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Whistleblower or Disruptive Physician: How Do You Know the Difference? Audio CD

Recorded May 18, 2004

Faculty: Susan Lapenta & Charlotte Jefferies

Every disruptive physician has an excuse for his or her behavior. You have probably heard many of them:

"The nurse was incompetent."
"The equipment was malfunctioning."
"The OR was not ready."
"I am only trying to protect my patients. No one else cares about quality patient care."

It is becoming increasingly common for disruptive physicians to cast themselves as the "champions of quality care" and any action by physician leaders or the hospital to address the physician's behavior as retaliation for "whistleblowing," or as a cover-up for poor quality.

The lone physician acting as an advocate for patients has great media appeal. Local newspapers are often willing, even eager, to publish the physician's allegations of poor quality care and a resulting cover-up. These play less well in court. Several courts have held that "whistleblowing" is no excuse for bad behavior and have upheld the termination of physicians' appointments and clinical privileges for such conduct.

However, one state supreme court refused to grant immunity under the Health Care Quality Improvement Act to a hospital and physician leaders who terminated the clinical privileges of a physician who undertook a letter-writing campaign to outside agencies complaining about the quality of care at the hospital. The court ruled that it would be against public policy to grant immunity in that situation.

Topics discussed in this audio CD include:

- Can a hospital take action against a physician who raises

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A New Approach for Dealing with the Disruptive Practitioner Audio CD

Recorded April 13, 2005
1:00 - 2:30 pm (Eastern Time)

Faculty: Susan Lapenta & Larry Harmon, PhD

In a recent survey conducted by the American College of Physician Executives, physician leaders across the country reported that they "routinely" have to deal with disruptive practitioners. These disruptive practitioners not only frustrate physician leaders, they drive away valuable nurses, adversely affect the operation of the organization and can adversely affect patient care.

It's time to do something about the difficult individual in your organization. Susan Lapenta, a partner of Horty, Springer & Mattern, and special guest, Larry Harmon, PhD, Director of the Physicians Development Program, discuss:

- who is the disruptive practitioner
- the need for clear rules of conduct (i.e., Code of Conduct)
- the risks and benefits of requiring a physical or mental evaluation
- legal considerations in dealing with the disruptive practitioner
- the P.U.L.S.E. survey, a work-place behavioral assessment tool to objectively measure disruptive behavior
- using the survey report to help a disruptive practitioner understand the impact of his or her conduct on team members
- referring the disruptive practitioner for anger management training
- the benefit of ongoing feedback to the disruptive practitioner
- the need for a behavioral contract and documentation
- the steps that can be taken when all other alternatives have failed

Audio CD: $195

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Investigations and Hearings — Should You Follow Your Bylaws? Maybe Not!

Audio CD

Recorded November 11, 2005

1:00 - 2:30 pm (Eastern Time)

Faculty: Barbara Blackmond & Susan Lapenta

Standard advice to physician leaders when investigating concerns about a colleague's competence or conduct or preparing for a hearing: Follow your bylaws!

But that advice is only as good as your bylaws. Sometimes, following your bylaws is not enough.

For instance, in regard to investigations, it is important to

- anticipate conflicts of interest;
- be able to obtain external reviews and assessments, if necessary; and
- provide for fair and reasonable input from the physician.

In regard to hearings, it is critical that

- lawyers don't take over the show with a lot of procedural arguments;
- information about "other" physicians is protected; and
- limitations can be imposed to prevent hearings from going on indefinitely.

What if your bylaws do not provide for these issues and you're in the middle of an investigation or heading for a hearing? Barbara Blackmond and Susan Lapenta discuss strategies for investigations and hearings, including:

- preparing a thorough record, including documentation of progressive steps, and a detailed "investigative" report
- conducting a broad enough investigation (how many cases are enough?)
- communicating with the physician about concerns raised
- imposing a precautionary suspension or other restrictions

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Clinical Privileges: Tough Issues and Solutions Audio Conference

Recorded July 26, 2005

Faculty: Linda Haddad and Monica Hanselovan

Do any of these situations sound familiar?

- Leapfrog standards say that critical care should be provided by intensivists. At your hospital, surgeons, internists and others follow their own patients in the ICU. If you require them to consult with the intensivists, or to turn those patients over to the intensivists, have you restricted or revoked their clinical privileges?
- Now that your hospitalist program is thriving, many family practitioners on your staff no longer come to the hospital. But, they still want clinical privileges. Can the family practitioners be granted clinical privileges when they have no hospital practice to assess?
- A great internist is returning from a three-year absence now that her youngest child is in pre-school. She kept up with CME during those three years, but did not care for patients. Does she qualify for clinical privileges?
- It's 6:50 am. The cath lab calls to ask if Dr. Smith has privileges to perform the new wild and wonderful procedure that he has scheduled for 7:15 am.
- The person who is most proficient in the use of the hospital's newly acquired surgical equipment is the sales rep. The orthopedist wants the rep in the OR when he uses it the first time. Must you grant clinical privileges to the sales rep? Can you?

Clinical privileges questions are among the stickiest of all credentialing issues. Besides the traditional requirement that an applicant demonstrate training and current clinical competence in the area in which clinical privileges are requested, there are new issues.

- How do you handle clinical privileges that cross specialty lines or the clinical privileges that come with new medical

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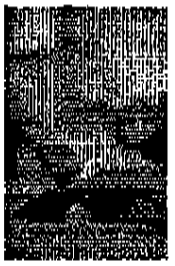

Untangling the Web: Credentialing and Contracting Audio CD

recorded March 23, 2004
1:00 - 2:30 pm (Eastern Time)

Faculty: Henry Casale & Susan Lapenta

- It should be easy to address behavioral concerns about an anesthesiologist who is subject to an exclusive contract.
- It should be a cinch to address clinical concerns about the neurologist you just recruited.
- It should be clear how to terminate the contract of an employed physician who is repeatedly disregarding the hospital's code of conduct.

