Wesley Medical Center

Medical Staff Leadership Program

June 4, 2026

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 9:00 a.m. **THE PEER REVIEW CONTINUUM – AN OVERVIEW**

Stuff happens on the very best of Medical Staffs! Whether it is a clinical concern, a behavior concern, or just a colleague's reluctance to follow the rules of modern hospital practice – what do you do first? What if you have to go further?

- What's the "scope" of peer review anyway? Clinical issues, professionalism issues, and health issues!
- What is the role of the MEC? What should it be?
- Progressive steps versus "formal" action? What's the difference? Who is authorized to intervene? And what limits apply?
- Performance improvement – communication is critical!
- The MEC's and Board's role in the routine peer review process
- How to make clinical performance improvement plans as effective as possible – and hopefully help save your colleagues!

9:00 to 10:00 a.m. **GETTING DISRUPTIVE BEHAVIOR UNDER CONTROL BEFORE IT RUINS YOUR CULTURE AND JEOPARDIZES PATIENT CARE**

There are many shades of unprofessional conduct. Sometimes it's angry, defiant, demanding, and argumentative. Sometimes charismatic and manipulative, even passive-aggressive. Sometimes, all of the above. The various shades do share a common characteristic however – they disrupt the care environment and undermine employee morale and patient safety. Using real-life examples of unprofessional conduct, this session will illuminate what unprofessional conduct can look like – and emphasize the value of a comprehensive professionalism policy and review process to guide management of these most difficult issues.

- Heading off retaliation against those who report conduct
- The dangers of diagnosing
- Managing distractions and avoidance tactics swiftly, administratively, and without breaking a sweat
- Drafting – and monitoring – performance improvement plans for a colleague with conduct issues

10:00 to 10:15 a.m. ***BREAK***

AGENDA

10:15 to 11:00 a.m. **PLANNING A COLLEGIAL MEETING TO DISCUSS A BEHAVIORAL CONCERN – A VARIATION ON A FAMILIAR THEME!**

We have a surgeon who is a perfectionist and expects everyone else to be one too! But what happens when her behavior crosses over the line? Can "progressive steps" be used to help manage the behavior and possibly save her career on our Medical Staff or is it time for more formal action?

- How to conduct an effective collegial intervention session when behavior is at issue - without losing your mind!
- Avoiding delay tactics – obtaining information, mandatory meetings, attorney participation
- Documentation – tone and content, and where is it kept?
- Addressing concerns about possible retaliation

11:00 a.m. to Noon **PRIVILEGING DISASTERS & MANAGING PRIVILEGING CHALLENGES**

As the saying goes, an ounce of prevention is worth a pound of cure! This rings particularly true in privileging where thoughtful decisions made on the front end – applied consistently across the board – can help to avoid the kind of disasters that often end in patient harm.

- Delineating Privileges: Core privileges, special privileges, and how to decide who is granted what
- Low and no volume
- Privileges for new treatments and procedures
- Privileges that cross specialty and lines
- Privileges for Advanced Practice Professionals

12:00 p.m. ***SESSION ADJOURNS***

Accreditation Statement

In support of improving patient care, this activity has been planned and implemented by the University of Pittsburgh and Horty 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

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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

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1

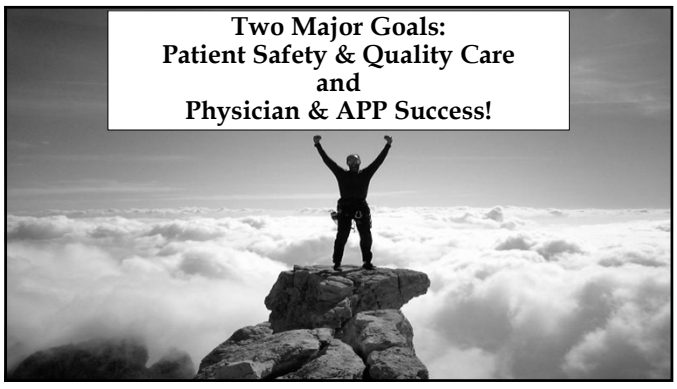
The "peer review" world has changed dramatically —and for the better!

Thinking!

Techniques!

Governing Documents!

2



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"Stuff" happens on the very best of Medical Staffs!

4

So, what's the "*scope*" of peer review anyway?

5

Clinical Quality

Unprofessional Conduct / "Disruptive" Behavior

Health/Age Issues

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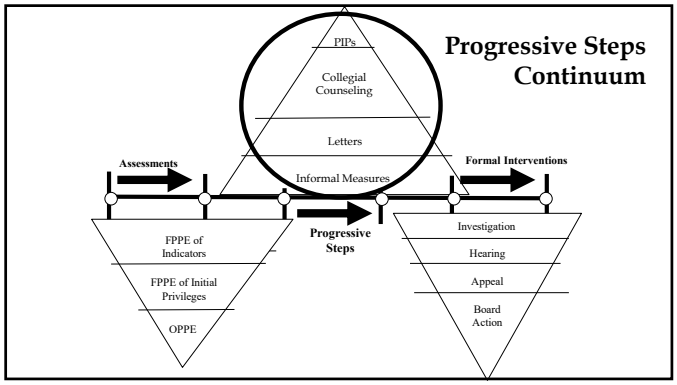


7

Collegial Efforts
and the
Progressive Steps Continuum
will successfully resolve almost all issues!

8

The centerpiece of every Medical Staff culture!

- **Publicized to the Medical Staff**
- **Known and used by the MS Leaders**
- **Passed generation to generation!**

9

PROGRESSIVE steps mean:

Intervene early!

"Discipline" is a last resort!

10

The Basics

- **Be *explicit* and *consistent* about the *"Progressive Steps Continuum"* in your documents:**
  - **Medical Staff Bylaws**
  - **Clinical Peer Review Policies**
  - **Professionalism Policy**
  - **Practitioner Health Policy**

11

The Basics

- **Provides helpful *guidance* to leaders**
- **Important for *peer review protection***

12

The Basics

- **Focus on *performance improvement* – not coding, scoring, or TRACKING AND TRENDING!**
- ***What replaces scoring/coding:***
  - **Is there an issue or concern?**
  - **What performance improvement tool can best help our colleague?**

13

Small issue?

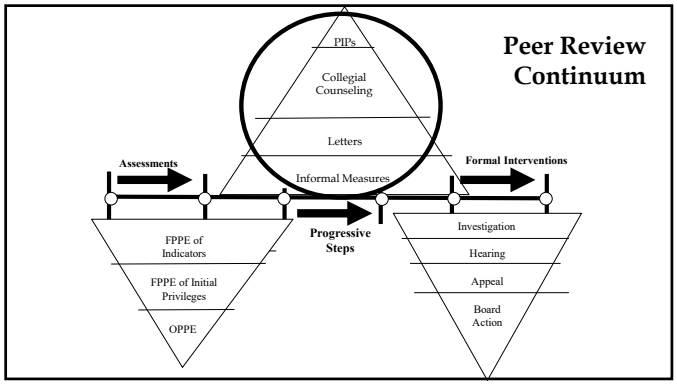
SMALL INTERVENTION!

