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AUGUST 2022 | VOL 10

Med-Staff Newsletter

QUARTERLY NEWSLETTER FROM THE MEDICAL STAFF PRACTICE GROUP

Medical Staff Leaders: 10 Things Your Lawyers Want You to Know

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Whether you are new to medical staff leadership or have served in the past and have been called to serve again, there are times when you will need to consult a lawyer who specializes in medical staff matters. While there is nothing simple about medical staff affairs, there are some basic guidelines and protections that your lawyers would like you to know that will make your term easier and make you more effective.

Understand that hospitals and medical staffs are highly regulated organizations with a myriad of laws and standards that must be followed. As a medical staff leader, advisor or medical staff professional, you are leading and advising the professionals responsible for practitioner competence and conduct within the organization. Medical staff law has evolved from the lawyer in the office who would return your call in a week, or fax you a letter, to a specialty area where your lawyer is your partner and there to assist in all aspects of medical staff affairs.

We hope you will benefit from and find the following 10 recommendations make your term or role more informed and manageable.

10. Keep Your Governance Documents Up to Date and Reflective of Actual Practice. We don't suggest you must read every page of your governance documents, but you should be sure you know where to look and how to use them. Governance documents include the medical staff bylaws, credentialing manual, hearing plan, rules and regulations, policies and other documents approved by the medical staff and designed to set and guide medical staff processes. Too often we have found the documents will conflict or are missing critical passages. Your medical staff bylaws or medical staff governance committee can be one of the strongest committees in the organization. This is the committee that will annually review the documents and make sure they are internally consistent, reflect actual practice and are relevant to your organization's practice and clinical services. Remember the medical staff bylaws set the overall guiding principles for the medical staff organization. All other governance documents flow from the foundation of the medical staff bylaws and must be consistent with their principles and mission. Undoubtedly, there will be some inconsistencies but look at those inconsistencies as opportunities to re-examine the principles and consider what is best for your organization. All governance documents should be reviewed in the context of the laws and regulations that require these documents. State and federal laws and regulations set out the basic requirements for the contents of the documents, as do many of the accreditation standards. It is far better to review and revise your governance documents regularly, rather than learn they are deficient during an unannounced survey or regulatory proceeding.

9. Use Your Committees Effectively. There are two types of committees: those with authority to act and those that are advisory. The committees with authority are generally the Medical Executive Committee ("MEC")

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and clinical department committees. All other committees are advisory to the MEC. Advisory committees can develop and recommend policies, rules and clinical practices. Authoritative committees approve policies and rules, take disciplinary action and make recommendations to the MEC. The MEC is the final medical staff authority that submits recommendations for final approval to the governing body. Knowing which committees to use and when is key to leadership success.

8. Know the Scope of Your Authority. As a leader, you are an agent of the medical staff and the spokesperson for the committee/department you chair. There are times when you will need to act without the benefit of input from your committee/department. Medical staff bylaws will generally identify the circumstances under which you can act alone and when your action(s) will need to be ratified by the committee. As the chair, you are acting on behalf of the committee/department between meetings. Do what is needed when needed, within the scope of your authority, but report your actions to the committee/department on a regular basis and be sure your actions are properly recorded in the appropriate minutes. If summary or urgent action is needed, do not hesitate to call a special meeting. You are better off to have the protection of a committee action than to be acting alone or without ratification.

7. Know the Peer Review Protections of HCQIA, Your State and Organization. Many, if not most, of your actions and the actions of your committees will be covered by federal, state and organizational protections. The Healthcare Quality Improvement Act ("HCQIA") provides protection from liability for members of a professional review body/medical staff, who take a professional review action (a) in the reasonable belief the action was in furtherance of quality health care, (b) after a reasonable effort to obtain the facts, (c) after adequate notice and hearing and (d) in the reasonable belief that the action was warranted by the facts. In addition to this federal protection, many states have laws that similarly protect peer review participants, and often, your organization will have an indemnification policy or provision that further protects you and your committee members from damages. Remind your committee participants and members on a regular basis of these protections and that they were specifically designed to encourage peer review by allowing free discussions aimed at improving patient care.

6. Know Your Reporting Obligations. The National Practitioner Data Bank ("NPDB") defines the circumstances under which a physician or dentist must be reported. Those include (a) when a professional review action adversely affects their clinical privileges for 30 days or longer or (b) when a physician surrenders clinical privileges while under investigation or in exchange for not conducting an investigation. The failure to report when required to do so can result in the loss of immunities under HCQIA for up to three years, along with a monetary fine. There are many nuances to reporting to the NPDB and we recommend you consult a medical staff attorney who can assist with identifying when to report and what to say. Additionally, each state may have reporting requirements for professional review actions to the state licensing board that exceed the NPDB's requirements. The state licensing board may also have defined penalties for failure to report. In one state, the knowing failure of a physician leader to report a practitioner to the state licensing board can be considered unprofessional conduct, which can subject the physician leader to state board action.

5. Understand Confidentiality and Peer Review Privilege Protections. A best practice at the beginning of each meeting is to remind committee members of the importance of maintaining confidentiality. State peer review privileges and protections are often dependent on maintaining confidentiality of the records and proceedings. The failure to maintain confidentiality can act as a waiver of the privilege and permit the introduction of confidential peer review documents and testimony in litigation in the future. Peer review privileges and protections are designed to promote candor in the peer review process. This permits free discussion and identification of opportunities to improve

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patient care. Without confidentiality and the corresponding privileges and protections, committee members would be reluctant to analyze and frankly discuss areas for improvement in a peer's clinical care. Obtain information about your state's peer review privilege and protections and fully understand the circumstances that may cause a waiver, which would permit confidential peer review information to be discussed in open court and stifle important, free-flowing discussion of quality of care at peer review meetings.

