confidentiality is a fundamental and essential element of an effective professional practice evaluation process.

- (1) **Documentation.** All documentation that is prepared in accordance with this Policy shall be maintained in appropriate Medical Staff files. This documentation shall be accessible to Hospital personnel and Medical Staff Leaders and committees having responsibility for credentialing and professional practice evaluation functions, and to those assisting them in those tasks. All such information shall otherwise be deemed confidential and kept from disclosure or discovery to the fullest extent permitted by state or federal law.
- (2) **Participants in the PPE Process.** All individuals involved in the PPE process (Medical Staff and Hospital employees) will maintain the confidentiality of the process. All such individuals shall sign an appropriate Confidentiality Agreement. Violations of this provision by Practitioners will be reviewed under the Medical Staff Professionalism Policy. Violations by Hospital employees will be referred to human resources.

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- (3) **Practitioner Under Review.** The Practitioner under review must maintain all information related to the review in a strictly confidential manner, as required by state law and hospital policy. The Practitioner may not disclose information to, or discuss it with, anyone outside of the review process set forth in this Policy without first obtaining the permission of the Leadership Council, except for any legal counsel who may be advising the Practitioner. Violations of this provision will be reviewed under the Medical Staff Professionalism Policy.

EVALUATION POLICY (PEER REVIEW)

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Sharing Peer Review Info. w/ Employers:

- General rule: NO
- Maybe exception if (1) employed by hospital or group with formal peer review and (2) policy specifically allows it

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6.N *Information Sharing with Employer.*

(1) *Scope.* This Section applies when the Practitioner subject to a review is an Employed Practitioner (see Section 1.D for the definition of Employed Practitioner).

PROFESSIONAL PRACTICE
EVALUATION POLICY
(PEER REVIEW)

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(2) *Information Sharing.* If the Practitioner involved is employed by the Hospital, the Leadership Council or PPEC may notify an appropriate Hospital representative with employment responsibilities of the review and request assistance in addressing the matter. If the Practitioner is employed by a Hospital-related entity or a qualifying private entity, the Leadership Council or PPEC may notify the peer review committee within the Employer and request assistance in addressing the matter. In all these situations, a representative of the Employer may be invited to attend meetings of the Leadership Council or PPEC, participate in discussions and deliberations, and participate in any interventions that may be deemed necessary. This Section is intended to supplement, not replace, any applicable Bylaw provision, policy, agreement or application form pertaining to the sharing of PPE/peer review information among the Hospital, Hospital-related entities, and private entities.

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But what if Dr. Dewy wants
to include her practice
partner(s)
in the conversation?

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Sharing Peer Review Info. w/ Employers:

- General rule: NO
- Maybe exception if (1) employed by hospital or group with formal peer review and (2) policy specifically allows it
- Leaders/Practitioner can *mutually* agree to include others

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Be sure to document the practitioner's request to involve a partner

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3. **NOTICE TO AND INPUT FROM THE PRACTITIONER.** An opportunity for Practitioners to provide meaningful input into the review of the care they have provided is an essential element of an educational and effective process.

3.A *Opportunity for Input.*

- (1) If any questions or concerns are identified about the care provided in a case under review, the Practitioner will be notified of the questions or concerns and offered an opportunity to provide input prior to the review being completed and any final determination made. The notice to the Practitioner shall include a time frame for the Practitioner to provide the requested input.
- (2) This prior notice and opportunity for input will always occur during the initial assessment of a case if any questions or concerns are identified, but subsequent levels of review may also seek input from the Practitioner if necessary or helpful to the review.
- (3) No Educational Letter, Collegial Intervention, or Performance Improvement Plan shall be implemented until the Practitioner is first notified of the specific concerns identified and given an opportunity to

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WHEN should practitioners be notified that their care is under review?

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3.A Opportunity for Input.

- (1) If any questions or concerns are identified about the care provided in a case under review, the Practitioner will be notified of the questions or concerns and offered an opportunity to provide input prior to the review being completed and any final determination made. The notice to the Practitioner shall include a time frame for the Practitioner to provide the requested input.

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Why not automatically send a notice to a practitioner every time one of his/her cases is identified for review?


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Is it okay for Dr. Dewy’s own group to review her case?

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6.C **External Reviews.** An external review may be appropriate if:

- (1) there are ambiguous or conflicting findings by internal reviewers;
- (2) the clinical expertise needed to conduct a review is not available on the Medical Staff; or
- (3) an outside review is advisable to prevent allegations of bias, even if unfounded.

Obtaining an external review is within the discretion of the Leadership Council or PPEC, acting in consultation with the Chief Executive Officer or Chief Medical Officer. No Practitioner has the right to demand that the Hospital obtain an external review in any particular circumstance.

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How to decide if risk of bias is too great?

- Consider the nature of the conflict of interest

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CONFLICT OF INTEREST GUIDELINES

Potential Conflicts	Levels of Participation								
	Provide Information	Individual Reviewer Application/ Case	Committee Member					Hearing Panel	Board
			Credentials	Leadership Council	PPEC	MEC	Investigating Committee		
Employment/contract relationship with hospital	Y	Y	Y	Y	Y	Y	Y	Y	Y
Self or family member	Y	N	R	R	R	R	N	N	R
Relevant treatment relationship*	Y	N	R	R	R	R	N	N	R
Significant financial relationship	Y	Y	Y	Y	Y	R	N	N	R
Direct competitor	Y	Y	Y	Y	Y	R	N	N	R
Close friends	Y	Y	Y	Y	Y	R	N	N	R
History of conflict	Y	Y	Y	Y	Y	R	N	N	R
Provided care in case under review (but not subject of review)	Y	Y	Y	Y	Y	R	N	N	R
Involvement in prior PIP or disciplinary action	Y	Y	Y	Y	Y	R	N	N	R
Formally raised the concern	Y	Y	Y	Y	Y	R	N	N	R

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Employment/contract relationship with hospital	Y	Y	Y	Y	Y	Y	Y	Y	Y	
Self or family member	Y	N	R	R	R	R	N	N	R	
Relevant treatment relationship*	Y	N	R	R	R	R	N	N	R	
Significant financial relationship	Y	Y	Y	Y	Y	R	N	N	R	
Direct competitor	Y	Y	Y	Y	Y	R	N	N	R	
Close friends	Y	Y	Y	Y	Y	R	N	N	R	
History of conflict	Y	Y	Y	Y	Y	R	N	N	R	
Provided care in case under review (but not subject of review)	Y	Y	Y	Y	Y	R	N	N	R	
Involvement in prior PIP or disciplinary action	Y	Y	Y	Y	Y	R	N	N	R	
Formally raised the concern	Y	Y	Y	Y	Y	R	N	N	R	

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How to decide if risk of bias is too great?

- Consider the nature of the conflict of interest
- Consider the nature of the review activity (what's at stake?)

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Employment/contract relationship with hospital	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Self or family member	Y	N	R	R	R	R	N	N	N	R
Relevant treatment relationship*	Y	N	R	R	R	R	N	N	N	R
Significant financial relationship	Y	Y	Y	Y	Y	R	N	N	N	R
Direct competitor	Y	Y	Y	Y	Y	R	N	N	N	R
Close friends	Y	Y	Y	Y	Y	R	N	N	N	R
History of conflict	Y	Y	Y	Y	Y	R	N	N	N	R
Provided care in case under review (but not subject of review)	Y	Y	Y	Y	Y	R	N	N	N	R
Involvement in prior PIP or disciplinary action	Y	Y	Y	Y	Y	R	N	N	N	R
Formally raised the concern	Y	Y	Y	Y	Y	R	N	N	N	R

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			Credentials	Leadership Council	PPEC	MEC	Committee Member			
Employment/contract relationship with hospital	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Self or family member	Y	N	R	R	R	R	N	N	N	R
Relevant treatment relationship*	Y	N	R	R	R	R	N	N	N	R
Significant financial relationship	Y	Y	Y	Y	Y	R	N	N	N	R
Direct competitor	Y	Y	Y	Y	Y	R	N	N	N	R
Close friends	Y	Y	Y	Y	Y	R	N	N	N	R
History of conflict	Y	Y	Y	Y	Y	R	N	N	N	R
Provided care in case under review (but not subject of review)	Y	Y	Y	Y	Y	R	N	N	N	R
Involvement in prior PIP or disciplinary action	Y	Y	Y	Y	Y	R	N	N	N	R
Formally raised the concern	Y	Y	Y	Y	Y	R	N	N	N	R

Y means

- May generally serve in this role because of no disciplinary authority and checks and balances
- Credentials/LC/PPEC chair always has authority and discretion to recuse a member in particular situation

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Grounds For Precautionary Suspension Or Restriction:

Whenever, in their sole discretion, failure to take such action may result in imminent danger to the health and/or safety of any individual, the MEC, a Medical Staff Officer, or a chair of a department, acting in conjunction with the CMO or the Hospital President, shall have the authority to...suspend or restrict all or any portion of an individual's clinical privileges as a precaution.

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Tone Matters!

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Calls can be okay:

- routine, informal matters
- where little substance will be discussed
- where the relationship is still relatively collegial/amicable
- Where you don't need "evidence" of the invitation
- Where there's no time for a written document



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Collegial, informal notice:

"The Committee would like to meet with you in the next few days to discuss next steps.

Please contact Philip Kozer, M.D., CMO, at 555-5555 to arrange a mutually convenient time.

We do not anticipate the meeting taking longer than 30-60 minutes.

Thank you, in advance for your participation in the process. We know this can be difficult. We look forward to talking with you soon."