14

Why do we "track and trend'?
Traditional Bylaws Language: All or Nothing

***Progressive Steps:* All, Nothing, and Everything in Between**

15



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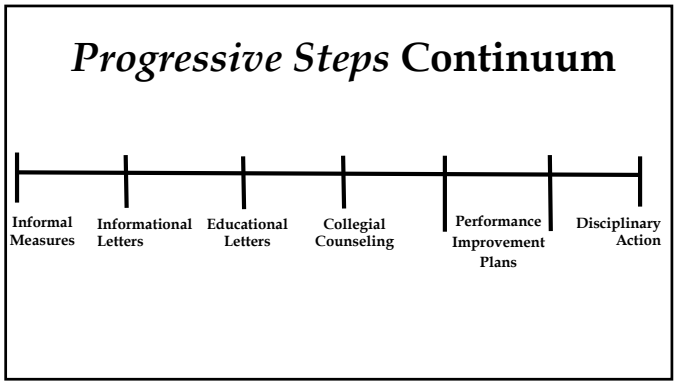


17

The *"Progressive Steps Continuum"* includes:

- ***Initial Mentoring Efforts/Informal Measures:***
  - **Informal discussions and coaching**
  - **Sharing comparative data/variations from clinical practice (OPPE)**
- ***Informational letters*** **to address minor, but still important, issues**
- ***Educational letters*** **to provide more specific guidance/suggestions**
- ***Collegial Counseling,*** **planned and face-to-face meeting to more directly provide assistance**
- ***Performance Improvement Plans*** **for more significant issues/pattern**
- ***"Disciplinary" Action*** **at MEC level**

18

The Basics

- *Empower* **leaders and committees to implement progressive steps (i.e., no MEC involvement!)**
- *Early progressive steps* **available to more leaders**
- **More** *intensive progressive steps* **for committees only**
- *Disciplinary action* **reserved for MEC/Board**

19

The Basics

- **With very limited exceptions,** *always* **get a colleague's input** *before* **making a final determination**
- **Don't confuse or blend a** *fact-finding meeting* **with formal** *"Collegial Counseling"*

20

The Basics

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

21

The Basics

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

22

The Basics

- **Be very careful using the word *"Investigation!"***
- **Term of art – NPDB**
- **Investigation begins *ONLY* after formal resolution of MEC**

23

The Basics

Last but not least… Progressive Steps *improve legal position* – even if it does not work!

24

Obtaining Input from Practitioner

- *No questions or issues identified* **in the initial review, no need to obtain input**
- *If any questions or issues identified,* **key details noted in order to obtain input from Practitioner**
- *Letter or e-mail* **sent to Practitioner seeking written input**
- **In addition to written input, did reviewer speak with Practitioner? If so, relevant details documented**
- *After* **input obtained, proceed to assessment and determination**

25

General Rules

- **Input can be sought at *any time***
- ***Multiple requests* may be made**
- **Request can include *office records***
- **Request should include *time frame* for practitioner input**

26

How does the practitioner provide input?

- *Written explanation* **of care, responding to specific questions**
- **Practitioner may also meet to discuss (in addition to written input)**
- **Stress professionalism/utilize effective, modern *consequences* for failure to provide input *(encourages adult behavior!)***

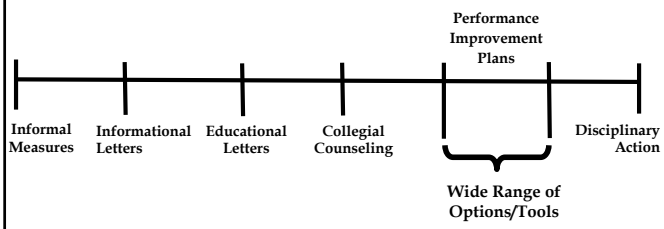
27

How does the practitioner provide input?

- **Decide whether request should notify practitioner of *consequences of failure to provide input*:**
  - **For most Practitioners, first letter probably doesn't need to discuss consequences**
  - **For outliers, or for those who ignore first request, identify consequences**

28

Progressive Steps Continuum



29

PIP Options for *Clinical Performance Issues*

30

Who develops and recommends PIPs?

Clinical Issues

31

Professional Practice Evaluation Committee (PPEC)

Role of Multi-Disciplinary PPEC

- **"Policy" Decisions**
- **Practitioner-Specific Reviews**
- **Lessons Learned & Shared**
- **Monitoring "System" Fixes**
- **Public Relations!**

32

Professional Practice Evaluation Committee (PPEC)

Practitioner-Specific Reviews

- **Educational letter**
- **Collegial Counseling**
- ***Performance Improvement Plan***
- **Refer to Employer *(maybe)***
- **Refer to MEC**

33

Performance Improvement Plans
(options used individually or in combination)

- **Additional education/CME**
- **Monitoring of next X cases**
- **Procedure indications checklist**
- **Second opinions/consultations**
- **Observational proctoring**
- **Retrospective proctoring (review of videos)**

34

Performance Improvement Plans
(options used individually or in combination)

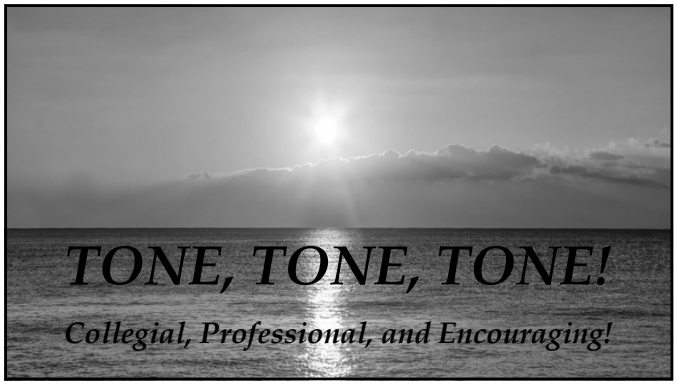
- **Participation in formal evaluation and assessment program**
- **Additional training/simulation**
- **Voluntary agreement to temporarily refrain from exercising privileges/Educational LOA**
- ***"Other"***

35

Keys to PIP Success

- **You can't be *nice* enough!**
- **Be *explicit on details/expectations* — develop and utilize a PIP checklist tool!**
- **Personal meeting with colleague, be transparent and helpful — *have a script!***
- **PIPs never leave PPEC's agenda until they are successfully completed!**

36



37

Confidential Peer Review

Re: Performance Improvement Plan

- **PPEC conducted review/developed PIP to successfully and constructively address issue**
- **Thanks for cooperation and input to date**
- **PIP details *(enclose applicable parts of checklist)***
- **Your voluntary agreement — not considered a "restriction" or "disciplinary action" by MS**
- ***No* hearing/reporting**

38

Confidential Peer Review

Re: Performance Improvement Plan

- **Demonstrate your commitment to work with us — sign and return within X days**
- **Next steps if fail to do so**
- **Copy placed in your file/may respond if you wish**

39

Confidential Peer Review

Re: Performance Improvement Plan

"Thank you for your cooperation and participation in the Medical Staff's ongoing efforts to improve the care that we all provide."