But is it?

Henry Casale and Susan Lapenta, partners at HortySpringer, team up to discuss the issues that can make credentialing of a contracted physician a tangled, tedious, and convoluted web.

Henry and Susan discuss:

- First things first – Don't forget to thoroughly credential all physicians with whom you are contracting
- Helpful provisions that should be in your exclusive, employment and recruitment contracts and contract provisions to avoid
- When to use (and when not to use) the credentialing process to address issues with contract physicians
- How to stop the bleeding once a problem is determined to exist with a contract physician
- Reporting obligations when contracts are terminated

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Credentialing and Medical Staff Records - Access, Control and Confidentiality Audio CD
Recorded September 13, 2006

Faculty: Alan Steinberg and Monica Hanslovan

- What should be included in medical staff committee, department and peer review meeting minutes? More importantly, what shouldn't?
- Can a physician review all of the documents in his or her credentials file? Even the most confidential ones?
- What information can be provided when outside entities such as government offices (state and federal), accrediting bodies and surveyors request peer review documents? How must those requests be made?
- Should any meetings (committees, department, peer review groups) be tape recorded?
- Should confidential peer review documents be distributed prior to meetings? If so, how?
- What should credentials files include?
- Which documents in credentials files should medical staff members be allowed to access? Under what circumstances?
- Who should have access to medical staff documents?
- How long must credentials files be kept? Can documents in them ever be thrown away?
- How can credentials files and peer review documents be shared within a system?

Materials include written guidance regarding the right (and wrong) ways to keep minutes, sample minutes for different kinds of meetings, a distribution letter for the sending of confidential peer review documents, bylaws language for the sharing of credentialing information within a hospital system, a Policy on Confidentiality of Medical Staff Records and a Policy on Medical Staff Member Access to Credentials and Quality Files.

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Don't Get Busted for Bad Peer Review: Tips to Help You Stay on the Right Side of the Law Audiotape

recorded February 24, 2003

Faculty: Henry Casale, Glenn Martin and Barbara Tanase

In December 2001, United Memorial Hospital of Greenville, Michigan and two physicians who served in leadership positions at the hospital were indicted for conspiring to defraud Medicare, Medicaid and private insurers based on unnecessary pain management procedures performed by an anesthesiologist on staff. Last month, on January 8, United Memorial pled guilty to wire fraud based on bills submitted for the unnecessary procedures. The two physicians agreed to be placed in a two-year federal Pretrial Diversion Program and pled guilty to state larceny charges.

On February 24, 2003, Henry Casale, a partner of Horty, Springer & Mattern, interviewed the Assistant United States Attorneys who prosecuted the case, Glenn Martin and Barbara Tanase during this special audio conference.

This case has been widely perceived as a criminal prosecution based on the failure to conduct adequate peer review. During the audiotape, Henry explores with the prosecutors:

- How the case first came to their attention
- Why the government filed criminal charges instead of a civil False Claims action
- Whether this case means that hospitals are guarantors that no unnecessary procedures are performed in their facilities
- How to respond to physician leaders who say, "If I can face criminal charges, it's not worth being a volunteer physician leader."
- And much more

Participants will also have an opportunity to ask questions and Henry will provide practical tips on not

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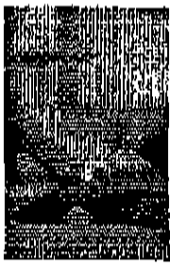

Medical Staff Bylaws: Can't Live with Them - Definitely Cannot Live Without Them

Audio CD

Recorded June 30, 2005

Faculty: Susan Lapenta and Phil Zarone

Bylaws, when properly drafted, provide a road map to guide the medical staff and others in the performance of their various responsibilities. Bylaws should outline how those tasks are to be accomplished, be legally correct, incorporate current JCAHO or other applicable accreditation standards affecting the medical staff, and take advantage of best practices that help the medical staff do its job. Outdated bylaws that fail to provide adequate guidance are a recipe for disaster.

Topics addressed include:

- Rethinking medical staff categories, including alternatives for appointment to the active staff, the benefits of senior active staff, and the parameters for community affiliate staff members
- New qualifications for medical staff officers and other leaders
- Voting and meetings: does the Internet offer new solutions to old problems?
- Attendance requirements - how to make them work
- Simplifying the amendment process: can it be done?
- Rethinking (and strengthening) criteria for appointment
- Rules for temporary privileges
- Key provisions to address new privileges and "turf battles," aid in reappointment, and encourage "collegial intervention"
- Providing needed guidance for investigations
- M&M exclusions, felony convictions, and other "automatic relinquishment" provisions
- "Precautionary" (not "summary") suspensions
- Regaining control of the hearing process
- Key steps in a major bylaws revision process

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Medical Staff Code of Conduct: A Matter of Patient Safety — and Maybe a JCAHO Requirement?

Audio Conference

Recorded December 20, 2005

Faculty: Barbara Blackmond & Rachel Remaley

"Disruptive behavior not only decreases staff morale, but also has a negative effect on patient safety."

While that may not come as a surprise to anyone who has had to work with an individual who engages in disruptive behavior, it is surprising that this statement is directly from the proposed patient safety goals for 2007 that the JCAHO released in December 2005. There, among prevention of patient falls, pressure ulcers and medication errors was "Goal 16: Discourage disruptive behavior." The first Implementation Expectation under this Goal is: "The organization develops a code of behavior which is embraced by the organization's governance, management, and medical and clinical leadership." The JCAHO is accepting comment on the proposed patient safety goals until Janurary 8, 2006.

This proposed patient safety goal from JCAHO is just the latest addition to a long list of reasons to adopt a Medical Staff Code of Conduct Policy. Yelling. Throwing surgical instruments. Inappropriate comments to patients, family members or staff members. Sexual harassment. These have long been recognized as the "hallmarks" of the disruptive practitioner. And most hospitals have policies on disruptive conduct and sexual harassment that address how the hospital will address such conduct.