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More formal notice:

"The Committee would like to meet with you to discuss next steps. The meeting has been scheduled for October 17th at 8:00 a.m. in the South Wing Board Room. Your attendance is mandatory.

If extenuating circumstances will prevent you from attending, please contact Philip Kozer, M.D., CMO, at 555-5555 to reschedule.

Thank you, in advance for your cooperation."

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"We're not messin' around anymore" notice:

"...As you know, the Committee has rescheduled this meeting twice to accommodate your schedule and both times you have canceled at the last minute.

Therefore, the meeting has now been scheduled for October 17th at 8:00 a.m. in the South Wing Board Room. Your attendance is mandatory. Your failure to attend will result in your automatic relinquishment of appointment and clinical privileges pursuant to Section 6.D.3 of the Medical Staff Credentials Policy.

Thank you, in advance for your cooperation."

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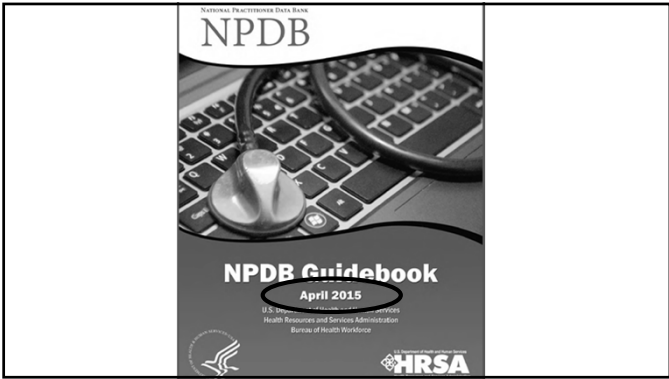
“Special” notice by certified mail:

“The Medical Executive Committee met on October 17 to discuss the investigation of your professional conduct at New Horizons Medical Center.

This meeting was the culmination of many years of unprofessional conduct by you at this institution and many years of the leadership attempting to assist you in bringing your conduct into compliance with expectations.

The Committee determined to suspend your Medical Staff appointment or clinical privileges for a period lasting thirty (30 days). The suspension is effective immediately. Please note that during the term of your suspension, you may not exercise any of the clinical privileges that you have been granted, nor may you exercise any of the prerogatives of Medical Staff membership...

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NPDB NATIONAL PRACTITIONER DATA BANK

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Home The NPDB Guidelines

22. Is an agreement not to exercise privileges during an investigation, without actually surrendering the privileges, a resignation while under investigation that is reportable?

Chapter 10 Information Sources

Appendix A: Glossary

Appendix B: Anonym Code

Appendix C: Change History

NPDB is not a federal agency. It is a non-profit organization that is authorized by the U.S. Department of Health and Human Services (HHS) to maintain the National Practitioner Data Bank (NPDB). NPDB is not a federal agency. It is a non-profit organization that is authorized by the U.S. Department of Health and Human Services (HHS) to maintain the National Practitioner Data Bank (NPDB). NPDB is not a federal agency. It is a non-profit organization that is authorized by the U.S. Department of Health and Human Services (HHS) to maintain the National Practitioner Data Bank (NPDB).

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NPDB NATIONAL PRACTITIONER DATA BANK

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Yes, the agreement not to exercise privileges is reportable if other reportability conditions are met. NPDB regulations state that "acceptance of the surrender of clinical privileges or any restriction of such privileges...while under investigation" is reportable. An agreement not to exercise privileges is a restriction of privileges. Any restriction of privileges while under investigation, temporary or otherwise, is considered a resignation and must be reported.

Appendix A: Glossary

Appendix B: Anonym Code

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NPDB NATIONAL PRACTITIONER DATA BANK

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16. A physician held clinical privileges at a hospital entitling him to perform specific procedures. The head of the physician's medical department pointed out to the physician that the physician was no longer performing some of the procedures, and the department head suggested that the physician voluntarily relinquish those privileges. The physician agreed. Should this voluntary relinquishment of privileges be reported?

Appendix A: Glossary

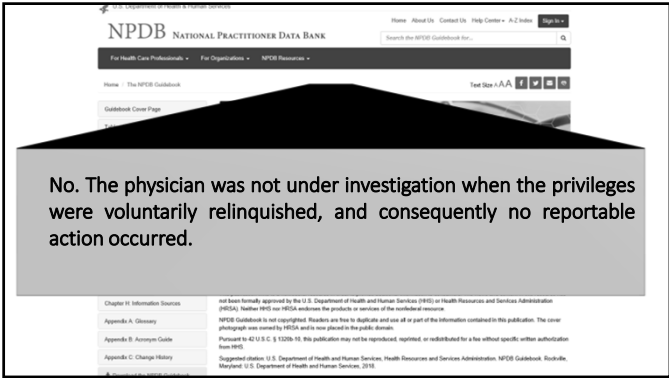
Appendix B: Anonym Code

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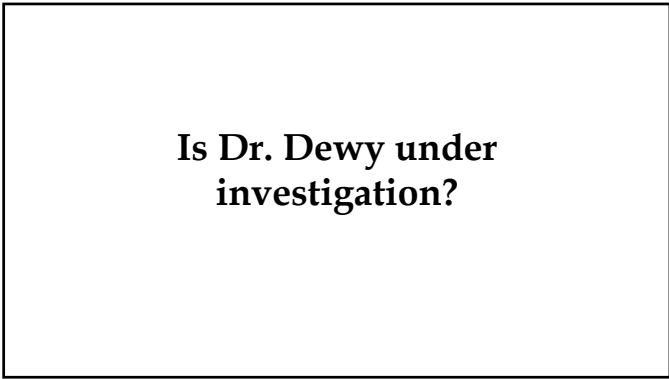
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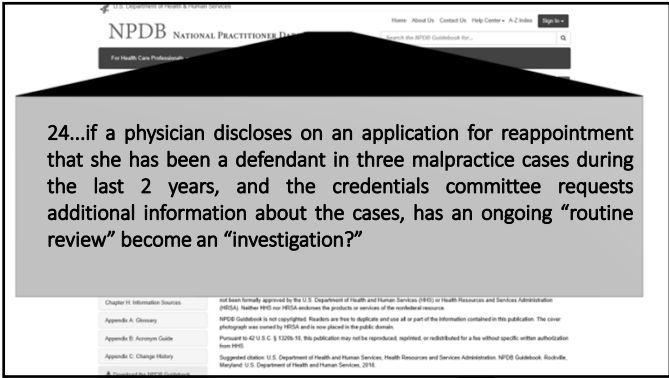
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[illegible]

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[illegible]

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Use Your Documents to Help Provide Clarity on Investigations

- Reference “investigation” as just one of many options

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Options Available to Leaders:

This Policy empowers Medical Staff Leaders and Hospital Administration to use various options to gather information and address and resolve concerns about Practitioners, including, but not limited to...

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...including, but not limited to:

- (a) ongoing and focused professional practice evaluation;
- (b) clinical competency evaluation;
- (c) fitness for practice evaluation;
- (d) collegial intervention and progressive steps;
- (e) mandatory meetings;
- (f) informal fact finding;
- (g) automatic relinquishment of Membership and Clinical Privileges;
- (h) leaves of absence;
- (i) precautionary suspension; and
- (j) *formal Investigation*

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**Use Your Documents to Help
Provide Clarity on Investigations**

- Reference “Investigation” as just one of many options
- Only the MEC or Board can begin Investigation

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Initiation of Investigation:

The Medical Executive Committee will review the matter in question, may discuss the matter with the Practitioner, and will determine whether to conduct an Investigation or direct that the matter be handled pursuant to another policy. An Investigation will commence only after a determination by the Medical Executive Committee or the Board.


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**Use Your Documents to Help
Provide Clarity on Investigations**

- Reference “Investigation” as just one of many options
- Only the MEC or Board can begin Investigation
- No other committees have “disciplinary authority” (e.g. they only handle collegial process)

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LEADERSHIP COUNCIL is a peer review and quality assurance committee that performs the following duties:


This committee possesses no disciplinary authority. Only the Medical Executive Committee has the authority to conduct non-routine, formal Investigations and to recommend restrictions of clinical privileges. The composition and duties of the Leadership Council are described in the Medical Staff Organization Manual.

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Use Your Documents to Help Provide Clarity on Investigations

- Reference “Investigation” as just one of many options
- Only the MEC or Board can begin Investigation
- No other committees have “disciplinary authority” (e.g. they only handle collegial process)
- Don’t use MEC for routine peer review process

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PROFESSIONAL PRACTICE EVALUATION COMMITTEE (“PPEC”) is a multi-specialty peer review and quality assurance committee that oversees the professional practice evaluation process, conducts case reviews, works with Practitioners in a constructive and educational manner to help address any clinical performance issues, and develops Performance Improvement Plans as described in this Policy. The PPEC possesses no disciplinary authority. Only the Medical Executive Committee has the authority to conduct non-routine, formal Investigations and to recommend restrictions of clinical privileges.