4. Know Your Options. Every professional competence or conduct situation you face will be different. A sound guideline to generally follow is selecting the least restrictive action that will protect patients. Keep in mind that the goal of all peer review is education and remediation. For example, if a practitioner is having complications with robotic surgery, evaluate whether the complications are the result of technical skill, which can be remediated with more practice, or if the complications are the result of poor clinical judgment, which reaches into all areas of performance. In the first case, proctoring, monitoring or an additional educational course may correct the problem. But with the second, the cause of poor judgment is more challenging and may require a further work-up, including a fitness for duty evaluation, retrospective review of cases, or an external expert review. Work with your committee and medical staff lawyer to identify all the facts and options to address the problem that has been brought to your attention. In some cases, it may be appropriate to have the issue addressed by the individual's department or interdisciplinary peer review committee, but in others, the nature of the problem may require the immediate attention of the MEC. In some cases, a discrete referral to your organization's well-being committee may be appropriate. Regardless, each matter must be carefully and thoughtfully analyzed in light of all the available facts. Then, with all appropriate actions on the table, an informed determination may be made.

3. Act When Indicated but Don't Shortcut the Process. The law and your medical staff bylaws provide for the ability to take emergency action against a practitioner's privileges when there is a concern of imminent threat to patients or others. What constitutes an "imminent" threat or danger is often the source of hours of discussion and analysis by medical staff lawyers throughout the country. Your legal team is invaluable in working through the facts of a given matter and determining whether a decision for summary suspension is legally sound. If there is a circumstance where emergency intervention via summary suspension is necessary to avoid patient harm after an initial evaluation of the matter, do not hesitate! Take the action to summarily suspend and remove an errant practitioner from the bedside. Afterward, there is time to re-examine the basis for the action and analyze whether continued suspension is necessary to protect patients or others. At that time, it is important to call on your MEC and legal team for their analysis and determination of whether the summary suspension should be upheld.

There are also times when summary suspension will be considered prospectively to address a chronic problem that is rising to an acute stage. The practitioner whose disruptive, bullying and retaliatory conduct has been tolerated may have reached a level where the cumulative effect creates the potential for patient harm because staff, for example, are afraid to call the physician at night about a patient's health condition, seek clarification of an order, or question whether a procedure is being done on the right side or on the correct patient. Following the medical staff bylaws investigation process will allow for a careful analysis of the reported conduct, which will provide a solid framework for later defense, should it be necessary. That process will almost always involve a committee evaluation of the facts, interview of the practitioner, and a determination of the appropriate next steps. Each of these steps, if followed, will support the action when later scrutinized by a court or jury.

2. Do What is Right for the Patients. Always put the patients first. There may be procedural missteps during a disciplinary process as the healthcare organization balances the need to protect patients with providing a practitioner due process. However, if the peer review being conducted is based in the foundation of improving patient care and patient safety, courts will generally consider the health care organization's goals before making a determination that would go against the organization and potentially place patients in harm's way.

1. Utilize Internal or External Counsel to Navigate Medical Staff Law so You Can Focus on Improving Patient Care. I (Erin) was asked recently what possible motivation there would be for a physician to enter leadership in a medical staff organization if their role consisted solely of consulting with a medical staff lawyer. In response, I reminded this physician that medical staff leadership and medical staff lawyers work together on challenging matters and daily operations with the lawyer recommending limitations and guardrails and advising on how to avoid legal missteps and pitfalls. This advice from the lawyer enables the leader to focus on monitoring the business of the organization and improving patient care.

Final Take-Aways

Our medical staff organizations need people who are willing to serve as leaders during challenging times when caregivers are stretched thin, suffering burnout and subjected to daily difficulties that can be demoralizing. Strong leaders who are reassured of their legal protections can perform their leadership responsibilities without fear of reprisal when following the advice of their legal counsel. We encourage you to reach out and make your lawyer an integral part of your team so that they can understand your organization and business and provide you the best available advice that will reassure you and other leaders in the organization of the legal protections and immunities.

Case Update: EEOC Challenges Yale New Haven's "Late Career Practitioner Policy" in Discrimination Suit

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The United States Equal Employment Opportunity Commission (the "EEOC") sued Yale New Haven Hospital ("Yale Hospital" or the "Hospital") on February 11, 2020, alleging the Hospital is in violation of the Age Discrimination in Employment Act ("ADEA"), 29 U.S.C. § 621 et. seq., the Americans with Disabilities Act ("ADA"), 42 U.S.C. §12101, et. seq., and Title I of the Civil Rights Act of 1991, 42 U.S.C. §1981a, by adopting and implementing a "Late Career Practitioner Policy" ("Policy") in 2016.[1] In a previous article, we examined the nature of the age-based screening policies, the Hospital's Policy and the underlying law at issue in this case. This article provides an update as the litigation progresses through the District Court.