But disruptive conduct can take other forms - disrupting the administrative functions of the hospital or medical staff in department or committee meetings, attempting to "hijack" the peer review process for personal reasons, or publicly disparaging the quality of care provided by the hospital, staff members or physicians.

Some recent court decisions have highlighted what may be the next wave of litigation - disruptive physicians who claim that their

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Incredible Shrinking Peer Review Privilege: New Developments ... Effect of State Tort Reform on Peer Review

Privileges Audiotape

recorded February 13, 2003

Faculty: Dan Mulholland & Barbara Blackmond

Do you think your peer review documents can never be discovered in a malpractice case?

Do you believe that you and the other people in your organization will be protected if a disgruntled physician tries to challenge a professional review action?

Not necessarily. Courts and administrative agencies have been chipping away at the privileges and immunities that have long protected good faith peer review actions in hospitals and other health care entities.

These days, you can't rely on blanket legal protections. You've got to be smart and you've got to be careful about what you say and do.

Medical staff leaders, health care executives, credentialing professionals, board members and attorneys will all want to purchase HortySpringer's audiotape on this critical issue. It will be filled with analysis and advice.

Topics covered include:

* The Basics of Peer Review: What Is Privileged and Who's Immune?
* HCQIA Immunity and Data Bank Reports
* State Peer Review Protection Laws
* Erosion of Immunity: Discrimination Cases; Whistleblowers; Federal Lawsuits
* "End-runs" Around HCQIA and How to Block Them
* The Incredible Shrinking Peer Review Privilege:

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Audio Conference Series #1: "An Ounce of Prevention..."

Audio CD #1: Don't Appoint Problem Physicians

Recorded September 24, 2004
1:00 - 2:30 pm (Eastern Time)

Faculty: Alan Steinberg & Susan Lapenta

Topics to be covered include:

Only Consider "Eligible" Applicants

- Establish threshold criteria for appointment and for clinical privileges
- Make sure your recruiter knows your criteria
- Make all employment/contract language contingent on meeting all criteria and getting through the credentialing process
- Provide applications only to those who meet the criteria — including "current" clinical competence

Don't Make Ad Hoc Decisions!

- Grandfathering (pros and cons)
- Waivers/exceptions (pros and cons)

Only Process Complete Applications

When Proctoring or Mentoring Is a "Must"

- Define precisely what proctoring or mentoring means
- Use of conditional appointment

What Do You Tell Those Who Are Not Eligible or Who Don't Qualify?

Help Your New Physicians Be Successful

- Statement of expectations
- A real orientation program — with a preceptor
- Appointment letter and "acceptance"

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Audio Conference Series #1: "An Ounce of Prevention..."

Audio Conference #3: Quality/Performance Improvement & Peer Review Best Practices

Recorded October 20, 2004

Faculty: Barbara Blackmond & Paul Verardi

Topics covered include:

Best Peer Review Practices – The Power of Data

- Communicate often – not only when a case "falls out"
- Provide summary data/comparisons with aggregate data of others in same specialty
- Quarterly reports/graphs provided to physicians with invitations to discuss
- It works – practice patterns change!

Adopt Patient Care Benchmarks and Help Physicians Achieve Them

- Make participation in protocol development the only "mandatory" medical staff participation
- Have salaried "champions" of each clinical area whose task is to lead the development, educate, and counsel those who may not meet standards

Retool the Traditional Process

- What triggers peer review?
- Physician review
  - When is it required?
  - Use constructive review forms
  - Avoid votes and scores

Make the Problem Part of the Solution

- Alternatives to Peer Review by Departments
- Department committees
- Multidisciplinary committees

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- Charity Care Class Action Lawsuits
- Charity Discount Rules
- Clinical Privileges: Tough Issues and Solutions
- CMS Clarification on Hospital Privileging
- CMS Finally Proposes Revisions to 4 COPs
- CMS: The New Rules for Informed Consent
- Community Need for Physicians: How to Analyze, Prove and Document it
- Compliance Program Guidance for Hospitals: New Risks and Opportunities
- Compliance Troubleshooting
- Can You Put a Computer in Your Doctors' Christmas Stockings?

How to Structure Conditional Reappointments Audiotape

recorded July 22, 2003

Faculty: Charlotte Jefferies & Susan Lapenta

Topics:

Tired of dealing with complaints from the OR about a surgeon's abusive conduct?

Fed up with reports that a physician is not answering pages or rounding on patients?

Exhausted by corrective steps to deal with the physician who is chronically delinquent in completing her medical records?

Looking for a solution with some teeth?

Try conditional reappointment! It is the perfect tool to deal with physicians who continuously present behavior or clinical performance problems. Through the process of conditional reappointment, you can:

- articulate expected standards of performance
- encourage compliance and at the same time outline the consequences if those standards are not met
- narrow the scope of any disciplinary proceeding that might result

This audiotape will help you learn how to deal with these physicians in a way that is more effective and productive.

Topics covered include:

- practical and legal benefits of conditional appointment
- when conditional appointment should be

Audio Conferences

Audio Conferences

- 20th Anniversary of the Health Care Quality Improvement Act
- 2007 JCAHO Credentialing and Privileging Standards - What's Different? What Do You Need to Do?
- JCAHO Posts Revisions to Standard MS.1.20 for Field Review! What Do the Proposed Revisions Mean for...
  - ... Medical Staff Bylaws? September 28, 2006
  - ... Investigations and Precautionary Suspensions October 17, 2006
  - ... Medical Staff Provisions in Corporate Bylaws? October 30, 2006

Audiotapes/CDs

- The Aging Physician and Credentialing: Stuck Between a Rock and a Hard Place?
- Allied Health Practitioners & the Health Care Revolution
- Board Conflicts of Interest
- Charity Care Class Action Lawsuits
- Charity Discount Rules
- Clinical Privileges: Tough Issues and Solutions
- CMS Clarification on Hospital Privileging
- CMS Finally Proposes Revisions to 4 COPs
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- Community Need for Physicians: How to Analyze, Prove and Document It
- Compliance Program Guidance for Hospitals: New Risks and Opportunities
- Compliance Troubleshooting
- Can You Put a Computer In Your Doctors' Christmas Stockings?