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Use Your Documents to Help Provide Clarity on Investigations

- Reference “investigation” as just one of many options
- Only the MEC or Board can begin investigation
- No other committees have “disciplinary authority” (e.g. they only handle collegial process)
- Don’t use MEC for *routine* peer review process
- Define indicators that will *routinely* be reviewed for all practitioners as part of the PPE process

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SURGERY

Surgery Related Event/Issue: Ambulatory Surgery Pt. Admitted for Complications of Procedure
Surgery Related Event/Issue: Neuro/Surgical Spinal Fluid Leak
Surgery Related Event/Issue: Unplanned Injury or Removal of an Organ
Surgery Related Event/Issue: Pneumothorax S/P Line Insertion or Procedure
Surgery Related Event/Issue: Unplanned Return to Surgery
Surgery Related Event/Issue: Untoward Result of Treatment or Procedure
Surgery Related Event/Issue: Indications Not Met
Surgery Related Event/Issue: Surgical Infection

TISSUE/PROCEDURE DISCREPANCY

Tissue/Procedure Discrepancy: No Tissue Submission to Pathology
Tissue/Procedure Discrepancy: Normal Tissue Pathology
Tissue/Procedure Discrepancy: Preop/Postop and Path Diagnosis Disagree

TRAUMA

Trauma Related Event/Issue: Intracranial Inj.-Trans, w/o Airway Management
Trauma Related Event/Issue: No Trauma Consult
Trauma Related Event/Issue: Craniotomy > Four Hours After Arrival in ED
Trauma Related Event/Issue: Delay in Activating Trauma Team
Trauma Related Event/Issue: Delay Response to Trauma

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Use Your Documents to Help Provide Clarity on Investigations

- Reference “Investigation” as just one of many options
- Only the MEC or Board can begin Investigation
- No other committees have “disciplinary authority” (e.g. they only handle collegial process)
- Don’t use MEC for *routine* peer review process
- Define indicators that will *routinely* be reviewed for all practitioners as part of the PPE process
- Define when Investigation is concluded/closed

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The NPDB Guidebook is ambiguous. But, *some* voluntary refrains, in *some* situations, will be reportable.

Always consult legal counsel in these situations

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Dr. Dewy:

- Three cases fell out under defined indicators - any physician would have this type of case reviewed in this situation (*routine*; not targeted)
- The cases are still within the collegial peer review process - not a precursor to professional review action
- No one has threatened Dr. Dewy with Investigation or adverse action
- The individuals/committees she is dealing with have no disciplinary authority


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Dr. Dewy:

- The MEC and Board - which have disciplinary authority - are not involved
- The "expert" review has not been conducted, so we have no "concern" about Dr. Dewy's performance at this stage

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Faith Regional Health Services



No Legal Counsel or Recordings During Collegial Meetings.

To promote the collegial and educational objectives of this Policy, all discussions and meetings with a Practitioner shall generally involve only the Practitioner and the appropriate Medical Staff Leaders and Hospital personnel. No counsel representing the Practitioner or the Medical Staff or the Hospital shall attend any of these meetings.

58

What preparation should the Leadership Council do before meeting with Dr. Dewy?

59

Preparation?

- Review practitioner history
- Look at current cases identified for review
- Read the Bylaws/Policies!
- Consult legal counsel

60

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*What is the goal of
meeting with Dr. Dewy?*

61

*What is the goal of
meeting with Dr. Dewy?*

*Temporary
&
voluntary refrain*

62

*What should be the tone
of the meeting?*

63

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*What should be the tone
of the meeting?*

Collegial

64

*Anticipate the practitioner's
concerns/reaction:*

- *Embarrassment*
- *Defensiveness*
- *Reluctance to have practice partners find out*
- *Reluctance to take time off work*

65

*Anticipate the practitioner's
concerns/reaction:*

- *Feeling unfairly targeted*
- *Feeling like you've already reached the conclusion that she's "guilty"*
- *Feeling like a subject - rather than participant - in the process*

66

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Anticipate the practitioner's perspective:

- *Cares about her patients*
- *Cares about her reputation*
- *Wants to be successful at your hospital*
- *Wants to resolve this matter efficiently*

67

What should be said?

68

What should be said?

- *Thank you for meeting*
- *We know this must be difficult for you*
- *All cases with these indicators are reviewed (it's not personal!)*

69

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What should be said?

- *No findings have been reached*
- *We are still at the beginning of the process*
- *We will include you in this process and keep you informed*

70

What should be said?

- *We want to ensure patient safety while the process takes place*
- *We know you share our concern for patient safety*
- *Our goal is to take the least restrictive steps consistent with keeping patients safe*

71

What should be said?

- *Have you considered taking a step back while we find out what's going on?*
- *Do you have any other ideas for maintaining patient safety while we get to the bottom of things?*
- *Tell us your concerns*

72

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What should not be said?

73

What should not be said?

- *Investigation*
- *Precautionary suspension*
- *If you don't, then we will...*

74

*Don't go into the meeting with a
precautionary suspension letter
ready to deliver.*

75

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Cooperation from a practitioner does not negate the need for documentation and follow-up

76

Does the Leadership Council have the authority & resources to document & track a voluntary proctor/assist arrangement?

77

Do your leaders need MEC/Board approval for routine peer review activity?

78

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*Do you want “disciplinary”
authorities involved in
collegial processes?*

79

*What sort of plan
would be best for
Dr. Dewy?*

80

Dewy’s PIP:

- Going to include proctoring (as per her suggestion)
- Anything else?

81

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Performance Improvement Plan *Options*

- Education/CME
- Monitoring (for example, through chart review of next X cases) or more frequent gathering of data
- Procedure indications checklist
- Second opinions/consultations
- Live observation (proctoring)
- Retrospective observation (review of videos)

82

Performance Improvement Plan *Options*

- Formal evaluation and assessment programs
- Hands-on ("live") training/simulation
- Educational LOA/voluntary agreement to temporarily refrain from exercising some or all privileges
- "Other"

83

Dewy's PIP:

- Going to include proctoring (as per her suggestion)
- Anything else?
 - Education/CME?
 - Evaluation program?
 - Training/simulation?
 - Leave of absence? Voluntary refrain?

84

Faith Regional Health Services

Keys to PIP Success

- Be explicit on details/expectations
- You can't be *nice* enough!
- Personal meeting with colleague, be transparent and helpful
- PIPs never leave PPEC's agenda until they are successfully completed!

85

Develop A Checklist Tool!

PIP DESIGN	IMPLEMENTATION DESIGN
Additional: Examination TIME: Wide range of options	Design of Program: <input type="checkbox"/> Do you have a "what type?" <input type="checkbox"/> Acceptable program includes: <input type="checkbox"/> PIPs approved before practitioner results. <input type="checkbox"/> "Sign-off" approval <input type="checkbox"/> Date of approval: _____ <input type="checkbox"/> Time taken: <input type="checkbox"/> Practitioner must notify: <input type="checkbox"/> CME must be completed by: <input type="checkbox"/> Who pays for the CME course? <input type="checkbox"/> Practitioner return to PIP: <input type="checkbox"/> Standard tool: <input type="checkbox"/> Confidential: <input type="checkbox"/> Specify documentation of completion that must be submitted to PPEC: <input type="checkbox"/> Case submission: Additional Information: <input type="checkbox"/> Will the individual be asked to voluntarily return from receiving additional clinical privileges until completion of additional education? <input type="checkbox"/> Yes <input type="checkbox"/> No Follow Up: <input type="checkbox"/> After CME has been completed, how will monitoring be done to be sure the process has been implemented properly (e.g. improved? "ground perspective monitoring" (proctoring)?

86

Live Observation (Proctoring)

A proctor must be present to observe the provision of care

87

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Live Observation (Proctoring) Details:

- What type of care is subject to proctoring (e.g. all care or just certain procedures?)
- Can the practitioner continue to be on-call during period of proctoring?

88

Live Observation (Proctoring) Details:

- How many cases must be proctored, at least initially?
- Based on practice patterns, estimated time for completion?
- Who will review the results with the Practitioner? After each case? After total number of cases?
- How will review/modification/termination of PIP occur?

89

Live Observation (Proctoring) Details:

- Who will be the proctor(s) (if up in the air, state that PPEC must approve proctor(s) prior to PIP implementation)
- Compensation for proctor? If yes, who pays?
 - Practitioner subject to PIP?
 - Medical Staff?
 - Hospital?
 - Combination?

90

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Live Observation (Proctoring) Details:

• Responsibilities of the practitioner:

- ✓ Provide reasonable notice to proctor (2 days prior to elective)
- ✓ Ensure that all information necessary for proctor to evaluate care plan is in the medical record (e.g., H&P, results of diagnostic tests)?
- ✓ Discuss proposed procedure with proctor?
- ✓ If proctor must personally evaluate patient:
 - i. inform patient that the proctor will be examining patient, and
 - ii. include general progress note that proctor examined patient and discussed findings with Practitioner

91

Live Observation (Proctoring) Details:

• Responsibilities of the proctor:

- ✓ Review medical record, evaluate patient (if applicable), discuss proposed procedure with Practitioner
- ✓ Be present (in the room) for all important parts of the procedure, which means from _____ until _____ (e.g. from the commencement of anesthesia until the patient is transferred to the recovery area)
- ✓ Is proctor authorized to intervene?
- ✓ Complete Proctoring Form and submit to the PPE Specialists
(not for inclusion in the medical record!)

92

Live Observation (Proctoring) :

- The proctor is not bound by the PIP (that's between the leadership and the practitioner).
 - So, outline the proctor's duties in a letter
 - Require proctor to sign and return letter
- PPEC Chair or CMO should meet with proctor(s) to outline expectations and discuss legal protections

93

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Performance Improvement Plan ("PIP").

...The plan should specify how the Practitioner's compliance with, and results of, the PIP will be monitored. One or more members of the PPEC should personally discuss the PIP with the Practitioner to help ensure a shared and clear understanding of the elements of the PIP. The PIP will also be presented in writing, with a copy being placed in the Practitioner's file, along with any statement the Practitioner would like to offer.