Brief Background on the Hospital Policy

Yale Hospital developed a multistep-step assessment process for all clinicians aged 70 and older who apply for, or seek to renew, medical staff privileges at the hospital. The first step in this assessment is a screening with multiple tests to evaluate cognitive ability by a neuropsychologist.[2] According to the Hospital, "the cognitive screening battery of tests was developed and designed to balance brevity with broad coverage of abilities relevant to clinical practice. The instrument was constructed to account for the cognitive decline and neurodegeneration commonly associated with aging."[3] The final step in the Hospital assessment process is a review of the cognitive test results by the Hospital's Medical Staff Review Committee (the "Committee"), which provides its recommendations to the medical staff credentialing panel.[4]

Legal Considerations for Age-Based Policies

It is estimated that only 5 to 10 percent of U.S. hospitals mandate screening of late career physicians.[5] Some hospitals assert that these late career screening policies are necessary to abate concerns for litigation risk. The federal government and many states have enacted some form of prohibition against age discrimination in employment.[6] Senior or late-career physicians negatively affected by age-based policies could potentially sue health care facilities based on claims under Title VII, the ADEA, and the ADA or similar state laws. Legal challenges to late career screening policies have seen mixed results. While courts have held some hospitals liable under Title VII,[7] the ADEA[8] and the ADA,[9] many hospitals have successfully defended ADEA claims by demonstrating that the age-based testing program is reasonably necessary for public safety. The Supreme Court of the United States explained: "The ADEA is not an unqualified prohibition on the use of age in employment decisions, but affords the employer a 'bona fide occupational qualification' defense."[10] Specifically, the ADEA provides that it is not a violation of the Act to take an action based on age when "age is a bona fide occupational qualification reasonably necessary to the normal operation of the particular business, or where the differentiation is based on reasonable factors other than age."[11] But this defense "has only 'limited scope and application' and 'must be construed narrowly.'"[12]

The EEOC's Claims against Yale Hospital's Policy

The EEOC contends that the additional medical examinations required by Yale Hospital's Policy are solely due to the provider's age with no particularized suspicion that the provider's eyesight

1 *EEOC v. Yale New Haven Hospital Inc.,* D. Conn., No. 3:20-cv-00187.
2 Leo Cooney, M.D., Thomas Balcezak, M.D., et al. *Cognitive Testing of Older Clinicians Prior to Recredentialing,* Journal of the American Medical Association, January 14, 2020, https://jamanetwork.com/journals/jama/article-abstract/2758602
3 *Id.*
4 *Id.*
5 *See* Stanford Health Care, Stanford Hospital and Clinics Late Career Practitioner Policy, available at https://stanford-healthcare.org/content/dam/SHC/health-care-professionals/medical-staff/medstaff-update/late-career-practitioner-policy/docs/late-career-practi-tioner-policy-8-12.pdf; Ann Weinacker, *Medical Staff: MedStaff Update: Stanford to Implement a Late Career Practitioner Policy,* Stan. Health Care, 2012, available at https://stanfordhealthcare.org/health-care-professionals/medical-staff/medstaff-update/2012-august/stanford-to-implement-a-late-career-practitioner-policy.html.
6 Employment Discrimination Coordinator Analysis Of State Law § 1:14 (Sept. ed. 2018). 1-6, (2012).
7 Michael R. Lowe, *Stirring Muddled Waters: Are Physicians with Hospital Medical Staff Privileges Considered Employees under Title VII or the ADA Act When Alleging an Employment Discrimination Claim?*, 1 DePaul J. Health Care L. 119, 121 (1996), https://via.library.depaul.edu/cgi/viewcontent.cgi?article=1295&context=jhcl.
8 *See* California Public Protection And Physical Health, Inc., Assessing Late Career Practitioners: Policies And Procedures For Age-Based Screening, at 14, (2014), available at https://www.cppph.org/wp-content/uploads/2015/07/assessing-late-career-practitioners-adopted-by-cppph-chang-es-6-10-151.pdf.
9 *Id.*
10 *Hazen Paper Co. v. Biggins,* 507 U.S. 604, 616 (1993) (citing 29 U.S.C. § 623(f)(1) (2012).
11 29 U.S.C. § 623(f)(1) (2012).
12 *E.E.O.C. v. Exxon Mobil Corp.,* 560 F. App'x 282, 284 (5th Cir. 2014) (quoting *W. Air Lines, Inc. v. Criswell,* 472 U.S. 400, 412 (1985)).

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or neuropsychological ability may have declined.[13] The EEOC believes the Policy violates the ADEA because it "subjects employees to the stigma of being singled out due to their age," which ultimately has the "effect of depriving medical providers age 70 and older from equal employment opportunities."[14] The EEOC also alleges that the ophthalmologic and neuropsychological exams are medical examinations that violate the ADA's prohibition against subjecting employees to medical examinations that are not job-related and consistent with business necessity.[15] Lastly, the EEOC claims that the medical examination interferes with the clinician's right to enjoy their employment free from unlawful medical examinations.[16]

The EEOC is seeking a permanent injunction enjoining the Hospital from engaging in any employment practice that discriminates based on age, an injunction against the Hospital's Policy, instatement, reinstatement, front pay, back wages, liquidated damages, punitive damages and costs.

Status of the Litigation

On June 29, 2021, the District Court ruled that the Hospital was required to turn over the Hospital's peer review and credentials files for 115 practitioners to the EEOC. While the District Court acknowledged state law granting privileged status to documents concerning medical peer review, it ultimately sided with the EEOC, finding that no federal privilege protected the documents the Hospital sought to withhold from disclosure to the government agency. In addition to the peer review and credentials files, the Hospital was also required to produce the underlying neuropsychological exams and the test administrator's notes on the exams.