The "Independent" Medical Staff – What Would It Really Mean? Audio CD

Recorded April 6, 2004

1:00 - 2:30 pm (Eastern Time)

Faculty: Barbara Blackmond and Dan Mulholland

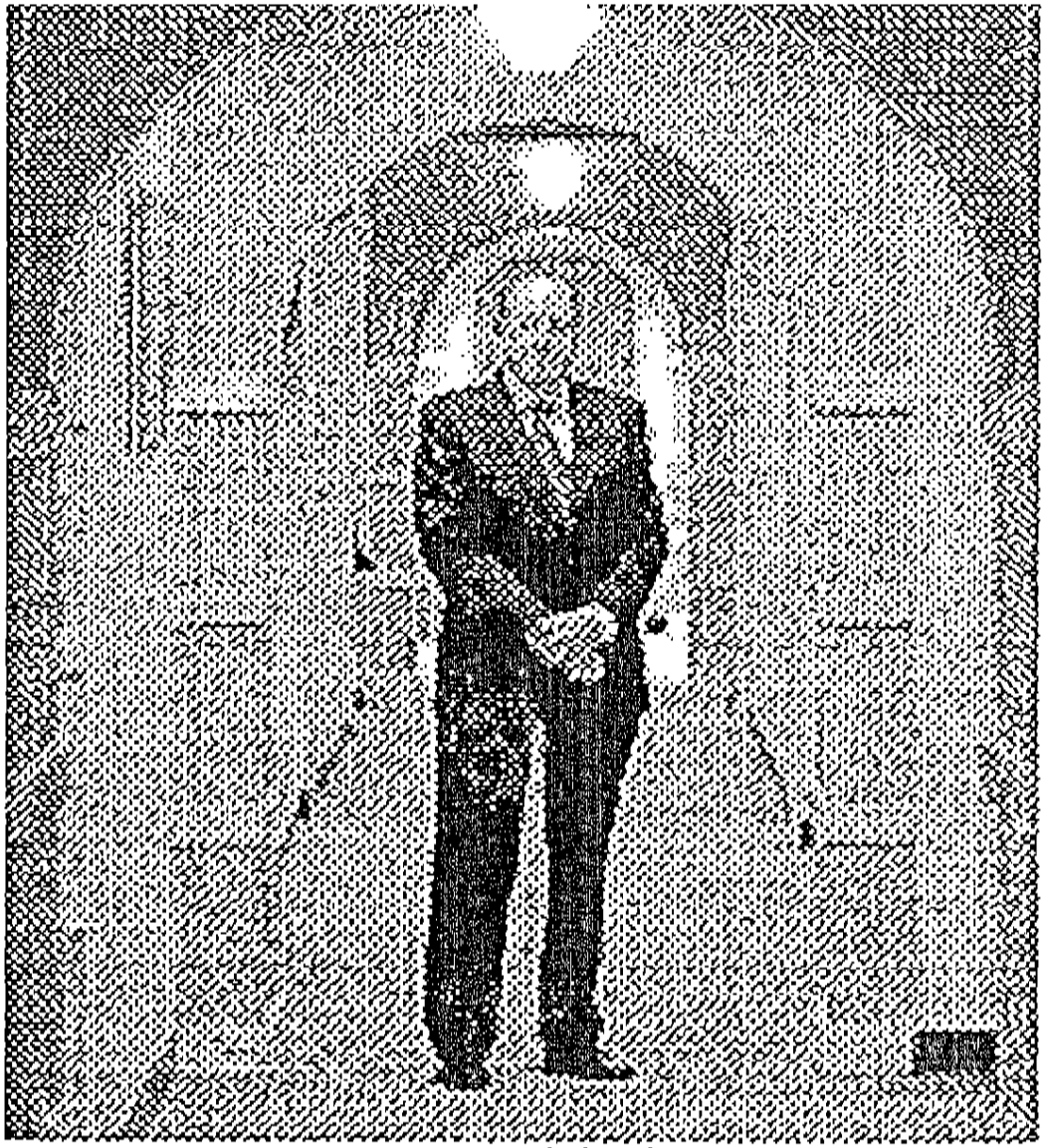
Hospital-physician relationships have always had their ups and downs. But lately, some voices have begun to whisper in the ears of medical staff leaders that maybe things would be better if the medical staff declared independence from the hospital by separately incorporating and controlling all credentialing, peer review and quality assurance activities.

While this notion has appeal to some doctors who are sincere about improving patient care and feel this can best be done by physicians alone, without administrative or board "interference," all too often, the concept of an independent staff is pushed by those with a personal agenda - subpar practitioners looking to thwart meaningful peer review, economic competitors of the hospital looking to hide conflicts of interest, or those who hold exclusive contracts seeking to protect their interests.

Not only is this idea of a medical staff that functions as a completely separate organization from its hospital a legal non sequitur, it would spell absolute disaster for the physicians on the medical staff. It also puts medical staff leaders in legal jeopardy.

Barb and Dan discuss the following topics:

- The legal status of the medical staff – what the courts and other authorities have said.
- Self-governance vs. independence – a big difference.
- How to separate special interests from common purposes.
- Who would pay to set the medical staff up on its own?
- Liability for privileging disputes and negligent credentialing if the medical staff was independent.
- Would peer review privileges and immunities apply?
- Responsibility of an independent medical staff to indemnify the hospital.
- Would an independent medical staff ever get insurance?
- What your bylaws ought to say.