94

Voluntary Nature of PIPs.

If a Practitioner agrees to participate in a PIP developed by the PPEC, such agreement will be documented in writing. If a Practitioner disagrees with the need for a PIP developed by the PPEC, the Practitioner is under no obligation to participate in the PIP. In such case, the PPEC cannot compel the Practitioner to agree with the PIP. Instead, the PPEC will refer the matter to the Medical Executive Committee for its independent review and action pursuant to the Medical Staff Credentials Policy.

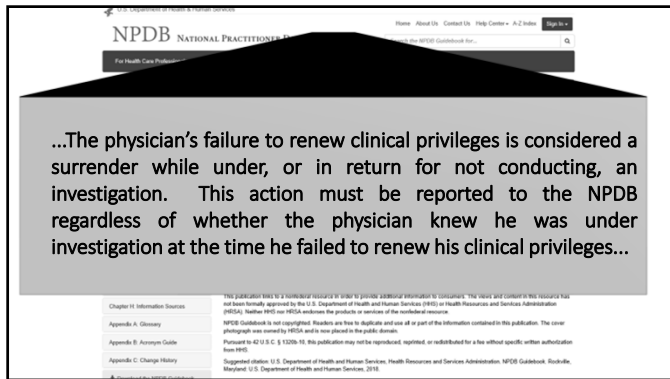
95

NPDB NATIONAL PRACTITIONER DATA BANK

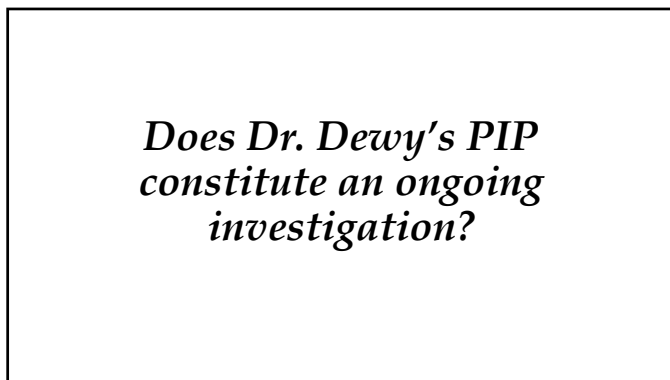
18. A hospital began an investigation of a physician on staff at the hospital for issues related to professional competence 4 weeks prior to the expiration of the physician's clinical privileges. The physician failed to renew the clinical privileges while the investigation was ongoing. Should this event be reported to the NPDB?

96

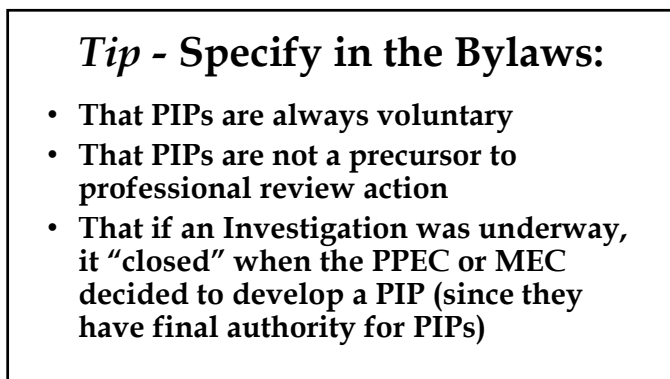
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97



98



99

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Is Dr. Dewy in "Good Standing?"

- Her appointment & privileges are intact
- She was never subject to an adverse professional review action
- She was cooperative with PPE
- She took voluntary steps to resolve any concerns

100

**So, how should the hospital
respond to South Coast?**

101

Thank you for submitting a "Hospital Affiliation Request" for Dr. Darci Dewy. At this time, the Medical Center is unable to complete your form but would be glad to provide information regarding Dr. Dewy's tenure at New Horizons after obtaining her authorization and release for our response...

102

Faith Regional Health Services

A copy of our authorization and release is enclosed. Once we receive an unaltered copy that has been executed by Dr. Dewy, we would be glad to respond with additional information.

103

Buffer “bad” news with kindness

104

*Look at the credentials file
before you respond*

105

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Reach a conclusion about what you can say:

- Remember to be factual!
- Include all relevant details, so as not to mislead
- If the practitioner was cooperative, **say so**. A history that includes *collegial* peer review efforts does not have to be viewed negatively!

106

Dr. Dewy joined the Active Staff of New Horizons Medical Center in December 2017 and has remained a member of the Medical Staff since that time. There have been no investigations or adverse actions involving Dr. Dewy. Beginning in the fall of 2018, in response to some complications she was having with advanced gynecological surgeries, Dr. Dewy voluntarily began having a practice partner accompany her on all such surgeries. The decision to conduct gynecological surgeries with her partner was entirely Dr. Dewy's. That decision was memorialized in a Performance Improvement Plan, with the full cooperation of Dr. Dewy. The Medical Center and its leaders have had no concerns regarding her professionalism or cooperation with the peer review process. At the time of this letter, the Performance Improvement Plan remains in effect and Dr. Dewy is in full compliance.

Review of the fact that you are showing will be included advanced gynecological surgeries independently at New Horizons. Therefore, I prepare the following language to be provided by you.

107

Dr. Dewy joined the Active Staff of New Horizons Medical Center in December 2017 and has remained a member of the Medical Staff since that time. There have been no investigations or adverse actions involving Dr. Dewy. Beginning in the fall of 2018, in response to some complications she was having with advanced gynecological surgeries, Dr. Dewy voluntarily began having a practice partner accompany her on all such surgeries. The decision to conduct gynecological surgeries with her partner was entirely Dr. Dewy's. That decision was memorialized in a Performance Improvement Plan, with the full cooperation of Dr. Dewy. The Medical Center and its leaders have had no concerns regarding her professionalism or cooperation with the peer review process. At the time of this letter, the Performance Improvement Plan remains in effect and Dr. Dewy is in full compliance.

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Faith Regional Health Services

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Members of the fact that you are showing not to conduct advanced gynecological surgeries independently at New Horizons. Therefore, I prepare the following language to provide by law.

109

Dr. Dewy joined the Active Staff of New Horizons Medical Center in December 2017 and has remained a member of the Medical Staff since that time. There have been no investigations or adverse actions involving Dr. Dewy. Beginning in the fall of 2018, in response to some complications she was having with advanced gynecological surgeries, Dr. Dewy voluntarily began having a practice partner accompany her on all such surgeries. The decision to conduct gynecological surgeries with her partner was entirely Dr. Dewy's. That decision was memorialized in a Performance Improvement Plan, with the full cooperation of Dr. Dewy. The Medical Center and its leaders have had no concerns regarding her professionalism or cooperation with the peer review process. At the time of this letter, the Performance Improvement Plan remains in effect and Dr. Dewy is in full compliance.

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Members of the fact that you are showing not to conduct advanced gynecological surgeries independently at New Horizons. Therefore, I prepare the following language to provide by law.

111

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What important things does this reference reveal?

- Clinical performance issues
- BUT - No adverse professional review actions
- An intervention to protect patients/ improve performance was implemented
- The performance improvement measure was voluntary - and not mandated

112

What important things does this reference reveal?

- The performance improvement measure is still in place
- The peer review process is still monitoring the practitioner
- The practitioner is in full compliance
- We are not concerned about practitioner - as long as history is known

113

Even when you're being nice (and factual), get the practitioner's authorization & release first

114

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Wrap-Up Tips for Navigating the Progressive Steps of Peer Review

115

TIP

**Wisdom of an empowered
*Multi-Disciplinary
Peer Review Committee
(CPE)***

116

Value of empowered CPE:

1. Consistency
2. Fairness
3. Oversight/accountability
4. Advisory/Non-disciplinary

117

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Keys to CPE Success:

1. Specialty representation
2. Avoid too much overlap with MEC
3. Experienced leaders serving longer, staggered terms
4. Adequate Training
5. Adequate PPE support
6. Empowered to act without prior MEC/ Board approval

118

TIP

**Focus on performance
improvement.**

Not scoring.

119



120

Gross deviation from
the standard of care

121



122

What replaces scoring?

1. Is there an issue or concern?
2. What performance improvement tool can best help our colleague?

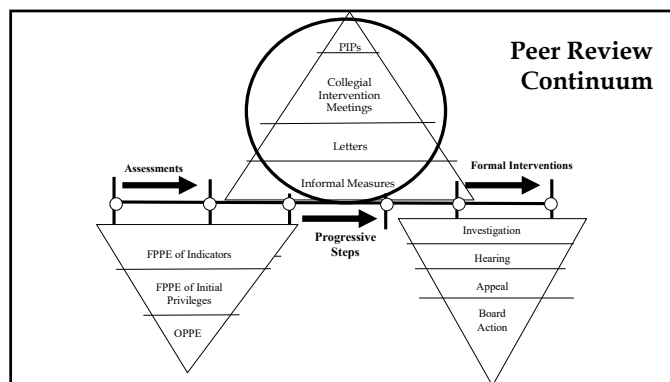
123

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How Do You Decide Between Progressive Steps vs. Formal Intervention?

- Practitioner history (pattern?)
- Previous intervention efforts?
- Number of incidents/concerns
- Severity of incidents/concerns
- Unique legal implications (sexual harassment, EMTALA, HIPAA violations, etc.)