On March 3, 2022, the EEOC filed a motion for partial summary judgment on a single dispositive issue for its ADA claim. Specifically, the EEOC asserted that the Hospital "admitted the elements of the EEOC's prima facie claim, and so the only outstanding issue [as to this claim] is whether the examinations under the Hospital's policy are 'job-related and consistent with business necessity.'"[17]

On March 18, 2022, the Hospital submitted its memorandum in opposition of the EEOC's motion for partial summary judgment. The Hospital objected to the filing of an early summary judgment motion, stating that such a motion would be prejudicial at this stage in the case. The Hospital argued that ongoing discovery is relevant to the basis of the EEOC's motion; specifically, the EEOC has yet to respond to the Hospital's requests for "documents and information related to any independent examination and/or assessment of an Affected Individual's cognitive abilities, after the Affected Individual underwent neuropsychological testing pursuant to the LCP Policy."[18] Additionally, the Hospital argued that expert discovery will be ongoing through mid-summer of 2022, at a minimum, and that such discovery is "expected to be a critical element to [the Hospital] establishing its defenses," and that at least one expert report "will focus directly on the testing process which is the subject of the EEOC's challenge under the ADA."[19]

On April 29, 2022, the District Court denied the EEOC's motion for partial summary judgment. In its order, the District Court sided with the Hospital, stating that because discovery in this matter has not yet closed and the Hospital had demonstrated that it continues to develop evidence that is relevant to its business necessity defense, permitting such a motion at this stage would be prejudicial to the Hospital.

Conclusion

Late career practitioner policies are open to challenges throughout the country. We will continue to provide updates as this case develops.

As a groundbreaking case, the Yale Hospital litigation will be instructive on many key issues and protections under Title VII, the ADEA and the ADA.

13 *See EEOC, supra* note 1 at 7.
14 *Id.*
15 *Id.*
16 *Id.*
17 *See EEOC, supra* note 1.
18 *Id.*
19 *Id.*

The Corporate Practice of Medicine in the Wake of *Dobbs*

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In *Dobbs v. Jackson Women's Health,* 142 S.Ct 2228 (2022) the Supreme Court of the United States held there was no federal constitutional right to abortion and returned the matter to the states to regulate individually. Since the Court's decision on June 24, 2022, a variety of state laws have taken effect that ban abortions with limited exceptions. The resulting patchwork of laws between—and even within—states has generated many questions as physicians and their attorneys struggle to understand what conduct violates such laws.

Texas, for example, has multiple laws that ban abortions. Two of these laws were passed in 2021 and another set of laws was passed nearly 100 years prior in 1925. Whether and how the 100-year-old laws will be enforced is currently being litigated. However, there are already companion civil and criminal statutes in effect that ban virtually all abortions. The Texas Heartbeat Act is a civil law that allows private citizens to sue anyone suspected of providing an illegal abortion.[1] This law effectively halted abortions in the state of Texas upon its passage and subsequent de facto sanctioning by the Supreme Court of the United States in a pre-*Dobbs* ruling.[2]

For medical staff members, the most consequential abortion ban in Texas is the Human Life Protection Act of 2021. This criminal law mandates up to life in prison for anyone performing an abortion with the only exception to save the life of the mother.[3] Given the severe penalties for violating the law, attorneys have been careful to advise clients on the ramifications of terminating a pregnancy before a complication rises to the level of a life-threatening matter. The Human Life Protection Act has disrupted maternal care in the state of Texas as it compels medical staff members to consider their own life in prison before acting to save the life of a pregnant patient.

Such an intolerable scenario has led some to question the independence of physician's medical judgment in making life-saving decisions in exam rooms. On August 4, 2022, Texas State Senator Bryan Hughes (R) wrote to the Texas Medical Board expressing concerns over perceived violations of the state's Corporate Practice of Medicine. Senator Hughes cited "allegations that hospitals, their administrators or even their attorneys may be wrongfully prohibiting or seriously delaying physicians from providing medically appropriate and possibly lifesaving services to patients who have various pregnancy complications." Senator Hughes demanded that any deviation from protecting the life of the mother and major bodily function "be investigated as potential malpractice and a non-physician (including hospitals) instructing a physician to act should be investigated as a prohibition on the corporate practice of medicine." Senator Hughes authored the Human Life Protection Act of 2021.[4]

The Corporate Practice of Medicine

Texas is one of several states with a Corporate Practice of Medicine doctrine ("CPOM Doctrine") which generally prohibits corporations from practicing medicine.[5] Some entities are excepted from the CPOM Doctrine, such as nonprofit community hospitals, critical access hospitals and rural health clinics.[6]

Violating the Texas CPOM Doctrine is punishable by an administrative penalty on the Texas corporation of $5,000.00 for each violation.[7] Each day a violation continues or occurs is a separate violation for purposes of imposing a penalty.[8] As such, a determination that a Texas corporation violated the CPOM Doctrine through medical decision-making, each day for one year could result in a fine up to $1,825,500.00. Should the judgment become final, a court may require the penalty be paid, interest will be accrued, in addition to court costs, reasonable attorneys' fees, investigative costs, witness fees and deposition expenses.[9] A person who "practices medicine" in Texas in violation of the CPOM Doctrine is also subject to a criminal third-degree felony charge.[10] This carries a penalty of two to ten years in prison.[11]

Medical Emergencies

In the wake of the Supreme Court's decision in *Dobbs*, confusion over what constitutes a "medical emergency" under the Human Life Protection Act and the difficult risk

1 Tex. Health & Safety Code § 171.201, et.seq.
2 *Whole Women's Health v. Jackson*, 142 S.Ct. 522 (2021).
3 Tex. Health & Safety Code § 170A.001, et.seq.
4 Patrick Svitek, The Texas GOP lawmaker behind the abortion ban, voting restrictions bill and more, (Sept. 17, 2021), https://www.texastribune.org/2021/09/17/texas-abortion-ban-voting-bryan-hughes/
5 22 Tex. Admin. Code §177.17; e.g., California, Ohio, Illinois, New Jersey and New York.
6 22 Tex. Admin. Code § 177.17.
7 Tex. Occ. Code §164.001; Tex. Occ. Code §165.003.
8 *Id.* at Tex. Occ. Code §165.003(a).
9 Tex. Occ. Code § 165.008(b); Tex. Occ. Code § 165.103(a).
10 Tex. Occ. Code § 165.1.
11 Tex. Penal Code § 12.34.