40

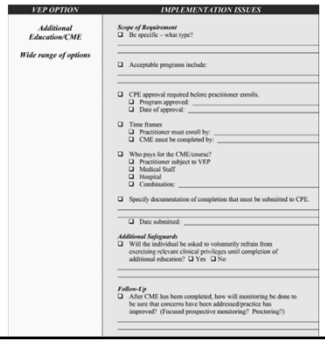
Keys to PIP Success

- **You can't be *nice* enough!**
- **Be *explicit on details/expectations* — develop and utilize a PIP checklist tool!**
- **Personal meeting with colleague, be transparent and helpful— *have a script!***
- **PIPs never leave PPEC's agenda until they are successfully completed!**

41

42

Develop A Checklist Tool!



VEP OPTION	IMPLEMENTATION ISSUES
Additional Education/CME *Wide range of options*	*Scope of Requirement* ❑ Be specific – what type? ❑ Acceptable programs include: ❑ CPE approval required before practitioner enrolls. ❑ Program approved: _____ ❑ Date of approval: _____ ❑ Time frames ❑ Practitioner must enroll by: _____ ❑ CME must be completed by: _____ ❑ Who pays for the CME/course? ❑ Practitioner subject to VEP ❑ Medical Staff ❑ Hospital ❑ Combination: _____ ❑ Specify documentation of completion that must be submitted to CPE. ❑ Date submitted: _____ *Additional Safeguards* ❑ Will the individual be asked to voluntarily refrain from exercising relevant clinical privileges until completion of additional education? ❑ Yes ❑ No *Follow-Up* ❑ After CME has been completed, how will monitoring be done to be sure that concerns have been addressed/practice has improved? (Focused prospective monitoring? Proctoring?)

43

Be EXPLICIT on PIP details and implementation!

- **Additional education/CME**
- **Monitoring/retrospective chart review of next X cases**
- **Develop procedure indications/checklist**
- **Second opinions/consultations**
- **Observational proctoring**
- **Retrospective proctoring (review of videos)**

44

Second Opinions/ Consultations

Before the practitioner proceeds with a particular treatment plan or procedure, he/she must obtain a second opinion/consultation

45

Second Opinions/Consultations

- **What types of cases are subject to the second opinions/consultations?**
- **How many cases should be reviewed, at least initially?**
- **Based on practice patterns, estimated time for completion?**
- **Must consultant evaluate patient in person prior to treatment/procedure?**

46

Second Opinions/Consultations

- *Responsibilities of Practitioner subject to PIP:*
  - **Provide reasonable notice to consultant (e.g., two days prior to scheduled, elective procedures? As soon as patients are admitted for medical consults?)**
  - **Ensure that all information necessary for effective consultation is available in the medical record (e.g., H&P, results of diagnostic tests)**
  - **Discuss proposed treatment/procedure with consultant**
  - ***If consultant must personally evaluate patient, inform patient in advance that consultant will be visiting and examining patient***

47

Second Opinions/Consultations

- **PPEC approves consultant(s) *prior* to PIP implementation**
- **Chair or CMO meets with consultant to outline expectations and discuss legal protections**
- ***Responsibilities of the consultant:***
  - **Review medical record, evaluate patient (if applicable), discuss proposed treatment/procedure with Practitioner**
  - **Complete Second Opinion/Consultation Form and submit to leadership *(not for inclusion in the medical record!)***

48

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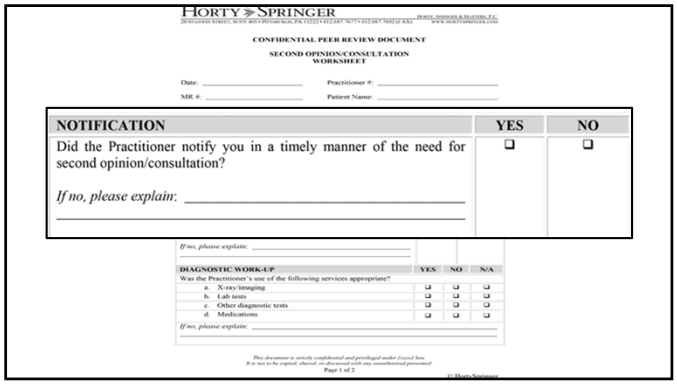

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CONFIDENTIAL PEER REVIEW DOCUMENT

SECOND OPINION/CONSULTATION WORKSHEET

Date: _____ Practitioner #: _____

MR #: _____ Patient Name: _____

NOTIFICATION	YES	NO
Did the Practitioner notify you in a timely manner of the need for second opinion/consultation? *If no, please explain*: _____	❑	❑

If no, please explain: _____

DIAGNOSTIC WORK-UP	YES	NO	N/A
Was the Practitioner's use of the following services appropriate?			
a. X-ray/imaging	❑	❑	❑
b. Lab tests	❑	❑	❑
c. Other diagnostic tests	❑	❑	❑
d. Medications	❑	❑	❑

If no, please explain: _____

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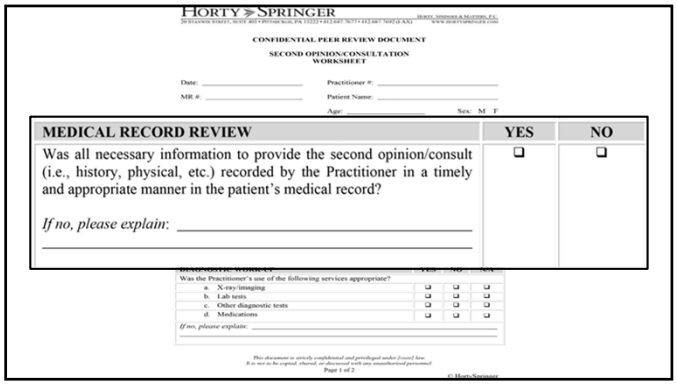

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CONFIDENTIAL PEER REVIEW DOCUMENT

SECOND OPINION/CONSULTATION WORKSHEET

Date: _____ Practitioner #: _____

MR #: _____ Patient Name: _____

Age: _____ Sex: M F

MEDICAL RECORD REVIEW	YES	NO
Was all necessary information to provide the second opinion/consult (i.e., history, physical, etc.) recorded by the Practitioner in a timely and appropriate manner in the patient's medical record? *If no, please explain*: _____	❑	❑

Was the Practitioner's use of the following services appropriate?

a. X-ray/imaging ❑ ❑ ❑

b. Lab tests ❑ ❑ ❑

c. Other diagnostic tests ❑ ❑ ❑

d. Medications ❑ ❑ ❑

If no, please explain: _____

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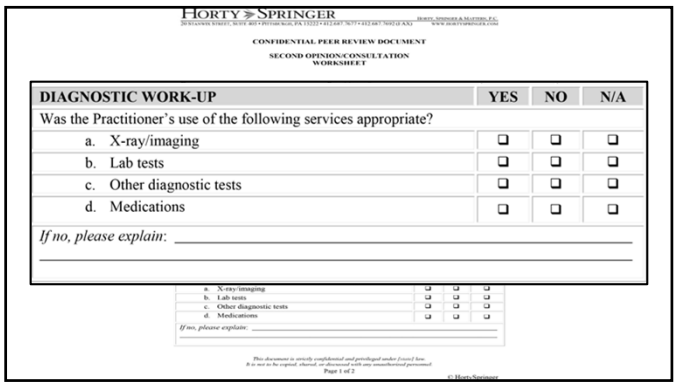