124



125

The "Progressive Steps Continuum" includes:

- *Informal Measures*- coaching, mentoring, and other informal meetings or letters to address low-level concerns that require little or no follow-up/response from the practitioner and which leadership has discretion to document
- *Letters* - both educational and informational
- *Collegial Intervention Meetings* - planned, face-to-face meetings to address more significant or repetitive concerns, that require advance notice and written follow-up
- *Performance Improvement Plans* - formal written plan with the practitioner, by which practitioner voluntarily addresses more significant issues/patterns

126

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Progressive Steps Continuum

- *VOLUNTARY* – Not Professional Review *Action*
- Most require no hearing and no NPDB Report

127

TIP

Use the *least restrictive approach* consistent with *safe care and good quality!*

128

PROGRESSIVE steps

- Intervene early!
- *Improves your legal position* – even if it doesn't work
- "Discipline" as the last resort!

129

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TIP

Assign responsibility for progressive steps and other interventions

130

Who Does What?

Individuals (Chief, CMO)
Clinical Reviewers
Leadership Council
CPE
MEC
Board

Coaching/Mentoring
Letters
Collegial Intervention
Meetings
PIPs
Precautionary
Suspensions
Investigations
Corrective Action

131

Who Does What?

Individuals (Chief, CMO)
Clinical Reviewers
Leadership Council
PPEC
MEC
Board

Coaching/Mentoring
Letters
Collegial Intervention
Meetings
PIPs
Precautionary
Suspensions
Investigations
Corrective Action

132

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Who Does What:

- Early progressive steps available to more leaders
- More intensive progressive steps reserved for committees
- “Corrective action” reserved for MEC/Board

133

TIP

**Don't forget, things happen
between meetings:**
Authorize chairs/leaders to act

134

TIP

**Require active
participation in the peer
review process**

Use your enforcement tools!

135

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Administrative Enforcement Tool - *Automatic Relinquishment*

- For failure to respond to request for information
- For failure to obtain fitness for practice evaluation
- For refusal to attend mandatory meeting

136

TIP

***Document,
Document,
Document!***

And Then, Document Some More!

137

Documentation:

For every progressive step?

- ***Informal Measures*** - Leaders may choose not to document
- ***All other Progressive Steps*** - Should result in follow-up letter to practitioner

138

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Tone Matters!

139

Tone Matters:

- “Thank you for meeting with us”
- “We know these types of meetings can be difficult”
- “We appreciate the professionalism you have shown during this process”
- “We would like to commend you on the progress you have made toward completing the requirements of the PIP”
- “We know you share our commitment to quality and safety for our patients”

140

TIP

**Share follow-up
documentation with
practitioners**

And allow them to document too!

141

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TIP

**Reserve
precautionary suspension
for situations involving
imminent danger**

142

Precautionary Suspension

- Different from a disciplinary suspension
- NOT “summary” suspension
- NOT for “orderly operations of the Hospital”

143

Grounds For Precautionary Suspension or Restriction:

Whenever, in their sole discretion, failure to take such action may result in imminent danger to the health and/or safety of any individual, a Medical Staff Officer or department chair, acting in conjunction with the CMO or CEO, or the MEC shall have the authority to...suspend or restrict all or any portion of an individual’s clinical privileges as a precaution.

144

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Precautionary Suspension

**Don't use precautionary suspension
when precautionary restriction will do**

145

Precautionary Suspension

- **If at all possible, meet with the physician *before* imposing a precautionary suspension.**
- **Consider voluntary refrain instead - *but tread carefully* at how you arrive there!**

146

Precautionary Suspension

- **Pull (and read and follow) your *Bylaws***
- **Call your *lawyer***
- **Make sure you can *articulate clearly (and in writing) the imminent risk***

147

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Precautionary suspension is just the *beginning* of the process:

- Send written notice
- Build an expedited review process into Bylaws
- Meet with practitioner as part of expedited review
- No hearings!

148

No Hearings?!?!



How is that fair?

149

Precautionary Suspension

- Remember: NOT a disciplinary suspension
- *Interim step* in the review process
- Does not imply any wrongdoing
- You likely *do not have the facts* of the matter
- *No conclusions* have been made regarding competence or conduct

150

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Introducing...

The Dos Ruptive Guy

151



152



He isn't always charming.


But, when he is, it's with
"important" people.

153

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He doesn't want to treat nurses badly.


But, when he does, it's because they're incompetent.




154

He doesn't always complete his medical records on time.

But, when he does, it's to bash the ER doctor who "did not run the right tests over the weekend."



155



He doesn't always complain about the hospital.

But, when he does, it's loudly and in front of patients.

156

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He doesn't always
break the rules.

But, when he does, it's
because your rules are
dumb and he's very
busy, with important
things to do.

157

He's too busy for your
peer review meeting.

But, he wouldn't mind
a few minutes of your
time to tell you how to
do your job.



158

**Disruptive behavior is
not just a matter of
quirky personalities.**

159

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**Professionalism Policies
are essential – because they
are written for the 1%**

160

**Leal
v.
Secretary, U.S. Department of
Health and Human Services**

161

**“Like Alexander in the classic
children’s book, Dr. Leal was
having ‘a terrible, horrible, no
good, very bad day’”**

162

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"[A]t around 6:30 p.m., he was told that his use of the operating room was going to be delayed."

163

"Apparently, that was the final straw for him."

164

"What Dr. Leal did after he was told he would have to wait to use the operating room..."

165

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“...he pitched a fit.”

166

Hospital

**He became so
enraged that he
broke a telephone**

Dr. Leal

**He accidentally
broke a telephone
when he tripped on
its long cord**

167

Hospital

**He shattered the
glass on a copy
machine**

Dr. Leal

**He closed the lid of
a copy machine
with “some force”
and the glass
cracked**

168

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Hospital	Dr. Leal
He shoved a metal cart into the doors of the operating suite so hard that it damaged one of them	He moved a metal cart that was blocking the doors of the operating suite

169

Hospital	Dr. Leal
He flung a medical chart to the ground when a nurse asked him for written authorization to proceed with surgery	When he was handed a medical chart by a nurse some of the chart's loose papers fell to the floor

170

Hospital	Dr. Leal
He threw jelly beans down the hallway in the surgical suite	He ate jelly beans, some of which may have fallen on the floor when he tried to throw away flavors that he did not like

171

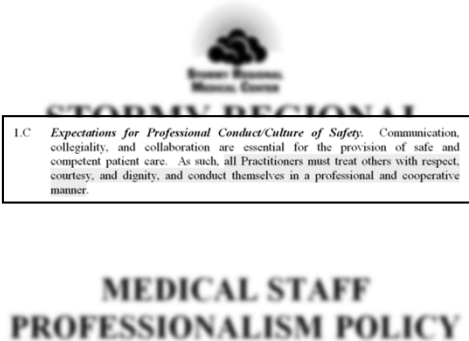
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"In other words, this urological surgeon, who earns his living wielding a razor-sharp scalpel on some of the most delicate parts of the body, does not have a bad temper... he is just clumsy."

172

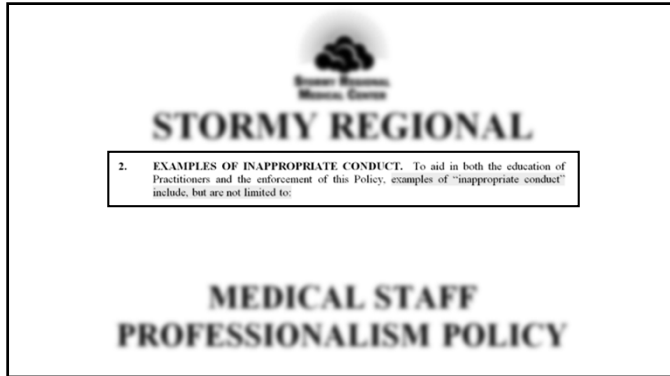
To avoid disputes and misunderstandings – use the Professionalism Policy to define appropriate vs. inappropriate conduct

173

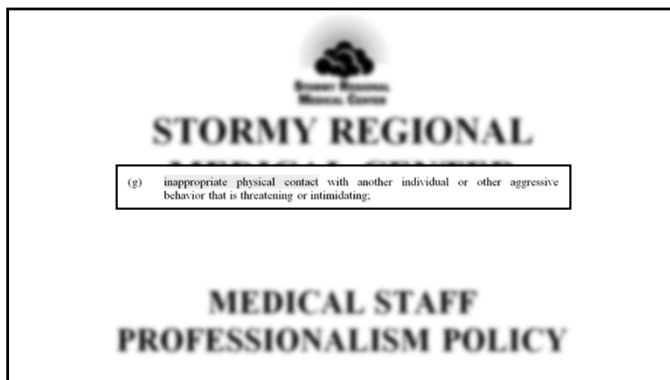


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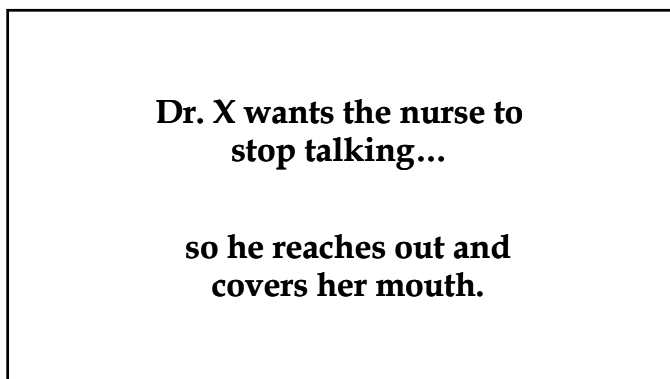
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175




176



177

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**STORMY REGIONAL
MEDICAL CENTER**

(c) refusal or failure to answer questions, or return phone calls or pages in a timely manner as defined in the Medical Staff Bylaws documents or other applicable policies;


**MEDICAL STAFF
PROFESSIONALISM POLICY**

178

After questioning why a nurse called him (the on-call ortho) to order an MRI, Dr. X provided the following phone number for follow-up the next day:

867-5309

179



**STORMY REGIONAL
MEDICAL CENTER**

(b) degrading, demeaning, or condescending comments regarding patients, families, nurses, Practitioners, Hospital personnel, or the Hospital;

**MEDICAL STAFF
PROFESSIONALISM POLICY**

180

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Dr. X has a known dislike of alcoholic and drug addicted patients.