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analysis that must be made has stymied maternal care. According to Senator Hughes' letter, examples of the corporate practice of medicine include "a hospital [that] instructed a physician to turn away a pregnant mother diagnosed with an ectopic pregnancy until it ruptured" and "the interference by at least two hospitals of care for premature ruptures of membranes and forcing these patients to return home to miscarry without proper pain management or care being provided at the hospital."

Even while "medical emergency" is defined in Texas law, uncertainty abounds as to what it means to be "a life-threatening physical condition aggravated by, caused by, or arising from a pregnancy that, as certified by a physician, places the woman in danger of death or a serious risk of substantial impairment of a major bodily function unless an abortion is performed."[12]

Senator Hughes included in his letter a list of pregnancy complications, which he described as "non-exhaustive," that could rise to the level of a medical emergency. Physicians and their attorneys, however, would be ill-advised to rely on Senator Hughes' letter as he is not a physician and his letter would likely have no evidentiary value in a criminal trial.[13]

Medical staff members and their attorneys are understandably concerned. The haste with which these laws took effect—some almost immediately upon the decision in *Dobbs*—has prevented any court from interpreting them and offering clarity. This lack of certainty coupled with the severe penalties for making the wrong choice has caused attorneys to counsel physicians and hospitals to proceed with caution. As physicians have understandably looked to administrators and attorneys for guidance in response to the *Dobbs* implications, Senator Hughes's recent letter raises an additional concern for physicians and hospitals in states with a prohibition on the corporate practice of medicine. Unless and until further guidance is offered, legislators can add themselves to the long list of individuals working to understand these laws and their implications.

12 Tex. Health & Safety Code § 171.002(3).
13 *See* Tex. Penal Code 8.03 containing descriptions of official statements where reliance could support an affirmative defense to prosecution.

Supreme Court of Texas Overturns $6 Million Jury Verdict in *Gomez v. Memorial*

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On April 22, 2022, the Supreme Court of Texas issued an opinion reversing the judgment of the court of appeals, finding instead in favor of Memorial Hermann Hospital System and eliminating a $6.3 million dollar judgment in favor of the doctor.[1] In 2017, a judge in the 333rd District Court of Harris County, Texas, based on a jury verdict, awarded a doctor $6.3 million dollars against a hospital at which the doctor formerly held privileges, in *Miguel A. Gomez, III, M.D. and Miguel A. Gomez, M.D., P.A. v. Memorial Hermann Hospital System, et al.,* Cause No. 2012-53962 (hereinafter the "Gomez Case"). The doctor was awarded damages on his claims of defamation and business disparagement at trial. On August 15, 2019, the Court of Appeals First District ("Court of Appeals") affirmed the judgment of the trial court. In its reversal of the Court of Appeals' decision and elimination of the trial court damages, the Texas Supreme Court rendered a take-nothing judgment in favor of Memorial Hermann Hospital System.

Dr. Miguel A. Gomez ("Dr. Gomez") is a cardio-thoracic surgeon. Dr. Gomez previously held clinical privileges and medical staff membership at Memorial City Hospital (the "Hospital"), which is owned and operated by Memorial Hermann Hospital System ("Memorial"). Dr. Gomez claimed that in 2009, Hospital representatives joined in a scheme to destroy Dr. Gomez's reputation and ability to practice medicine in the West Houston and Katy community when they learned Dr. Gomez intended to split his practice between the Hospital and Methodist West, a competitor. A representative of the Hospital created a statistical model of individual cardiovascular surgeon mortality rates, which allegedly showed that Dr. Gomez had a higher than average mortality rate. The individual surgeon mortality rate data was presented at a meeting of cardiovascular surgeons. Dr. Gomez alleged that the individual surgeon mortality rate data was flawed and misleading and was intended to damage his reputation.

At trial, Dr. Gomez presented two statements to the jury that formed the basis of his claims for business disparagement and defamation.

First, Dr. Gomez testified that after the meeting of a subcommittee of the Clinical Programs Committee concluded, he approached Byron Auzenne ("Auzenne"), the Hospital's Heart Service Line Leader and asked him why the statistical data was being presented. Dr. Gomez testified that Auzenne stated that, "he had spoken to CEO Keith Alexander and they had discussed it and they felt that the data needed to be shared, that we needed to be a transparent organization, that this was a safety issue."

Memorial argued on appeal that the Auzenne statement was not published to a third party, as required by Texas law, because it was made only to Dr. Gomez. The Court of Appeals held that Dr. Gomez's defamation complaint was based around the use and publication of the data itself, not Auzenne's statement to Dr. Gomez. The Court of Appeals determined the jury was entitled read the jury charge in a manner that would allow them to analyze whether the publication of the data itself was defamatory. The Supreme Court of Texas, however, determined that the jury charge should be interpreted according to its plain, commonsense meaning, and thus the question to the jury could only be read to ask whether the Auzenne statement to Dr. Gomez, rather than the data itself, was published to a third party. The Texas Supreme

1 *See* 65 Tex. Sup. Ct. J. 799.