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CONFIDENTIAL PEER REVIEW DOCUMENT

SECOND OPINION/CONSULTATION WORKSHEET

DIAGNOSTIC WORK-UP	YES	NO	N/A
Was the Practitioner's use of the following services appropriate?			
a. X-ray/imaging	❑	❑	❑
b. Lab tests	❑	❑	❑
c. Other diagnostic tests	❑	❑	❑
d. Medications	❑	❑	❑

If no, please explain: _____

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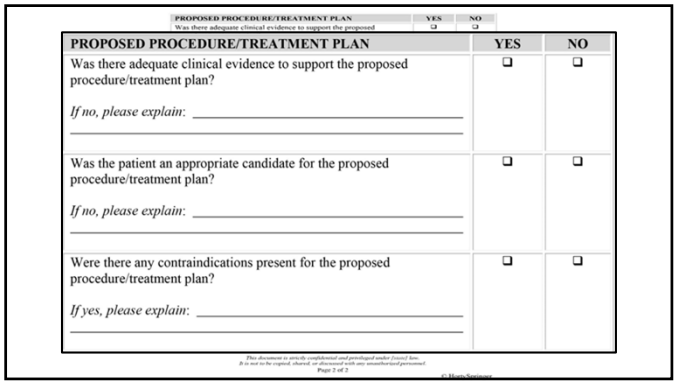

PROPOSED PROCEDURE/TREATMENT PLAN	YES	NO
Was there adequate clinical evidence to support the proposed procedure/treatment plan? *If no, please explain:* _____	❑	❑
Was the patient an appropriate candidate for the proposed procedure/treatment plan? *If no, please explain:* _____	❑	❑
Were there any contraindications present for the proposed procedure/treatment plan? *If yes, please explain:* _____	❑	❑

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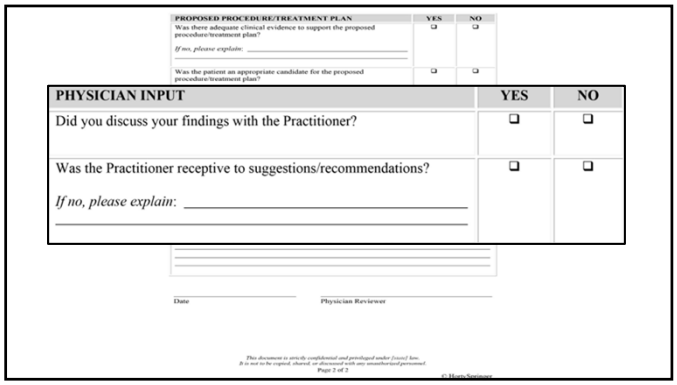

PROPOSED PROCEDURE/TREATMENT PLAN	YES	NO
Was there adequate clinical evidence to support the proposed procedure/treatment plan? *If no, please explain:* _____	❑	❑
Was the patient an appropriate candidate for the proposed procedure/treatment plan?	❑	❑

PHYSICIAN INPUT	YES	NO
Did you discuss your findings with the Practitioner?	❑	❑
Was the Practitioner receptive to suggestions/recommendations? *If no, please explain:* _____	❑	❑

Date Physician Reviewer

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53

PROPOSED PROCEDURE/TREATMENT PLAN	YES	NO
Was there adequate clinical evidence to support the proposed procedure/treatment plan? *If no, please explain:* _____	❑	❑
Was the patient an appropriate candidate for the proposed	❑	❑

ADDITIONAL COMMENTS
Please provide any additional comments or suggestions regarding your review of this case: _____ _____ _____
_____ Date _____ Physician Reviewer

Date Physician Reviewer

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54

Second Opinions/Consultations

- Compensation for consultant? If yes, who pays?
  - Practitioner subject to PIP?
  - Medical Staff?
  - Hospital?
  - Combination?
- Who will review the results with the Practitioner? After each case? After total number of cases?
- Will the Practitioner be removed from on-call responsibilities until the PIP is completed?

55

Is this a NPDB "restriction?"

56

NO!!!

- Recommended by PPEC, *a non-disciplinary committee* with no authority to restrict privileges
- *Voluntarily* accepted by Practitioner, and
- If there is any disagreement between Practitioner and consultant, others are included in the discussion to resolve the disagreement!

57

Is this a NPDB "restriction"?

Only if it is a

MANDATORY, CONCURRING CONSULTATION

- **Imposed by MEC**
- **Consultant has "veto power"**
- **In place for more than 30 days**

58

PIP Options for *Conduct/Behavior Issues*

59

Who manages behavioral concerns (and should therefore develop PIPs)?

60

Leadership **expertise – not** ***clinical*** **expertise – is the key to addressing behavior, health, and urgent clinical concerns!**

61

The wisdom of a ***Leadership Council!***

62

Not more bureaucracy – a vehicle for leaders to lead more effectively!

63

Leadership Council Options for Conduct Concerns
(outlined in a Professionalism Policy)

- **No further review or action required**
- **Educational Letter**
- **Collegial Counseling**
- ***Performance Improvement Plan***
- **Refer to Employer *(maybe)***
- **Refer to MEC**

64

PIP Options for Conduct

- **CME courses/education**
- **Required review of literature regarding behavior/safety and report to Leadership Council**
- **Heightened Collegial Counseling meeting involving full Leadership Council or other designated group, which can include Board Chair or member!**
- **Periodic/scheduled meetings involving Medical Staff Leaders or mentors**

65

PIP Options for Conduct

- **"Charm School"**
  - **Behavior Coach**
  - **Behavior Modification Course**
- **"Personal Code of Conduct"**
  - **(Continued Appointment/Conditional Reappointment)**
- ***"Other"***

66

Golfer tapes mouth shut in drastic effort to control anger issues

'Tried about everything'

"I mean, I'm not like proud. I don't want to create an experience for my playing partners that's not fair. And, you know, it's not fair to me either or other people. Having a tough time, and that was my solution today.

"At this point, I've tried about everything. I've read a lot of books. I've talked to people. Just too angry on the golf course. So I have run out of ideas."

Asked how he communicated with his caddie, McCormick added: "Mostly just writing down the numbers," he said. "I would just point and ask for a read sometimes. It made things a lot simpler."

67

What's the role of the *MEC* in clinical peer review or reviewing concerns about conduct or health?

68

MEC

MEC's Role

- **Approves relevant "routine review" Medical Staff policies (clinical peer review, practitioner health, professionalism policies)**
- **Broad oversight of process — review of aggregate data**
- **Policy committee — support for:**
  - **Protocols**
  - **Performance improvement initiatives**

69

MEC

MEC's Role

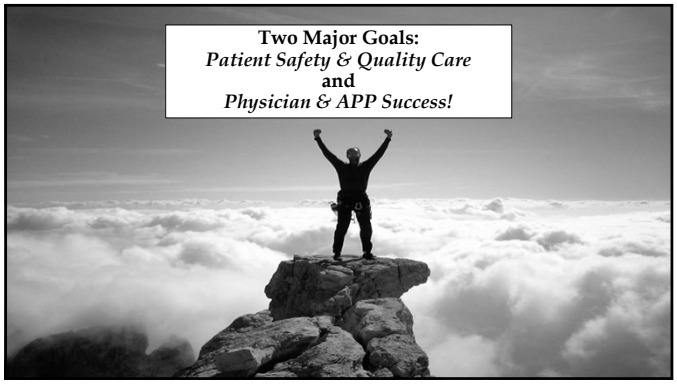
- *NO* involvement in day-to-day "routine review" activities
- *NO* review of detailed committee minutes!
- Disciplinary action, when necessary

70

Disciplinary Action

- Formal Investigations
- Long-term suspensions
- Revocations of appointment or clinical privileges
- Hearings

71



72

Introducing...