When called to the ED to treat a patient who is suffering from cirrhosis of the liver, he documents the prognosis and treatment plan as:

“A Song and A Prayer”

181

Dr. X writes, in the H&P:

“I have a chunky, persistently overweight Mexican male who still speaks no English, in no acute distress, who is cooperative. I have encouraged him to take some of his cigarette money and buy English lessons.”

182



(i) derogatory comments about the quality of care being provided by the Hospital, another Practitioner, or any other individual outside of appropriate Medical Staff and/or Hospital administrative channels;

**MEDICAL STAFF
PROFESSIONALISM POLICY**

183

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**A nurse reports that Doctor X
stated, in front of a patient:**

**“Hospital administration is
the death of my patients.”**

184

**In front of a patient, in response
to a nurse’s request for signature:**

**“Signatures don’t matter
when the nurses are busy
killing my patients.”**

185



(g) inappropriate physical contact with another individual or other aggressive behavior that is threatening or intimidating.

**MEDICAL STAFF
PROFESSIONALISM POLICY**

186

Faith Regional Health Services

Dr. X purchases a new handgun and then poses with it on Facebook in a post that says he “dares his employer [the Hospital] to tell him he has to be vaccinated...”

187



- (a) abusive or threatening language directed at patients, nurses, students, volunteers, visitors, Hospital personnel, or Practitioners (e.g., belittling, berating, and/or non-constructive criticism that intimidates, undermines confidence, or implies stupidity or incompetence);
- (b) degrading, demeaning, or condescending comments regarding patients, families, nurses, Practitioners, Hospital personnel, or the Hospital.

**MEDICAL STAFF
PROFESSIONALISM POLICY**

188

In response to a noted question, Dr. X writes, in the medical record:


“Congratulations. This is without a doubt the most asinine question that has ever been posed to me in my 30 years as a surgeon.

You are to be commended for your stupidity.

I don’t know how you make it to the hospital unassisted on a daily basis, but bully for you.”

189

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**STORMY REGIONAL
MEDICAL CENTER**

(v) engaging in identity-based harassment as described in this Policy.


**MEDICAL STAFF
PROFESSIONALISM POLICY**

190

Dr. X asks a nurse, in a room full of people:

“Should I call you JJ or Jugs?”

191



**STORMY REGIONAL
MEDICAL CENTER**

(f) retaliating against any individual who or organization that may have reported a quality and or behavior concern about a Practitioner, provided information related to such a matter, or otherwise been involved in the professional practice evaluation/peer review process in any way (this means a Practitioner may not, under any circumstances, discuss the matter with any such individual, nor may the Practitioner engage in any other retaliatory or abusive conduct such as confronting, ostracizing, or discriminating against such individual);

**MEDICAL STAFF
PROFESSIONALISM POLICY**


192

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Dr. X was sent a letter inviting him to meet with the MEC to discuss a reported incident.

The next day, he wrote a letter to the individual who filed the report, her husband, her children, and her elderly parents – and dismissed all of them from his group’s medical practice.

193



**STORMY REGIONAL
MEDICAL CENTER**

2. EXAMPLES OF INAPPROPRIATE CONDUCT. To aid in both the education of Practitioners and the enforcement of this Policy, examples of “inappropriate conduct” include, but are not limited to:

**MEDICAL STAFF
PROFESSIONALISM POLICY**

194

EXAMPLES OF INAPPROPRIATE CONDUCT. To aid in both the education of Practitioners and the enforcement of this Policy, examples of “inappropriate conduct” include, but are not limited to:

(1) abusive or threatening language directed at patients, nurses, medical residents, visitors, hospital personnel, or Practitioners; (2) belittling, teasing, or other demeaning or hostile, low-credence, demeaning, humiliating, or disparaging remarks or comments; (3) displaying, discussing, or communicating comments regarding patients, families, nurses, Practitioners, hospital personnel, or the hospital; (4) refusal to follow or ignore directions, or other phone calls or requests in a timely manner as defined in the Medical Staff Bylaws document or other applicable policies; (5) intentional misrepresentation in hospital communications, Medical Staff Letters, other documents, or data representation, in an attempt to give a personal benefit or to avoid responsibility for an action taken; (6) offensive language which may include profanity or abusive language while in the hospital and in this meeting with patients, nurses, or other hospital personnel; (7) violating against any individual who may have reported a quality and/or behavior concern about a Practitioner, any patient information stated in such a matter, or otherwise make a Practitioner aware of any communication concern given to only one other individual, nor may the Practitioner engage in any other conduct or abusive conduct such as belittling, teasing, or humiliating against such individual; (8) inappropriate physical contact with another individual or other aggressive behavior that is belittling or humiliating; (9) showing an intent of any kind, including but not limited to any medical neglect, intentional or negligent; (10) repeatedly failing to answer hospital-requested consultative prior to response; (11) disparaging comments about the quality of care being provided by the hospital, another Practitioner, or any other individual, or criticizing the hospital or the hospital’s policies or procedures, or questioning any employee representative; (12) imposing financially onerous requirements on hospital staff that have no impact on improved patient care, but are only to burden the hospital or hospital employees with “special” independent and provisions; (13) abusing or belittling any medical record entry or hospital document (including but not limited to, handwritten letters or being an entry or document to give the impression it was computerized) given to meet a specific requirement; (14) completing medical record entries based on a template without considering the care actually provided to the patient, or using the “copy and paste” or “pull forward” functions of the computerization program (which include word processing) for the document to create the medical document; (15) refusal to follow or use or use properly documentation technology (e.g., CPOE, EHR, and other appropriate technology); (16) inappropriate access, use, disclosure, or release of confidential patient information, audio, video, or digital recording that is not consented to by others present, including patients and other members of the care team; (17) use of social media in a manner that involves inappropriate conduct as defined in this Policy or other Medical Staff or hospital policies; (18) disruption of hospital operations, hospital or medical staff meetings, or departmental affairs; (19) misuse of social media, or making any individual (including colleagues or nonemployees) believe that performing an appropriate assessment and creating a proper medical record; (20) disregard of or refusal to abide by Medical Staff requirements as delineated in this Policy, the Medical Staff Bylaws, Governance Policy, Rules and Regulations, or other Medical Staff policies (including, but not limited to, emergency call, hours, response times, medical consultation, when patient care representation, failure to participate in conferences or rounds (interdisciplinary) and telemedicine with other facilities, and all other Medical Staff and hospital requirements) and/or; (21) engaging in clinical board harassment as described in this Policy.

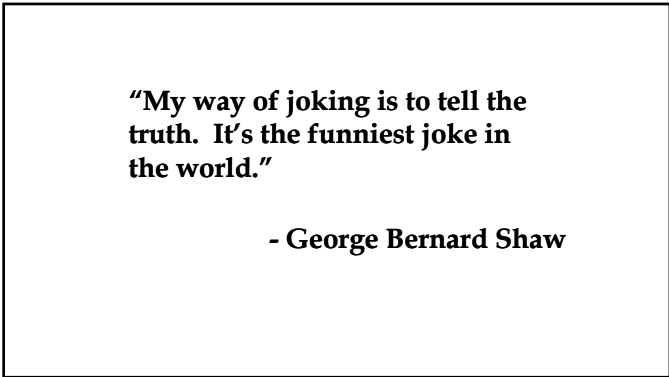
PROFESSIONALISM POLICY

195

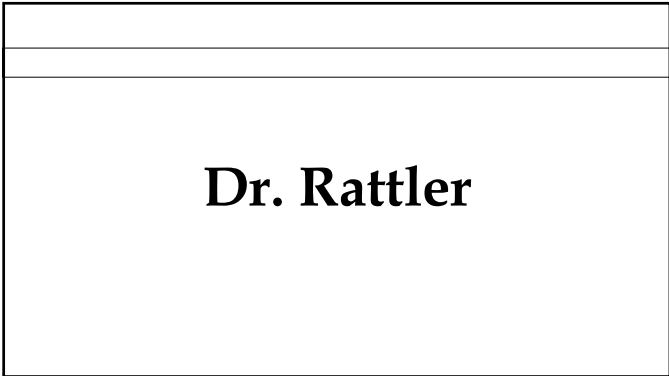
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196



197



198

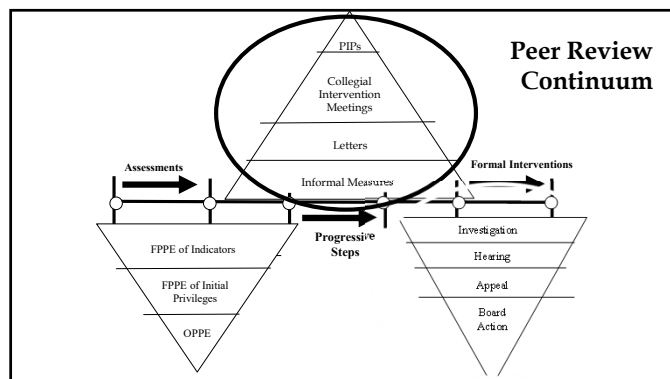
What can we do?