John Beale/Post-Gazette

From his office in Pittsburgh's Oakland section, attorney John Horty represents hospitals around the United states in cases involving physicians."The courts tend to defer to the hospital because most courts just don't want to take the responsibility of what might happen in the institution," he said.

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ng months to get a hearing before a

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The interactive edition of the Pittsburgh Post-Gazette

Rules of fair play don't always apply

In going up against hospitals, physicians find the deck is stacked against them

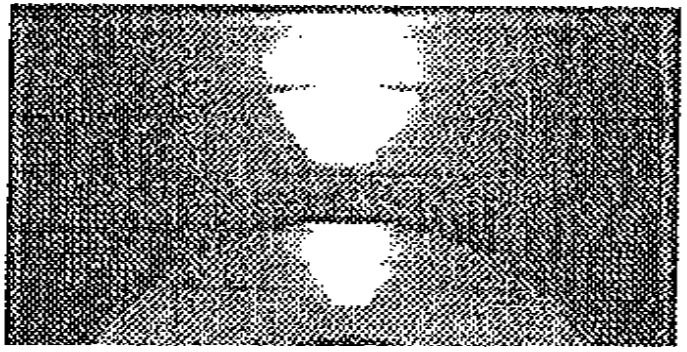
Monday, October 27, 2003

By Steve Twedt, Post-Gazette Staff Writer

Dr. Gil Mileikowsky, an obstetrician-gynecologist and fertility specialist, was abruptly suspended from an Encino, Calif., hospital nearly three years ago after he agreed to testify on behalf of a woman whose fallopian tubes had been removed without her consent.

Today, Mileikowsky, 52, still is waiting to get a full administrative hearing on possible restoration of his credentials. Two earlier hearings ended in disputes over procedural matters. He hasn't delivered a baby since December 2000.

Dr. David Gearhart was fired in 1998 for breach of contract, one month after he appeared on a St. Louis television program and criticized his hospital's decision to eliminate eight nurse surgical assistants.



Gearhart, 58, was dismissed even though his department chairman had approved his TV

requiring that hospitals meet a "clear and convincing" burden of proof rather than the more common "preponderance of evidence."

Hospital protections

The practice of having doctors review the actions of their colleagues has been around for a long time.

But the Health Care Quality Improvement Act of 1986 made a subtle but important change in that process by giving broad legal immunity to hospitals and panels reviewing physicians' performance.

Ironically, that protection was added partly because of a doctor who believed he had been mistreated by a hospital.

Pittsburgh lawyer John Horty, who is nationally known for his work on hospital legal issues, said the immunity provision in the health care act came out of discussions he'd had with former U.S. Rep. Ron Wyden, D-Ore., and later Rep. Henry Waxman, D-Calif., because of lawsuits such as the one brought by Oregon physician Dr. Timothy Patrick to overturn an unfavorable peer review ruling.

Not long after Patrick moved to Astoria, Ore., he declined an offer to join a private clinic and set up his own practice. A short time later, the clinic doctors reported Patrick to the state medical board for an alleged act of poor care. Then, in their roles with the hospital's peer review committee, they tried to revoke his admitting privileges to the only local hospital.

Patrick sued, citing antitrust violations, and a jury awarded him $2.2 million in damages. The U.S. Court of Appeals reversed that, saying peer review had civil immunity from lawsuits because it was a "state action." But the Supreme Court unanimously backed Patrick, noting the state did not supervise hospital peer review.

Faced with the specter of large numbers of peer review rulings being challenged, and

Editorial:
Abuse of the "Disruptive Physician" Clause

Lawrence R. Huntoon, M.D., Ph.D.

Buried deep in the "Corrective Action" section of most medical staff bylaws is a provision known as the "Disruptive Physician" clause. It is arguably the most dangerous and, in recent years, the most abused provision in medical staff bylaws.

The term "disruptive physician" is purposely general, vague, subjective, and undefined so that hospital administrators can interpret it to mean whatever they wish.

How this treacherous trap got into medical staff bylaws is no mystery in most instances. It was added at the urging of hospital administrators, often with help from a medical staff president who was duped into believing that the clause would only be used in those extreme cases where a physician was found running drunk or naked through the halls of the hospital.

Lack of vigilance by physicians, and failure of medical staffs to obtain independent legal advice on changes to the bylaws, allowed most hospital administrations to insert this clause without difficulty or any meaningful opposition.

Why this clause was strategically placed in medical staff bylaws is also no mystery. It is part of the strategic plan developed in 1990 by the hospital industry. The stated goal was to gain more control over physicians in hospitals. Abuse of the disruptive-physician clause and increasing use of sham peer review has allowed hospital administrations to make great strides in achieving that goal.

Attorneys who specialize in representing hospitals have definite recommendations on how "disruptive physician" can be

Although the disruptive-physician clause and sham peer review are current weapons of choice used by hospital administrations across the country, more weapons of physician destruction loom on the horizon.

Physicians should be aware of the "Code of Conduct" and "Exclusion from the Hospital Premises" clauses currently being promoted by the hospital bar.

AAPS has posted a letter dated January 31, 2003, to the General Counsel of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), which was drafted by the leaders of the credentialing and peer review practice group of the American Health Lawyers Association, in the Hall of Shame on our website (see www.aapsonline.org). The letter is rated "R" for stark Reality. Physicians need to wake up quickly and take notice because this is what hospitals really have in mind for medical staffs across the nation. Interested readers can also learn more about the hospital industry's strategic plan, developed in 1990: see "Hospital Industry Reveals Its Strategic Plan: Control Over Physicians" in the AAPS Hall of Shame.

Physician vigilance, and advice from knowledgeable, independent counsel, are key to preventing further abuse of medical staff bylaws by hospital administrations.