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Court held that because the Auzenne statement was only made to Dr. Gomez, the statement was not published, and any claims of defamation/business disparagement concerning such statement fail.

Second, Dr. Gomez alleged that a statement made by Jennifer Todd ("Todd"), a physician liaison for the Hospital, to Cyndi Peña ("Ms. Peña"), formerly a physician liaison for Methodist West, impaired his practice at Methodist West. At trial, Ms. Peña testified that Ms. Todd reached out to her because Ms. Todd heard that Dr. Gomez was going to practice at Methodist West. Ms. Peña testified that Todd told her to "[b]e careful," because "there's things being said here, and they're pertaining to the bad quality, mortality rate."

Memorial argued on appeal that Dr. Gomez failed to prove that the statement made by Ms. Todd to Ms. Peña caused any harm to Dr. Gomez because Ms. Peña testified that Ms. Todd's statement did not affect her esteem of Dr. Gomez, as she later hired Dr. Gomez at Methodist. Memorial argued that while the case was tried on the theory that Dr. Gomez's cardiovascular surgeries declined, and this decline was solely caused by a whisper campaign by the Hospital, Dr. Gomez never actually connected his lower surgical numbers to any particular instance of defamation. The Court of Appeals denied Memorial's argument and held that Dr. Gomez presented sufficient evidence of both the damages that the statement by Ms. Todd caused to his reputation (i.e., his decreased number of cases at Methodist West) and the mental anguish he suffered as a result.

The Supreme Court of Texas held that the evidence presented at trial did not establish that Ms. Todd's statement to Ms. Peña caused any reputational harm to Dr. Gomez because (a) Ms. Peña testified that Todd's statement did not cause her to change her opinion of Dr. Gomez and (b) Methodist West still hired Dr. Gomez. The Supreme Court of Texas rejected Dr. Gomez's argument that his decreased surgery count at Methodist West was evidence of reputation harm because nothing in the record connected Ms. Peña to any of Dr. Gomez's referring physicians. Thus, the Supreme Court of Texas found that there was no evidence that Ms. Todd's statement caused Dr. Gomez any loss of referrals or business.

Finding that the Auzenne statement was not published, and the Ms. Todd statement did not cause any damages to Dr. Gomez, the Supreme Court of Texas reversed the judgment of the Court of Appeals and rendered judgment in favor of Memorial.

Criminalizing Medical Errors: What Are Hospitals and Providers to Do?

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Medical errors are common. The health care community relies on proper and timely reporting of medical errors for the benefit of patient safety and building learning cultures within hospitals, medical groups, pharmacies and other health care organizations. Recent cases have placed a spotlight on criminalizing medical errors and have raised alarm among the medical community. The lack of a bright line between unintentional medical errors and intentional acts leaves hospitals and providers uncertain of when medical errors may lead to criminal prosecutions. Yet, these cases also highlight the importance of strong peer review processes, safety systems, and privilege and confidentiality protections for peer review of all providers.

A Trend Sending Shockwaves Throughout the Health Care Community

Examples of criminalizing medical errors include the cases of Dr. Geoffrey Kim, who is currently awaiting trial for the death of a teen undergoing plastic surgery, and former nurse RaDonda Vaught, who was recently convicted of criminally negligent homicide in the death of a patient due to a fatal medication error.

In the case of Dr. Kim, an eighteen-year-old patient went to his plastic surgery center in Colorado for breast augmentation surgery in August 2019.[1] The teen went into cardiac arrest when she was left unattended during the anesthesia phase of the procedure. Dr. Kim admitted to investigators that he did not call 911 for at least five hours after the teen went into cardiac arrest.[2] The patient was eventually transported to a local hospital nearly six hours after going into cardiac arrest.[3] The patient never regained consciousness and died fourteen months later.[4] Dr. Kim was formally charged[5] and a jury trial is scheduled to begin on October 25, 2022.

In December 2017, former nurse, RaDonda Vaught, administered the wrong medication to a 75-year-old patient at a Tennessee hospital.[6] The patient was claustrophobic and fearful of being in an enclosed space for a physician-ordered PET scan, so the physician prescribed a strong sedative.[7] Instead of retrieving the sedative, Ms. Vaught mistakenly selected and administered a powerful muscle relaxant that left the patient unable to breathe.[8] Unfortunately, the patient died shortly after the injection.[9] Ms. Vaught reportedly discussed her mistake with her supervisors immediately upon realizing what had occurred.[10] In February 2019, Ms. Vaught was arrested and charged with negligent homicide and abuse of an impaired adult. After trial in March 2022, a