199

How Do You Decide Which Review Process to Follow?

- Practitioner history (pattern?)
- Previous intervention efforts?
- Number of incidents/concerns
- Severity of incidents/concerns
- Unique legal implications (sexual harassment, EMTALA, HIPAA violations, etc.)

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**Also, is Dr. Rattler an
employed or contracted
physician?**

*...If so, you may have additional
options*

202

**Build in Early Notification to
Facilitate Employer
Awareness/Involvement.**

203

What Does the Contract Say?

- ...about employment duties/performance?
- ...about termination (cause/ without cause?)
- ...about ability of Hospital to request removal of individual providers (contracts for services)?
- ...about effect of termination/removal on clinical privileges (co-terminous?)

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Options:

Exercise Contract Rights

- Quick and easy
- Employer can more easily impose conditions
- Also - often best option if ready to "cut loose"

Refer for Management Through Medical Staff Peer Review Process

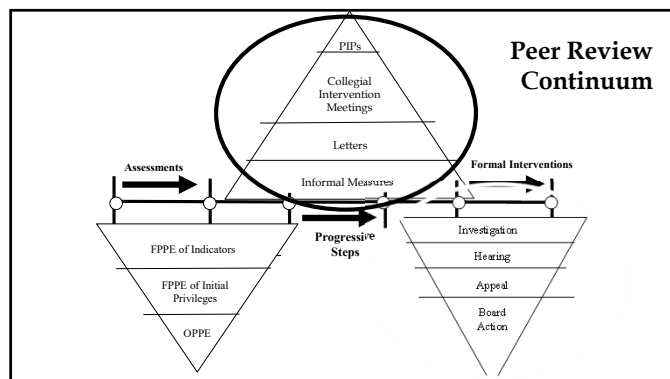
- Long and arduous
- Also - creates good record, for protected class/ whistleblower situations
- Best when hoping to "fix and keep" practitioner

205

Rattler:

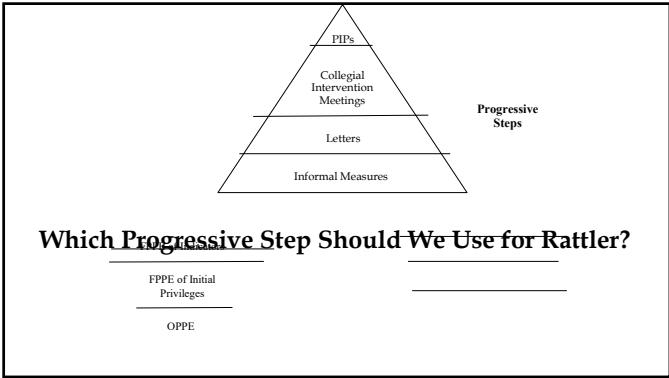
- Long history of low-level behavior concerns
- Three pending concerns
- Severity? One incident involves physical touching
- No previous interventions
- Not employed/contracted

206



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208

Keys for Successful Collegial Interventions

- Preparation!
- Preparation!
- Preparation!
- Preparation!
- Preparation!
- Preparation!

209

Collegial Interventions

- Gather any missing information

210

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Gather Information

- Have all facts been verified?
- Pull medical records, incident reports, etc.
- Pull practitioner history/file
- What collegial attempts have been tried before?

211

Collegial Interventions

- Gather any missing information
- Develop a game plan *before* you meet with the physician

212

Planning the Meeting

- What is the desired outcome/ objective?
- What is the physician's personality?
- What is likely to be the physician's perspective?
- Who is going to meet with the physician?
- What are our talking points (and who is addressing each)?
- Where is the meeting and how long?

213

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Collegial Interventions

- Gather any missing information
- Develop a game plan *before* you meet with the physician
- Provide adequate notice

214

***Remember:
Tone Matters!***

215

Provide Adequate Notice

- Date/time/location
- No lawyers!
- Description of concerns
- Confidentiality/ Non-Retaliation Agreement

216

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Collegial Intervention

- Gather any missing information
- Develop a game plan before you meet with the physician
- Provide adequate notice
- *At the meeting:* Don't get thrown off track

217

No Matter What Happens: *Don't Get Thrown Off Track*

- Remember the plan
- Focus on desired outcome
- Do not discuss the credentials and actions of others
- Stay focused on the inappropriate behavior, not its cause

218

**Sometimes, life throws
you a curve ball...**

219

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What If...

*"I'm sorry.
I'll try to do
better."*



220

Collegial Intervention

- Gather any missing information
- Develop a game plan before you meet with the physician
- Provide adequate notice
- Don't get thrown off track
- Follow-up

221

Follow-Up

- Look into any quality concerns raised by Dr. Rattler

222

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**Whistleblower Claims
Are Rampant!**

223

Don't ignore quality concerns
...but don't get thrown off track.

224

Follow-Up

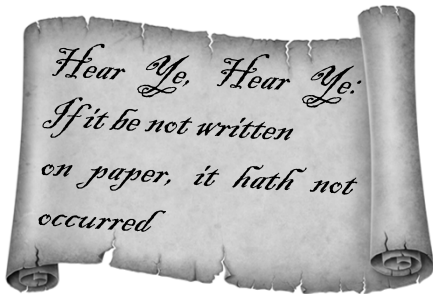
- Look into any quality concerns raised by Dr. Rattler
- Document!

225

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Documentation is increasingly important as you move up the peer review continuum!

226



227

Collegial Intervention Follow-Up Letter

- "Thank you for meeting with us"
- "We know these conversations can be difficult"
- "We appreciate your participation"

228

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Collegial Intervention Follow-Up Letter

- “As you know, we discussed _____”
- “The Bylaws state _____”
- “You agreed _____”
- “As you are aware, this is the second/third/fourth time we have had to revisit these issues. This causes us great concern” *(if applicable)*

229

Collegial Intervention Follow-Up Letter

- “I’m sure we do not need to mention this, but as a reminder, retaliation is not permitted” *(if applicable)*
- “A copy of this letter will be placed in your confidential peer review file”
- “You may submit a response, which will also be kept in your file”

230

Wrap-Up Tips for Navigating the Progressive Steps of Peer Review

Unprofessional Conduct

231

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Do behavioral concerns fall outside of the peer review process?

232

NO! Peer review encompasses *everything* related to qualifications:

- Clinical concerns
- Professionalism/behavioral concerns
- Health-related concerns

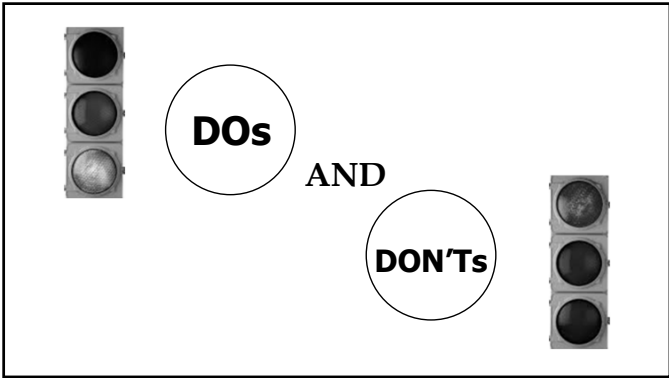
233

The *management* of the type of concern may (should?) differ -

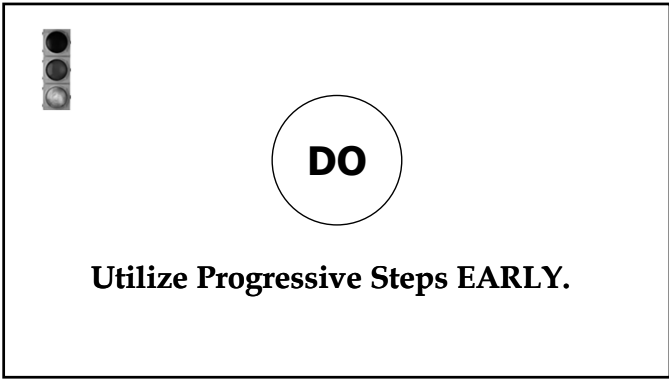
***Leadership expertise* is necessary for professionalism issues, not clinical expertise!**

234

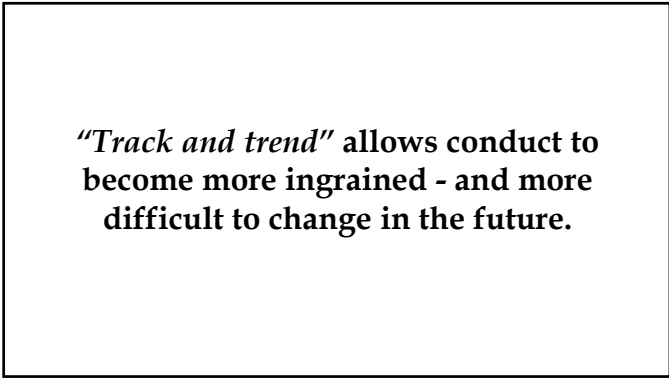
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235




236



237


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DON'T

Presume guilt

238



DO

Be prepared for avoidance tactics

239


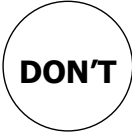
Avoidance Tactics are Common

- Lawyers + threats to sue
- Threats to take their business elsewhere
- Refusal to engage (won't meet/ won't write)
- Whistleblower claims (targeted champion of quality)
- Discrimination claims (targeted class member)
- Red Herrings ("Dr. Doe does it too!")
- Excuses (health, "he made me do it!")