The Dos Ruptive Guy

73

74

He isn't always charming.

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

75

Wesley Medical Center

He doesn't want to treat nurses badly.

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

76

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."

77

He doesn't always complain about the hospital.

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

78

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.

79

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.

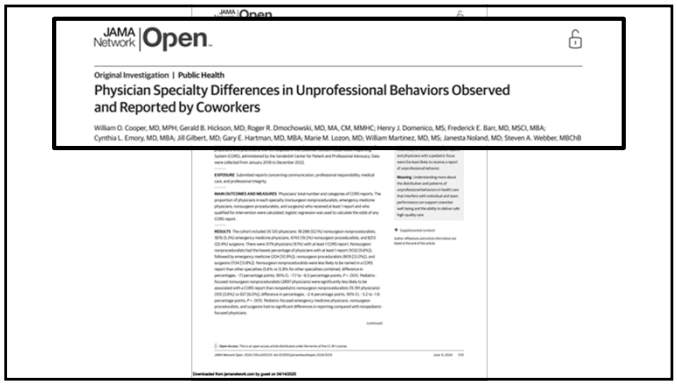
80

Disruptive behavior is <u>not</u> just a matter of quirky personalities.

81

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

82


JAMA Network Open.

Original Investigation | Public Health

Physician Specialty Differences in Unprofessional Behaviors Observed and Reported by Coworkers

William O. Cooper, MD, MPH; Gerald B. Hickson, MD; Roger R. Dmochowski, MD, MA, CM, MMHC; Henry J. Domenico, MS; Frederick E. Barr, MD, MSCI, MBA; Cynthia L. Emory, MD, MBA; Jill Gilbert, MD; Gary E. Hartman, MD, MBA; Marie M. Lozon, MD; William Martinez, MD, MS; Janesta Noland, MD; Steven A. Webber, MBChB

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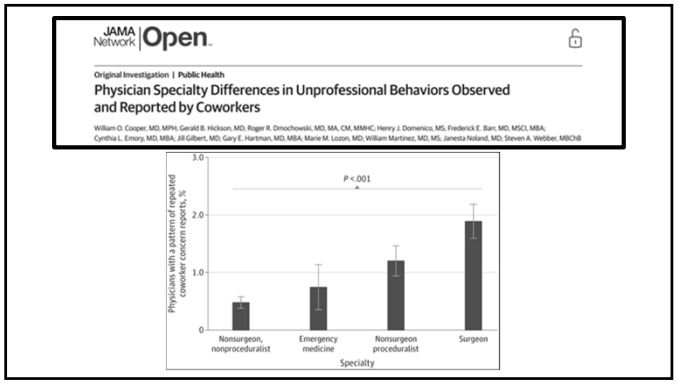


84

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

85

"Like Alexander in the classic children's book, Dr. Leal was having 'a terrible, horrible, no good, very bad day'"

86

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

87

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

88

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

89

"...he pitched a fit."

90

Wesley Medical Center

Hospital	Dr. Leal
He became so enraged that he broke a telephone	He accidentally broke a telephone when he tripped on its long cord

91

Hospital	Dr. Leal
He shattered the glass on a copy machine	He closed the lid of a copy machine with "some force" and the glass cracked

92

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

93

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

94

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

95

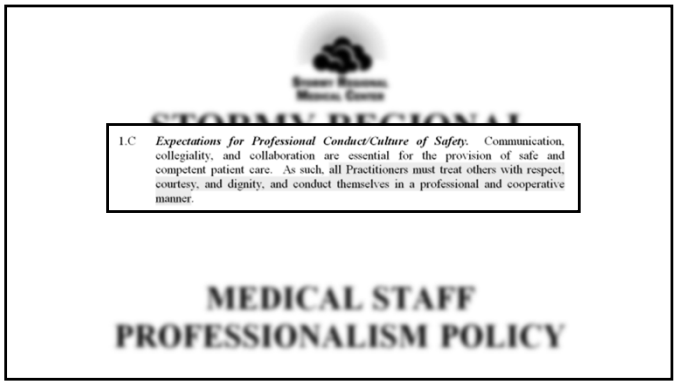
"In other words, this urological surgeon, who earns his living wielding a razor-sharp scalpel on some of the most delicate parts of the body, does not have a bad temper…

he is just clumsy."

96

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

97



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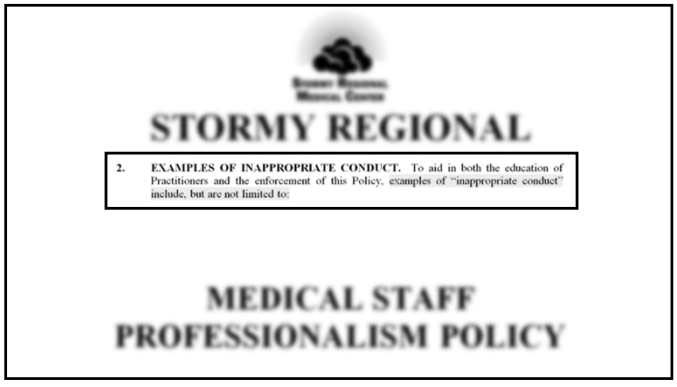

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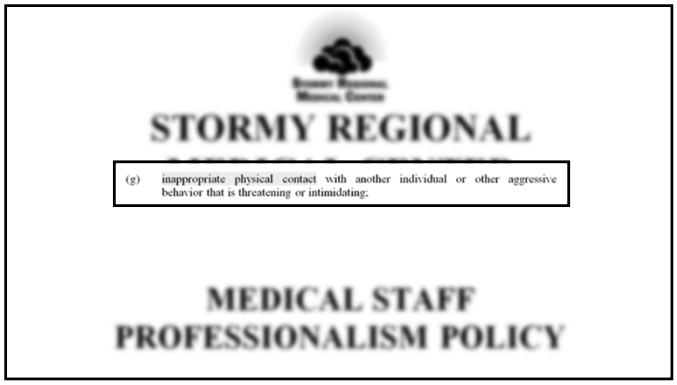


100

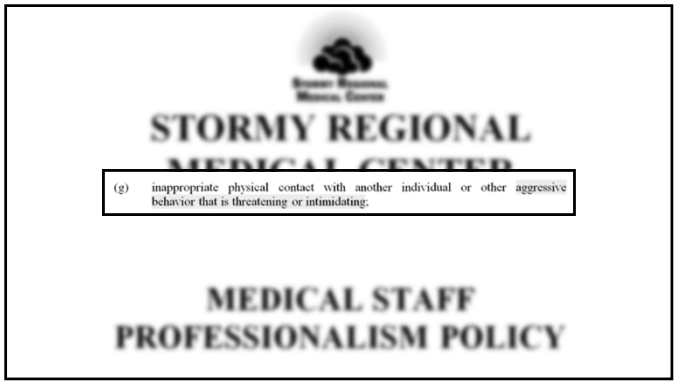
Dr. X wants the nurse to stop talking…

so he reaches out and covers her mouth.