Lawrence R. Huntoon, M.D., Ph.D., is a practicing neurologist and editor-in-chief of the *Journal of American Physicians and Surgeons*.

Memo to the Disruptive Physician

Why this clause was strategically placed in medical staff bylaws is also no mystery. It is part of the strategic plan developed in 1990 by the hospital industry. The stated goal was to gain more control over physicians in hospitals. Abuse of the disruptive-physician clause and increasing use of sham peer review has allowed hospital administrations to make great strides in achieving that goal.

Attorneys who specialize in representing hospitals have definite recommendations on how "disruptive physician" can be defined by a hospital, in order to remove a targeted physician from staff. In fact, some law firms offer seminars for hospital officials and their legal representatives that teach optimal methods for eliminating certain physicians that the hospital dislikes. Here are a few of the criteria for identifying a "disruptive physician":

1. **Political:** Expressing political views that are disagreeable to the hospital administration.
2. **Economic:** Refusing to join a physician-hospital venture, or to participate in an HMO offered to hospital employees, or offering a service that competes with the hospital.
3. **Concern for quality care:** Speaking out about deficiencies in quality of care or patient safety in the hospital, or simply bringing such concerns to the attention of the hospital administration.
4. **Personality:** Engaging in independent thought or resisting a hospital administration's "authority."
5. **Competence:** Striving for a high level of competence, or considering oneself to be right most of the time in clinical judgment.
6. **Timing:** Making rounds at times different than those of the "herd."

Physician vigilance, and advice from knowledgeable, independent counsel, are key to preventing further abuse of medical staff bylaws by hospital administrations.

Lawrence R. Huntoon, M.D., Ph.D., is a practicing neurologist and editor-in-chief of the *Journal of American Physicians and Surgeons*.

Memo to the Disruptive Physician

Oh how we strive
For quality high,
For health
And most of all safety.

But a word to the wise:
Reproof we despise
And outspoken physicians:
We hate thee.

Feel free to opine.
But note we define
All critics
As never constructive.

And, thus shall ensue
A sham peer review
And henceforth
You're labeled "disruptive."

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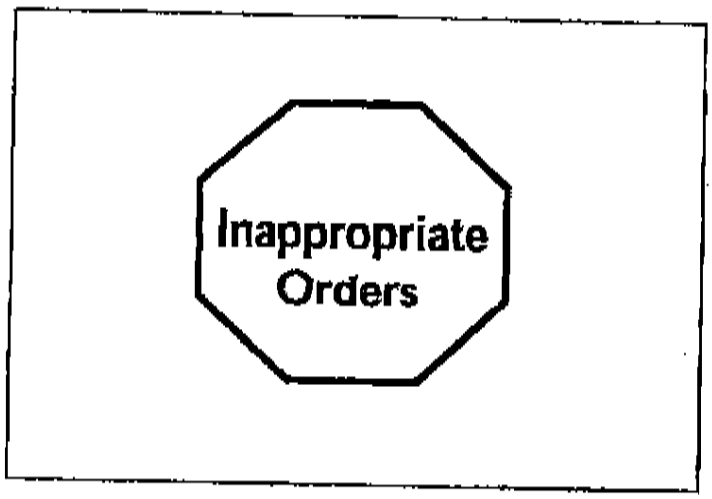
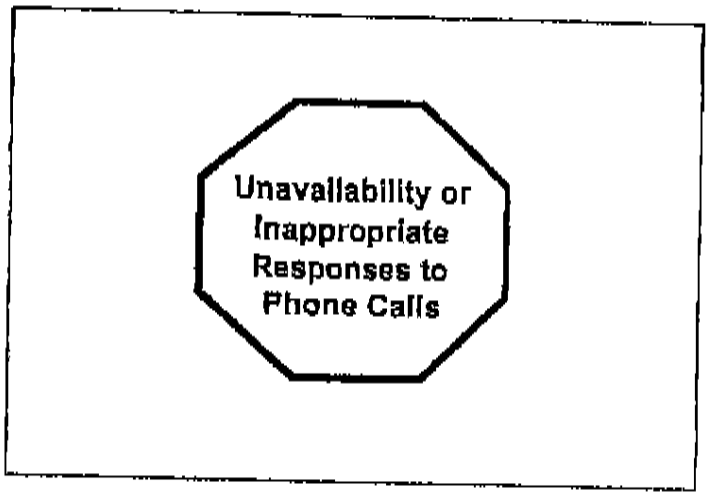
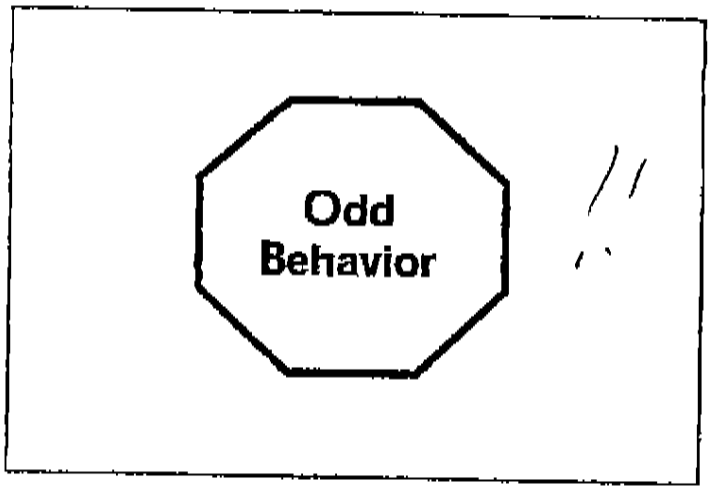
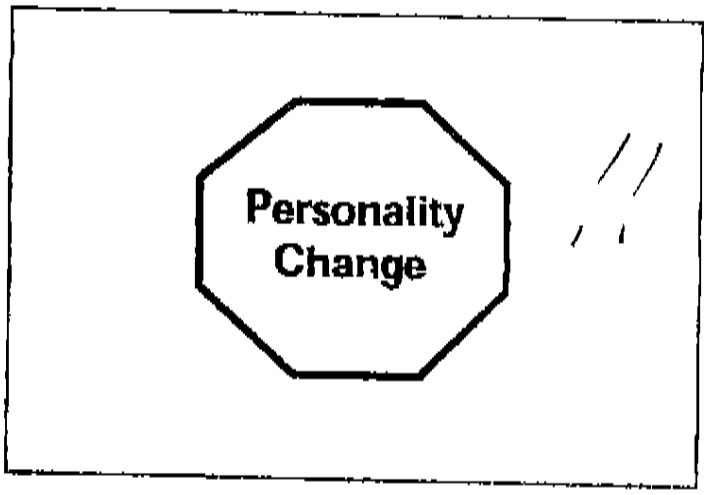
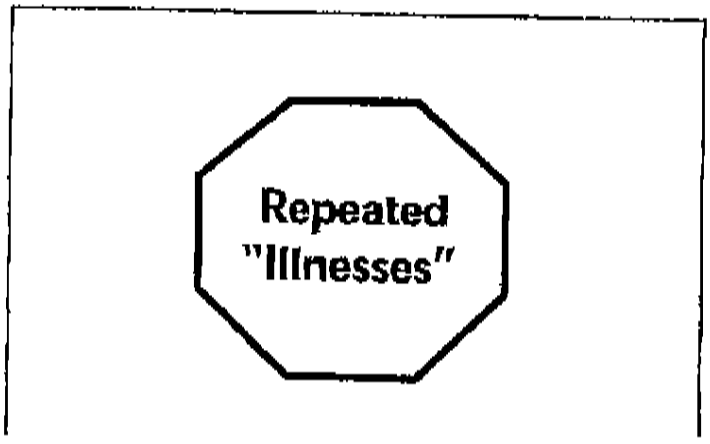
Impaired Physicians