1 Marjorie Hernandez, *Colorado Plastic Surgeon Faces Manslaughter Charges For the Death of 18-year old,* New York Post (Feb. 18, 2022, 12:30 AM), https://nypost.com/2022/02/18/colorado-plastic-surgeon-geoffrey-kim-faces-manslaughter-charges-for-death-of-18-year-old-emmalyn-nguyen/.
2 *Id.*
3 *Id.*
4 *Id.*
5 The criminal complaint is protected and unavailable to the public. However, the court docket lists the case type as homicide, yet the specific charges are unknown.
6 Mariah Timms, *Prosecutors, defense lay out framework in homicide trial of ex-Vanderbilt nurse RaDonda Vaught*, The Tennessean, (Mar. 22, 2022 2:39 PM), https://www.tennessean.com/story/news/crime/2022/03/22/radonda-vaught-ex-vanderbilt-nurse-homicide-trial-opening-statements/7078764001/; *Former Tennessee nurse RaDonda Vaught found guilty in woman's death after accidently injecting her with the wrong drug*, CBS News, (Mar. 29, 2022, 7:57 AM), https://www.cbsnews.com/news/radonda-vaught-nurse-guilty-death-charlene-murphey-wrong-drug/.
7 *Id.*
8 Timms, *surpa* note 13.
9 Brett Kelman, *The RaDonda Vaught trial has ended. This timeline will help with the confusing case*, The Tennessean, (Mar. 27, 2022, 2:57 PM), https://www.tennessean.com/story/news/health/2020/03/03/vanderbilt-nurse-radonda-vaught-arrested-reckless-homicide-vecuronium-error/4826562002/; Mariah Timms, *'Zero regrets about telling the truth': Ex-nurse RaDonda Vaught speaks out ahead of guilty verdict*, The Tennessean, (Mar. 25, 2022, 1:15 PM), https://www.tennessean.com/story/news/crime/2022/03/25/radonda-vaught-speaks-out-jury-verdict-homicide-trial/7167520001/.
10 *Id.*

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jury found her guilty of the lesser charge of criminally negligent homicide.[11] She initially faced up to eight years in prison but was ultimately sentenced to three years of supervised probation.[12]

The Health Care Community's Collective Response to Criminalizing Errors

Organizations including the American Nurse Association ("ANA"), Texas Nurses Association ("TNA"), the New York chapter of the ANA, the American Hospital Association ("AHA"), the American Organization for Nursing Leadership ("AONL") and the American Association of Critical-Care Nurses ("AACN") issued statements after Ms. Vaught's conviction. Below are brief summaries of their concerns and proposed alternative processes when errors occur.

- The ANA believes there are more effective ways of handling unintentional medical errors. In the ANA's press release, it stated, "we are deeply distressed by this verdict and the harmful ramifications of criminalizing the honest reporting of mistakes."[13] The ANA went on to state that "the criminalization of medical errors is unnerving, and this verdict sets into motion a dangerous precedent. There are more effective and just mechanisms to examine errors, establish system improvements and take corrective action. The non-intentional acts of individual nurses like RaDonda Vaught should not be criminalized to ensure patient safety."[14]
- The TNA strongly agreed with the ANA and further stated, "[the TNA] encourages Texas health care organizations to create safe patient care environments where honest mistakes can be reported, addressed and corrected systematically, rather than forcing nurses and other health care professionals to hide problems for fear of criminal prosecution."[15]
- The ANA-New York issued an additional statement recommending administrative remedies rather than criminal proceedings for unintentional medical errors. The ANA-New York stated "the conviction of [Ms. Vaught] for a tragic medication error will make all providers worry that reporting errors could move professional disciplinary procedures beyond the administrative/civil system to criminal proceedings. The culture of safety in health care rightfully puts patient safety first and mandates that all errors be reported. Best practices require that the entire process leading to the error undergo an investigation to make sure all gaps in safe process are corrected . . . To protect patient safety and create accountability, all stakeholders must be honest and forthright throughout the process. The handling of this case raises troubling questions about every aspect of the investigation, response and outcome."[16]
- In a joint statement, the AHA and AONL stated that Ms. Vaught's conviction would have a chilling effect on the culture of safety in health care.[17] Quoting such statement, "the Institute of Medicine's landmark report *To Err Is Human*[18] concluded that we cannot punish our way to safer medical practices. We must instead encourage nurses and physicians to report errors so we can identify strategies to make sure they don't happen again. Criminal prosecutions for unintentional acts are the wrong approach. They discourage health caregivers from coming forward with their mistakes and will complicate efforts to retain and recruit more people in to nursing and other health care professions that are already understaffed and strained by years of caring for patients during the pandemic."[19]
- Lastly, the AACN cited *To Err Is Human*[20] to show that criminalizing medical errors only decreases patient safety due to less reporting. The AACN stated: "Decades of safety research, including the Institute of Medicine's pioneering report *To Err Is Human*,[21] has demonstrated that a punitive approach to health care errors drives problems into the shadows and decreases patient safety. In addition, catastrophic errors are often the result of many factors, and the ability to safely report errors allows for root cause analysis and correction of systemic problems. Vaught immediately reported her error to her supervisors and took responsibility for her actions. This criminal prosecution and verdict will negatively impact the timely and honest reporting of errors. In addition, this case has further demoralized an already exhausted and overworked nursing workforce in the face of existing nurse staffing shortages."[22]

11 *Id.*
12 Mackenzie Bean, *'I will never be the same': RaDonda Vaught speaks out after sentencing,* Beckers Hospital Review (May 23, 2022), https://www.beckershospitalreview.com/nursing/i-will-never-be-the-same-radonda-vaught-speaks-out-after-sentencing.html#:~:text=RaDonda%20Vaught%20spoke%20out%20about,of%20supervised%20probation%20May%2013.
13 *Statement in Response to the Conviction of Nurse RaDonda Vaught*, (Mar. 25, 2022), https://www.nursingworld.org/news/news-releases/2022-news-releases/statement-in-response-to-the-conviction-of-nurse-radonda-vaught/
14 *Id.*
15 Gabi Nintunze, *Press Release: Texas Nurses Association Echoes American Nurses Association Cautionary Statement*, (Mar. 28, 2022), https://www.texasnurses.org/news/600466/Press-Release-Texas-Nurses-Association-Echoes-American-Nurses-Association-Cautionary-Statement.htm.
16 *ANA-NY Statement in response to the Conviction of Nurse RaDonda Vaught*, (Mar. 31, 2022), https://ananewyork.nursingnetwork.com/nursing-news/188747-ana-ny-statement-in-response-to-the-conviction-of-nurse-radonda-vaught.
17 *Statement in Response to the Conviction of Nurse RaDonda Vaught*, (Mar. 28, 2022), https://www.aonl.org/press-releases/Statement-in-Response-to-the-Conviction-of-Nurse-RaDonda-Vaught.
18 Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson, *To Err is Human: Building a Safer Health System*, Washington (DC): National Academies Press (US), 2000, https://www.ncbi.nlm.nih.gov/books/NBK225182/
19 *Statement in Response to the Conviction of Nurse RaDonda Vaught*, *supra* note 17.
20 Kohn, *supra*, note 18.
21 *Id.*
22 *AACN's Statement on the Conviction of RaDonda Vaught*, https://www.aacn.org/newsroom/aacns-statement-on-the-conviction-of-radonda-vaught.