101

In response to the Director of Care Management addressing Dr. X's continued insistence on scheduling inpatient procedures with an outpatient classification, in violation of hospital policy, Dr. X spat on her

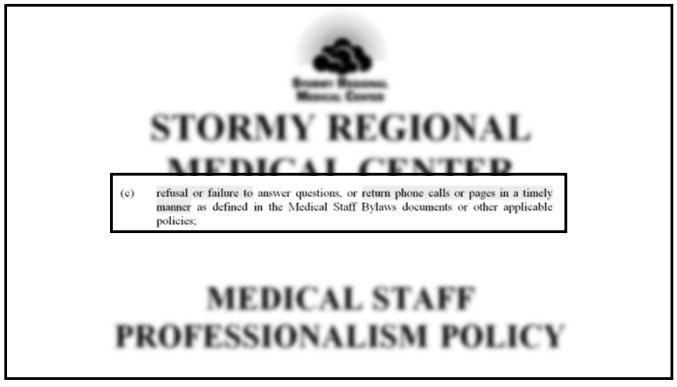
102



103

Frustrated that a case started two hours late – and a tech chose an incorrect piece of equipment – Dr. X punched the wall and stormed out of the OR

104



105

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

106

STORMY REGIONAL MEDICAL CENTER

(e) 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

107

When asked to clarify the patient's smoking status, Dr. X responds:

"No Fing Clue! C'mon."

In order to accurately reflect the patient's severity of illness and clinical management, please assist us in clarifying the following issue:

Documentation in the social hx section of the H&P indicates that this patient is a non-smoker. Conflicting documentation of the past medical/surgical history, contained in the anesthesia record, indicates that the patients smokes.

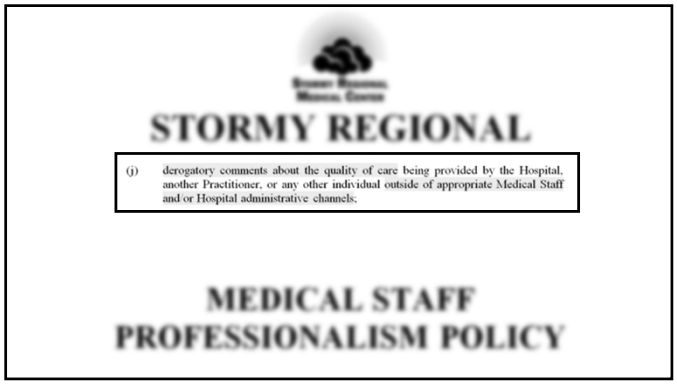
Please clarify the patient's smoking status below or as an addendum to the H&P:

____ Patient is a current smoker
____ Patient is a non-smoker
____ Patient is a former smoker
____ Smoking status unknown
____ Other. Please specify.

No Fing Clue! -C'mon...

Signature Date

108



109

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

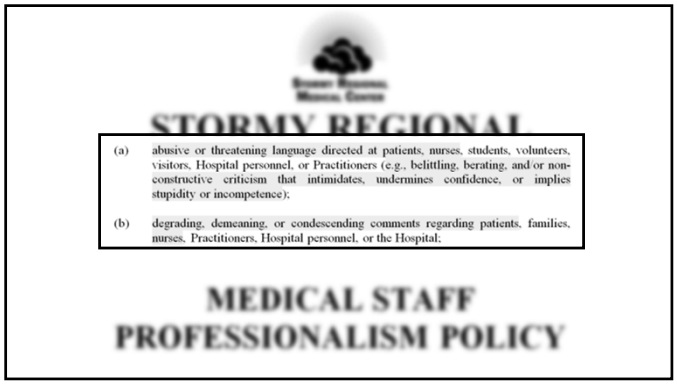
"Signatures don't matter when the nurses are busy killing my patients."

110

Following a patient death, the surgeon says to the anesthesiologist (*in front of the OR team*):

This was a very poor effort.
You didn't really try.
You…purposefully didn't resuscitate him.
You just euthanized my patient.

111



112

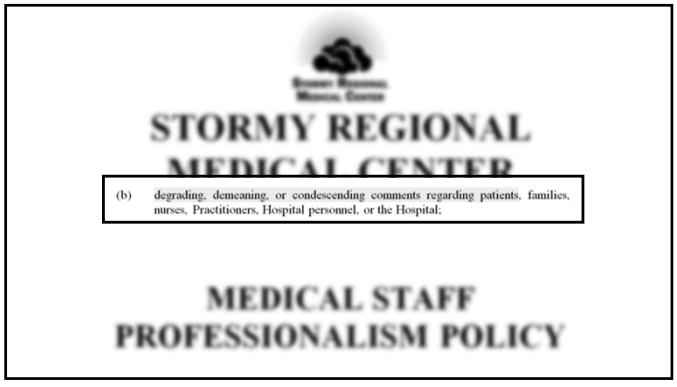
In response to a noted question, Dr. X writes, in the medical record:

"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."

113



114

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"

115

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."

116

STORMY REGIONAL MEDICAL CENTER

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

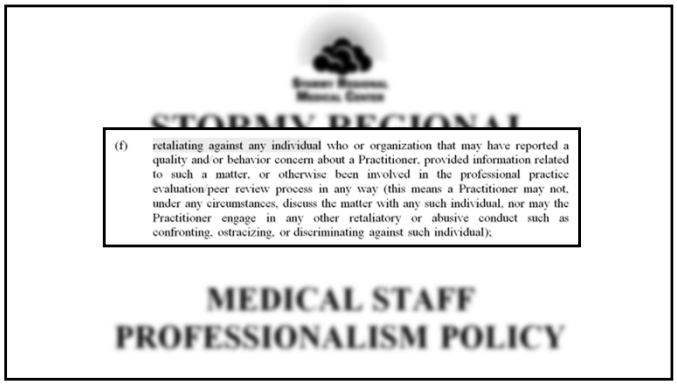
MEDICAL STAFF PROFESSIONALISM POLICY

117

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

"Should I call you JJ or Jugs?"

118

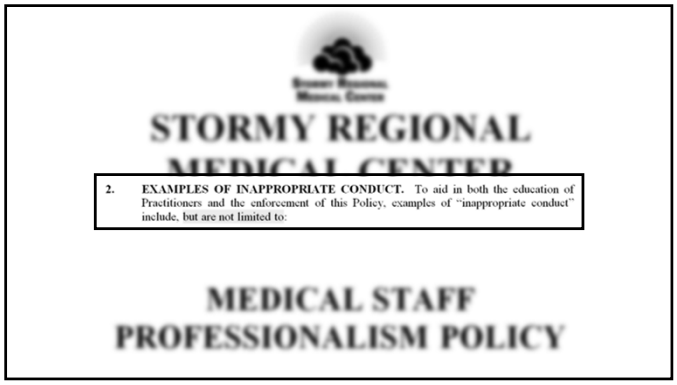


119

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.