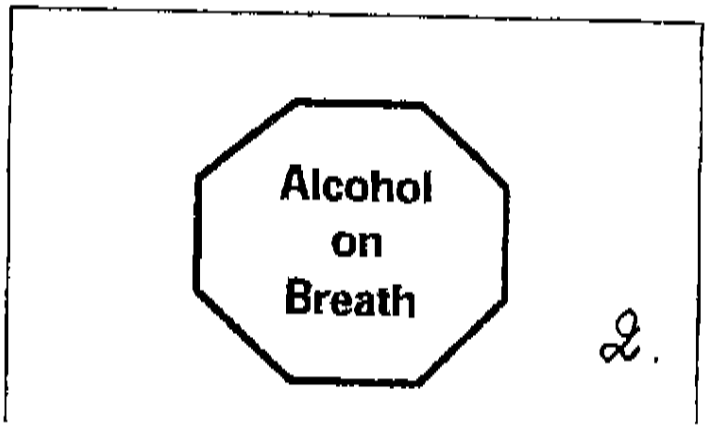












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Faculty:
Dan Mulholland & Henry Casale

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Faculty:
Barbara Blackmond & Linda Haddad

- Do physicians have a right to medical staff appointment even if they own part of a surgicenter, cath lab, or GI or oncology center that diverts patients and staff from the hospital?
- Does a hospital have any recourse if a physician competitor sends all patients whose care is poorly reimbursed to the hospital while sending all well-reimbursed cases to the for-profit surgery center in which he or she invests?
- Can physicians whose interests are not aligned with the hospital be excluded from the medical staff?

Boards must be good stewards of the hospital's and community's resources. A hospital cannot subsidize for-profit care (by taking a disproportionate share of the "expensive" care) at the expense of its community.

In this special audiotape HortySpringer senior partners Barbara Blackmond and Linda Haddad review the legal and practical problems in reconciling conflicting financial interests between physicians and hospitals and suggest an approach to this difficult predicament.

We also discuss how to:

- Reasonably evaluate possible responses to physician competition
- Understand the Legal Authority of Hospital Boards?
- Identify potential legal arguments, and plan carefully and properly, to minimize legal risk
- Build financial conflict of interest criteria into a Medical Staff Strategic Plan
- Develop and implement a financial conflict of interest policy

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Hospital Preparedness for Physicians
Hot New Compliance Issues
Impaired Physicians
Intermediate Sanctions

Hospital-Based Physician Contracts Audiotape

Faculty:
Dan Mulholland & Henry Casale

Outline:

- How does the national shortage of hospital-based physicians -- real or perceived -- affect:
  a. Your negotiations with the current group?
  b. The decision to change groups?
  c. The terms of the Agreement?
  d. Who employs the non-physician providers, especially CRNAs?
  e. The process a hospital should follow to change providers or enter into an exclusive agreement for the first time?
- What type of financial demands are being made by hospital-based groups?
- How are hospitals reacting to those demands?
- Contract provisions to help deal with privileges that cross specialty lines

This audiotape is part of a series regarding hospital-physician contracts. The others in the series are:

Providing Financial Incentives to Physicians

Audio Conferences
Unanticipated Outcomes and Patient Discounts
Audiotapes
Allied Health Practitioners
Compliance Troubleshooting
Conflicts of Interest
Corporate Compliance
Disruptive Practitioners
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Hospital-Based Physician Contracts
Hospital Compliance on the Medical Staff
Hospital Preparedness for Disasters
How Are Compliance Issues
Impaired Physicians

Critical Checkpoints in Bylaws Audiotape

Faculty: Charlotte Jefferies & Lauren Massucci

Bylaws: Very Important

Outline:

- Last things first - how to prepare so that amendments get passed
- What makes the most sense - one document or two or three?
- Medical staff categories
- Rethinking (and strengthening) criteria for appointment
- Restructuring and streamlining
- Provisions to aid reappointment, address "turf" battles and encourage "collegial intervention"
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- "Precautionary" (not "summary" suspensions)
- How to regain control of the hearing process

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Impaired Physicians: Complying with the New JCAHO Standard Audiotape

Faculty:
Barbara Blackmond & Paul Verardi

Outline:

- What does the new Standard require?
- Elements of an effective Impaired Physician Policy
- Leaves of absence
- Safeguards at reinstatement
- What about the Americans with Disabilities Act?
- How to address the aging practitioner
- Who should serve on the Physician Health Committee?
- What's reportable?