240

Stay focused on the inappropriate behavior.

241



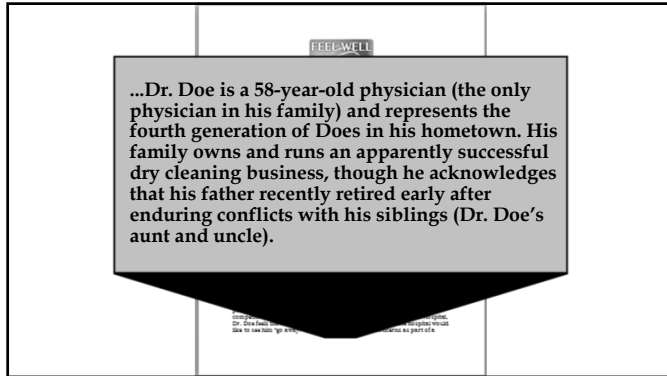
Diagnose

242

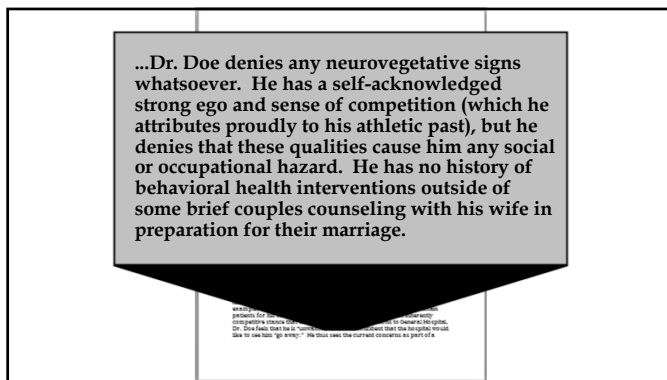
“But normal people don’t act this way!”

243

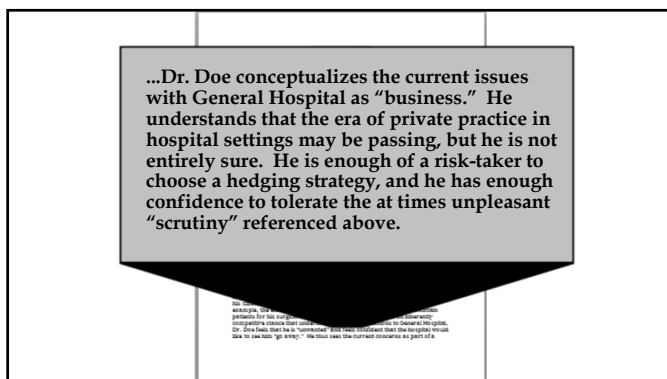
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244



245



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... It is my opinion that Dr. Doe is without behavioral issues related to professionalism and there is no need for any behavioral intervention. If the hospital is willing to continue to have him on staff, efforts should be directed toward the goal of peaceful coexistence. If the hospital finds that Dr. Doe's personal business agenda is untenable, I would advise direct negotiation around separation. I would be most willing to assist with any of these efforts.

247

- A psych evaluation often merely kicks the can down the road
- And sometimes, it creates a roadblock to meaningful action

248

DON'T

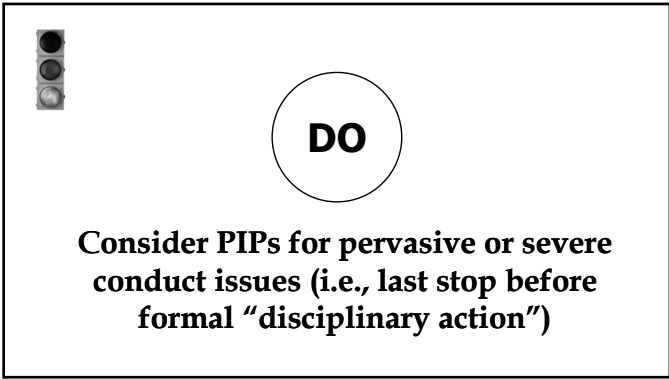
Make empty threats.

249

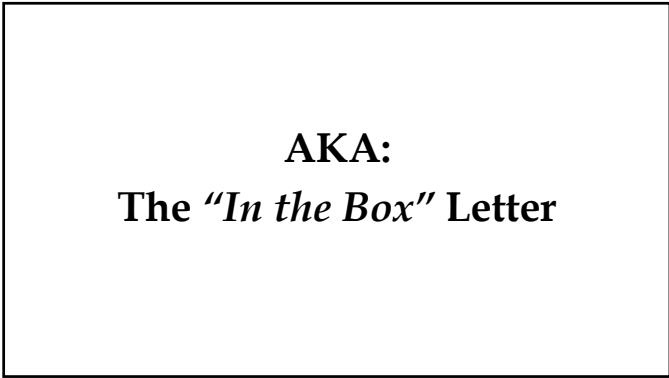
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250



251



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PIP Options for Conduct

- CME (documentation, time management, HIPAA, sexual harassment, time-out procedures, stress management, etc.)
- Literature review (and report to leadership)
- High-level collegial intervention meetings (full committees! MEC! Board!)
- Periodic/scheduled meetings with leaders or mentors

253

PIP Options for Conduct

- Chart review for compliance (R&R compliance, such as time-outs, H&Ps on chart prior to surgery, informed consent documentation, timely response to coder inquiries, etc.)
- Assessment & retraining (behavior modification programs)
- Personal Code of Conduct (specific, written behavioral expectations)
- *Other*

254

Optional recommendations rarely work in a behavioral PIP

- E.g., "For your own good, we recommend that you seek professional counseling..."
- E.g., "While it is not required, it is strongly suggested that you obtain anger management coaching..."

255

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**What should be included in a
Performance Improvement Plan
*for professional conduct issues?***

256

5 Point Letter

Five Types of Content:

1. List of incidents
2. History of previous interventions
3. Bylaws/Policy requirement
4. Detailed do's and don'ts (expectations)
5. Or else (consequences)

257

**TIP: The Practitioner's Written
Agreement to the PIP can be
Essential to Enforcement**

258

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Getting the Practitioner's Written Agreement to a PIP:

- Don't draft the PIP until after you have obtained the Practitioner's input
- Present the PIP in person
- Be prepared to respond if the Practitioner refuses

259

PIP Follow-Up:

- At the meeting: Ask the Practitioner to sign & return
- Afterwards: Make sure you receive the signed copy of PIP
- Track Practitioner compliance - *keep track of deadlines and require proof!*
- Keep on Committee agenda until PIP is complete

260

DON'T

Delay in addressing disruptive conduct that might constitute identity-based harassment.

261

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Which creates the greatest risk of sexual harassment liability?

- (a) Gifts of perfume and flowers
- (b) Calling a nurse "Honey" or "Sweetheart"
- (c) Sex between a doctor and nurse
- (d) Backrubs exchanged at the nurse's station

262

Iyebote v. Meharry Medical College
(M.D. Tenn. Feb. 2022)

"Unwanted touching is one of the most offensive things that can occur in the workplace and should never be tolerated. As the Sixth Circuit has observed, uninvited physical touching 'is more severe than harassing comments alone.'"

263

Quid Pro Quo Harassment

A person's job, or any part of his or her job, is conditioned on the performance of sexual favors

264

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Hostile Work Environment

**Conduct of harasser is
sufficiently severe or pervasive
to alter conditions of employment**

265

**Would you engage in this
behavior if your partner or
spouse were in the room?**

266

**Would you want to see your
partner, spouse, or child treated
this way in the workplace?**

267

Would you be comfortable reading about your behavior in the newspaper?

268

“Affirmative Defense”

It’s a defense that the defendant used reasonable care to prevent and correct promptly sexually harassing behavior.

269

8. REVIEW OF REPORTS OF IDENTITY-BASED HARASSMENT

8.A. *Definition.* Identity-based harassment is verbal or physical conduct that: (i) is unwelcome and offensive to an individual who is subjected to it or who witnesses it; (ii) could be considered harassment from the objective viewpoint of a “reasonable person”; and (iii) is caused by one or more of the following: gender, sexual orientation, gender identity, gender expression, race, ethnicity, national origin, ancestry, marital status, pregnancy, childbirth or related conditions, age, disability, or genetic information. (b) Identity-based harassment includes, but is not limited to, sexual harassment and verbal, written, or physical harassment. (c) Harassment may be based on a combination of the above factors.

Due to unique legal implications, address identity-based harassment separately and differently

8.C. *Personal Meeting and Letter of Apology and Warning.* Two or more members of the Leadership Council shall personally meet with the Practitioner to discuss the incident. If the Practitioner acknowledges the seriousness of the matter and agrees that there will be no repeat of such conduct, the meeting shall be followed with a signed letter of apology and warning to be placed in the Practitioner’s confidential file. This letter shall also be filed and addressed, unless no evidence is presented, on the Practitioner’s current record in the Hospital as a result of the meeting.

8.D. *Referral to Medical Executive Committee.* The matter shall be immediately referred to the Medical Executive Committee if:

(1) the Practitioner refuses to acknowledge the concern, does not recognize the seriousness of it, or will not agree that there will be no repeat of such conduct; or

PRO

ICY

270

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What's the Solution?

- Intervene early
- Zero tolerance for abuse and retaliation

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Thank you!

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