120



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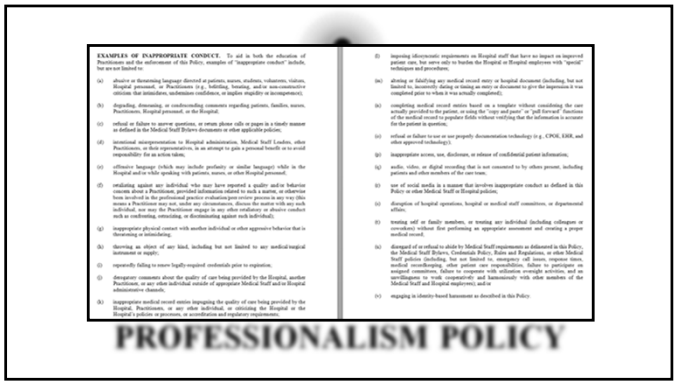


122

123

Dr. Cross

124

INVESTIGATIONS:
Whenever a serious question has been raised, or where collegial efforts have not resolved an issue…
the Medical Executive Committee will review the matter in question, may discuss the matter with the individual, 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.

125

Peer Review of Employed Physicians:

- **Involvement of Employer should be optional**
- **Leadership should decide if Employer involvement would be *helpful to the process***

126

Peer Review of Employed Physicians:

- **Involvement of Employer should be optional**
- **Leadership should decide if Employer involvement would be *helpful to the process***

Is Dr. Cross employed?

127

Peer Review of Employed Physicians:

- **Involvement of Employer should be optional**
- **Leadership should decide if Employer involvement would be *helpful to the process***

Did Leadership involve HR?

128

Precautionary Suspension?

- **Different from a disciplinary suspension**
- ***NOT* "summary" suspension**
- ***ONLY* in cases of "imminent risk" or "imminent danger"**
- ***NOT* for "orderly operations of the Hospital"**

129

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.

130

Does this incident rise to an *"imminent risk"* level of concern?

131

What is "the beginning" with Dr. Cross?

132

Dr. Cross:

- **Several non-documented "cup of coffee" conversations**
- **One letter of guidance on behavioral expectations after sharp exchange with nurse**
- **One letter of reprimand after Starbucks "excursion" and computer rage**
- **Pending complaint alleges bullying and hostile work environment**

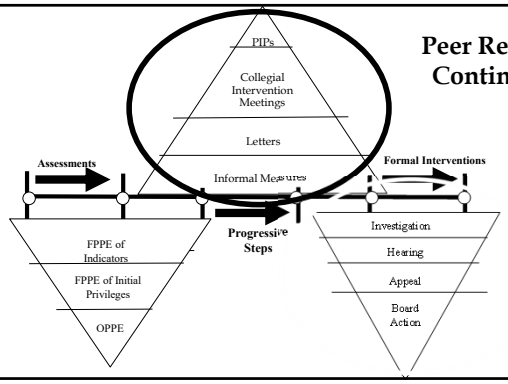
133

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.)**

134

Peer Review Continuum



135

When considering the process to use - is Dr. Cross an *employed* or *contracted* physician?

...If so, you may have additional options

136

Remember –
Build in Early Notification to Facilitate Employer Awareness/Involvement.

137

What Does the Contract Say?

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

138

Options:

Exercise Contract Rights	Refer for Management Through Medical Staff Peer Review Process
• Quick and easy • Employer can more easily impose conditions • Also – often best option if ready to "cut loose"	• Long and arduous • Also – creates good record, for protected class/ whistleblower situations • Best when hoping to "fix and keep" practitioner

139

Reasonable outcome?

140

In professionalism reviews –

Avoid a rush to judgment!

141

Keys for Successful Collegial Interventions

- **Preparation!**
- **Preparation!**
- **Preparation!**
- **Preparation!**
- **Preparation!**
- **Preparation!**

142

Collegial Interventions

- **Gather any missing information**
  - *Facts verified? Practitioner history reviewed? Previous interventions known?*
- **Develop a game plan *before* you meet with the physician**
  - *Who is meeting? What's the goal? Likely physician perspective? Personality? Talking points developed - in advance!*
- **Provide adequate notice**

143

Provide Adequate Notice

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

144

What if Dr. Cross responds to our letter notifying her of the meeting by demanding to see her "*secret*" file?

145

Address Confidentiality and Retaliation

- **Have a Policy on Access to Confidential Files**

146

LEVELS OF ACCESS

Routine Credentialing and PPE/Peer Review Documents

Sensitive Internal Documents

Sensitive External Documents

147

Sensitive documents (internal or external):

Sensitive documents that would reveal the identity of the individual who prepared or submitted the document will be *summarized or redacted*.

148

Address Confidentiality and Retaliation

- **Have a Policy on Access to Confidential Files**
- **Get the practitioner's signed agreement (if necessary)**

149

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**

150

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**

151

Be prepared for avoidance tactics

152

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!")**

153

Don't Get Thrown Off Track

What If...

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

154

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 after the meeting**

155

Follow-Up After the Meeting

- **Look into any quality concerns raised by Dr. Cross**

156

Whistleblower Claims Are Rampant!

157

Don't ignore quality concerns

...but don't get thrown off track.

158

Follow-Up After the Meeting

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

159

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

160

Collegial Intervention Follow-Up Letter

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

161

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*)**

162

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"**

163

Privileging Disasters and Challenges

164

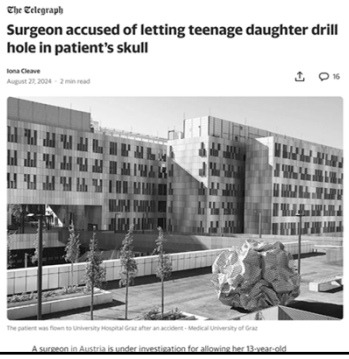
TIP

Privileges* and *Appointment:
Two distinct concepts, granted through the same process

165

No one can do anything to a patient in a hospital without authorization – provided *in advance*.

166



167

Types of Authorization

- *Clinical privileges*
- **Scope of practice**
- **Employment/HR process**
- **Vendor approval**
- **Observer approval**
- **Trainee affiliation**

168

Clinical privileges define the patient care and treatment services that can be provided by qualified individuals.

You **define, through your privileging process, who is qualified...and for what.**

169

The Board has the final authority to grant privileges.

170

Elements of Every Privilege Delineation:

- **Description of Privileges/ Procedures Included (Core or Laundry List)**
- **Education, Training, Experience**
- **Elements of FPPE**

171

Description **of Privileges/Procedures**

- **Core Privileging and Special Privileging**
- **Laundry List**

There are pros and cons to each method

172

Have a process –
no unilateral opt-outs!

173

TIP

When there's no data, or old data, proceed with caution

174

Low and No Volume Providers

Different *causes*, different *goals*, different "*solutions*" – some easier than others!