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Hearings: What is Required? What Works? Audiotape

Faculty:
Paul Verardi & Susan Lapenta

Outline:

- Grounds for Hearing
- Notice of Recommendation
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- Are other physicians' credentials files discoverable?
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This course is designed to provide leadership tools for current and future physician leaders in hospital departments of obstetrics and gynecology, managed care organizations, or private practice settings. The course also is appropriate for physicians and other providers who want to enhance their management and performance improvement skills.

After attending this course, you should be able to:

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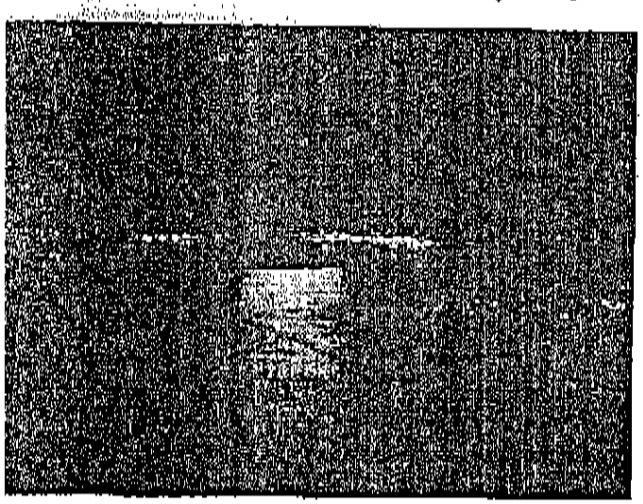
- Delineate the chairperson's role in and the legal implications of credentialing, privileging, and dealing with difficult physicians
- Use newer information technologies to improve clinical decision making
- Express the significance of medical errors in clinical practice and select strategies to improve patient safety



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  - Professional conduct: disruptive behavior, sexual harassment, unethical/illegal activities
  - Impairment: substance abuse, mental problems, aging practitioners, addictive behaviors, effect of the ADA
  - Dealing with economic competition from medical staff members
  - Peer review/QA process: how it works, internal vs. external peer review, relationship to credentialing and formal corrective action
- Investigations
  - When/how does a formal investigation commence?
  - Who should conduct it? Full MEC? Credentials Committee? Investigating Committee?
  - Witness interviews and summaries
- Credentials/MEC recommendations
  - Meeting with affected practitioner: when? should attorneys be present?
  - Form of recommendation
  - Referrals for reconsideration
  - Notice of adverse action
- Hearings
  - Selecting the hearing panel
  - Hearing officers
  - Role of counsel: in-house, outside attorneys
  - Notices
  - Prehearing conferences
  - Hearing procedures: supplemental procedures, managing disruption
  - Hearing record: exhibits, transcript, post-hearing statements
  - Hearing panel recommendation
- Board action: format, notice

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November 14-15 , 2002

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January 6-7, 2003

The Ritz-Carlton
Naples, Florida

Faculty

Barbara Blackmond

Dan Mulholland

- **Data Bank reports:** when they are required and when they are not
- **Negotiated settlements:** key terms, to report or not report?
- **Litigation challenging professional review actions**
  - Preparing for injunction actions
  - Forum for dispute: state/federal courts, administrative agencies
  - Alternative dispute resolution: arbitration, mediation
  - Common legal theories: antitrust, interference with business, defamation, civil rights/antidiscrimination laws, breach of contract
- **Immunities:** HCQIA, state peer review protection laws, volunteer protection act, state action immunity, importance of building a record
- **Preserving the peer review privilege**
- **Sharing peer review information:** the pros and cons of being forthright, releases, memorandums of understanding
- **Building a good foundation for future action**
- **Make your medical staff documents work for you:** bylaws, credentials policies, rules and regulations, allied health practitioners policy, medical staff development plan
- Related policies: physician code of conduct, physician health issues
- **Hospital bylaws provisions relating to the medical staff**
- **Medical Staff leadership:** description of duties, "fiduciary" pledge, indemnification
  - Compensation pros and cons
  - Relationship to hospital legal counsel
- **EMTALA**
  - On-call issues
  - Government investigations
- **Patient safety issues**
  - Unanticipated outcomes disclosure
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  - Patient safety legislation and reporting
  - Waiver of peer review privilege?

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- Medical Staff Code of Conduct
- Sample Bylaws, Letters and Forms Relating to Investigations
- Sample Bylaws, Letters and Policies Relating to Medical Staff Hearings
- Sample On-Call Policy

Seminar Schedule

Day One
7:00 am - 8:00 am
Registration & Continental Breakfast
8:00 am - 12:00 Noon
Seminar Session
12:00 Noon - 1:30 pm
Lunch
1:30 pm - 4:00 pm
Seminar Session
Day Two
7:00 am - 8:00 am
Continental Breakfast
8:00 am - 12:00 Noon
Seminar Session
**There will be one 15 minute break each morning and one in the afternoon.*

Who Should Attend

Legal Strategy & Tactics for Medical Staff Disputes is especially designed for health care lawyers, including in-house counsel and outside attorneys, as well as senior health care executives interested in the legal ramifications of their systems' operations.

We encourage participation by all individuals. If you have a disability, advance notification of any special needs will help us to better serve you. Please notify us of your needs at least two weeks in advance of the program.