175

The No and Low Volume Problem

Options:

- **"Membership-only" staff category (no volume, no privileges)**
- **Extra FPPE (low volume or short absence from clinical practice)**
- **Reentry Plan (extended lack of volume / absence from clinical practice)**

176

Reentry Plans:

- **At credentialing, processed like a request for waiver**
- **Requirements to be completed prior to beginning clinical practice (e.g., CME, non-hospital clinical duties during leave)**
- **Requirements to be completed after beginning clinical practice (e.g., proctoring, second opinion/consultation, monitoring)**

177

Reentry Plans:

- **After reentry plan is approved, processed like a PIP**
- **Appointment/privileges conditional on compliance with reentry plan**
- **Periodic review by designated committee**
- **Plan in place until practitioner is released**

178

TIP

New Procedures:
You Can't Grant Privileges that have Not Been Delineated

179

Columbia/JFK Med. Ctr. v. Sangounchitte

- **Long-standing neurosurgeon member of medical staff schedules a patient for a cervical spine procedure**
- **The procedure involved a posterior approach to implanting a rod to stabilize the cervical spine**

180

Columbia/JFK Med. Ctr. v. Sangounchitte

- **He had never performed a posterior approach**
- **Used a Luque Rod in the cervical spine - an "off-label" use - and subject to a black box warning**
- **Surgery resulted in paralysis**

181

Columbia/JFK Med. Ctr. v. Sangounchitte

$8.5 million negligent credentialing verdict

182

Who decides *and how*?

183

THE KEY:
Establish a consistent, fair *PROCESS*

184

Who considers?

Feasibility

- **Administration (with Medical Staff leadership/specialty expert input)**

Privileging Issues

- **Credentials Committee**
- **New Technology Committee**
- **Appointed ad hoc committee**

185

***Feasibility* factors to consider:**

- **Is different equipment/technique required?**
- **Is there sufficient space?**
- **Must others, besides physician, be familiar with this technique/modality to employ it effectively?**
- **Does it require increased or new staffing?**

186

Or an extension of a current procedure (privilege)?

187

Privileging factors to consider:

- **Is a different skill set required?**
- **Are there different/greater risks?**
- **Is this something in which proficiency is volume-sensitive, and would the requisite volume be available?**
- **Is it likely that multiple specialties will be/are interested in this procedure?**

188

New Procedures

Ultimately - Board decides - based on:

- **Hospital's mission statement**
- **Newness, riskiness, and general acceptance of new procedure**
- **Hospital's resources and personnel**
- **Recommendation of the Medical Staff**

189

TIP

Privileges that Cross Specialty Lines:
Neutrality is Key

190

Nurse Midwifery Assoc v. Hibbett **(6th Cir. 1990)**

- **Two nurse midwives asked for privileges**
- **The hospital had never privileged midwives before**
- **MEC appointed an ad hoc committee... of OB/GYNs**
- **The committee took spectacularly damaging minutes**

191

Nurse Midwifery Assoc v. Hibbett **(6th Cir. 1990)**

- **The committee concluded: No need for nurse midwives**
- **Court: OB/GYNs conspired, as individuals, to prevent competition. Not shielded by committee action**

192

While criteria for privileges can vary between specialties, the hospital must provide *a single standard of care*.

193

Goldenberg v. Woodard **(Nev. 2014)**

- **OB-GYN requests colonoscopy privileges**
- **Submits documentation showing he completed a weekend CME course observing a colonoscopy on a mannequin**
- **Granted privileges, subject to proctoring.**

194

Goldenberg v. Woodard **(Nev. 2014)**

- ***First case:*** **Proctor not timely, so physician proceeds**
- **"Difficulty advancing the scope"**
- **"Half-dollar size perforation"**
- **Patient in coma/ on ventilator for weeks**
- **Additional surgery/ permanent disability**

195

Goldenberg v. Woodard **(Nev. 2014)**

- **Jury - $610,000 in damages, plus $1 million**
- **OB/GYN liable for fraud — failed to tell patient her colonoscopy would be his first, he'd only been to a weekend course, and he'd had privileges denied at two hospitals**
- **Fraud claim not subject to statutory $350,000 cap for professional negligence**

196

Privileges that Cross Specialty Lines

- **Process is key!**
- **Limit role of competitors**
- **Allow all interested parties to provide input**
- **Utilize neutral review body (Credentials Committee or ad hoc committee)**
- **Exclusive contract involvement?**

197

Also Consider

Patient selection criteria
Ability to handle complications
On-call coverage
Ongoing peer review

198

Final decision is made by Board.

No applications processed until delineation complete!

199

TIP

Privilege delineations only work if they are *applied*

200

Frigo v. Silver Cross Hosp.
(Ill. App. Ct. 2007)

- **A 50-year-old critical care nurse had an elective bunionectomy**
- **Though she was diabetic and had an ulcer on her foot, her podiatrist decided to proceed**
- **Infection resulted in amputation**

201

Frigo v. Silver Cross Hosp.
(Ill. App. Ct. 2007)

- **The podiatrist had not completed a podiatric *surgical* residency**
- **Nor was he certified by the American Board of Podiatric Surgery**

...both of which were required by the Hospital's own documents!

202

Frigo v. Silver Cross Hosp.
(Ill. App. Ct. 2007)

- **The podiatrist had been "grandfathered" for category II surgical privileges at the hospital**
- **But had not submitted any evidence of training or experience for these privileges**

203

Frigo v. Silver Cross Hosp.
(Ill. App. Ct. 2007)

- **Podiatrist settled in malpractice lawsuit**
- **Negligent credentialing adopted as a theory of liability in Illinois for the first time resulting in . . .**

204

Frigo v. Silver Cross Hosp.
(Ill. App. Ct. 2007)

. . . a verdict against the hospital for $7.75 million

205

TIP

Privileges for Advanced Practice Providers

…the same, except where it's different!

206

What Does CMS Say?

Practitioners who provide a "medical level of care" and/or conduct surgical procedures in the hospital must be credentialed and *privileged through the Medical Staff process.*

Director, CMS Survey and Certification Group Memorandum, November 14, 2004

207

Should APP applicants be required to establish "*current clinical competence*" before privileges are granted, as with physicians?

YES!

208

Does "current clinical competence" mean the *demonstration of specialty-specific experience* for the APP to be eligible for certain privileges?

Can it? Maybe?

209

Delineating Privileges for APPs When:

- **APPs are pursuing specialty work?**
- **APPs are changing specialty practice areas during a career?**

210

Is "on-the-job" training for specialty practice in hospitals acceptable, where specialty-specific training programs are few and evolving?

211

Options for APP Privilege Delineation
(Training/Experience):

- **Maintain specialty-specific APP delineation of privileges that require defined period of specialty-specific experience**
- **Require CAQ or postgraduate specialty training**
- **"On-the-job" training with supervising physician in the form of *tight* FPPE**

212

What About Peer Review?

Focused Professional Practice Evaluation (FPPE)
and
Ongoing Professional Practice Evaluation (OPPE)
for *anyone* with clinical privileges

213

Hot Topics…

- **Should APPs be permitted to practice at the top of their licenses?**
- **Should APPs be appointed to the Medical Staff?**
- **Should APPs be appointed to serve on Medical Staff committees? With vote?**

214

Super *Hot* Topic?

***Privileging* of non-physicians who "perform surgical tasks"**

- **Surgical Assistants**
- **First Assists**
- **Registered Nurse, First Assistant (RNFAs)**

215

Super *Hot* Topic?

Privileging of non-physicians who "perform surgical tasks"

- **Long required by Medicare Conditions of Participation (circa 2004!)**
- **Now being enforced by accrediting bodies**
- **"Wait and see" approach has risk**

216

Thank you!

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