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Collectively, health care organizations believe criminal prosecution for unintentional acts is the wrong approach. The trend demonstrated in these recent cases moves beyond administrative disciplinary processes, such as peer review, to criminal prosecution of nurses, physicians, pharmacists and other allied health professionals. Health care organizations are concerned that criminalizing unintentional medical errors may prevent health care professionals from being transparent and honest when errors occur. As a result, timely reporting, transparency and patient safety may be compromised because health care professionals fear criminal prosecution for inadvertent mistakes.

Closing Considerations

Criminalizing medical errors leaves hospitals and providers uncertain and fearful of criminal prosecution. The issue is further complicated by inconsistent state peer review privilege and immunity protections, particularly as related to peer review of allied health professionals and non-physician providers. Hospital and provider fears and uncertainty of criminal prosecution for medical errors is likely to be further exacerbated by new abortion laws in states across the country.

The health care community is not entirely without tools to mitigate potential criminal liability. Hospitals and providers should perform thorough reviews of their protocols to make sure any gaps in safe processes are corrected. Hospitals and providers should also reinforce and encourage self-reporting, which ultimately aids in identifying strategies to correct the issues that lead to medical errors. Several effective tools include strong peer review processes, safety systems and privileged and confidential peer review of all providers. These tools will help to protect patient safety and create accountability.

A Practical Review: Managing Exclusive Contracts in Medical Staff Bylaws

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Many hospitals today use exclusive contracts to engage a single medical group or individual as the exclusive provider of a given hospital-based service. Exclusive contracts can span an entire department of the medical staff (e.g., radiology, pathology), cover a narrow service line within a department (e.g., neurosurgery), or address a function within a service (e.g., specialty call coverage). The legality of exclusive contracts have generally been upheld by courts under the theory that these contracts promote the consistency of available services and contribute to improvements in quality.

Although exclusive contracts primarily fall within the ambit of the hospital's governing body, they significantly implicate the medical staff, particularly with respect to several key provisions of a medical staff's bylaws, including those addressing qualifications for medical staff membership, suspension or termination of medical staff membership or clinical privileges, and the medical staff's responsibility to oversee the quality of patient care and to establish the organized medical staff's structure. This review addresses the relevant Centers for Medicare and Medicaid Services ("CMS") Conditions of Participation ("CoPs") and accreditation organization standards and provides practical best practice tips regarding the ways medical staffs may address exclusive contracts in their bylaws.[1]

Qualifications for Medical Staff Membership

Exclusive contracts first implicate the bylaws provisions regarding qualifications for Medical Staff membership. The CMS CoPs and The Joint Commission ("TJC") and DNV Healthcare accreditation standards all require medical staff bylaws to include the qualifications for appointment to the medical staff.[2] Regardless of whether an individual practitioner or their medical group has executed a contract with the hospital to provide a service on an exclusive basis, individual practitioners must still go through the medical staff's credentialing and privileging process.

If a department or service line operates on a closed basis pursuant to an exclusive contract with particular individuals or groups, then the hospital's governing body could not grant a practitioner clinical privileges in that department or service-line to non-contracted individuals or groups without violating the contract. Conversely, if the qualifications for membership and clinical privileges set forth in the medical staff's bylaws do not account for situations where departments or service-lines operate pursuant to an exclusive contract, then uncertainty could arise as to how to address the application of a non-contracted practitioner and a practitioner could possibly be entitled to a lengthy hearing and appeal process if the hospital denies the applicant's request for appointment.

As such, membership, employment, or subcontracting with the group or person that holds the exclusive contract should be a de facto required qualification that must be met by an applicant for the medical staff to recommend that a candidate be granted clinical privileges by the governing body in that department or service-line. Therefore, to comply with the CoPs, and TJC or DNV accreditation standards, if a hospital has entered into an exclusive contract or operates a closed department or service-line, then the hospital's medical staff bylaws must include as a basic qualification for medical staff membership and the granting of clinical privileges that the applicant be a member, employee, or subcontractor of the group or person that holds the exclusive contract or participates in a closed panel. If not, the applicant will be deemed ineligible.

Automatic Suspension or Termination of Clinical Privileges

Exclusive contracts also implicate bylaws provisions addressing automatic suspension or termination of a practitioner's medical staff membership and/or clinical privileges. By their nature, exclusive contracts limit non-parties (or their sub-contractors) from exercising clinical privileges in the affected department or service-line. Therefore, three scenarios arise where a practitioner's clinical privileges (and possibly membership) should be terminated as a result of an exclusive contract: 1) when the hospital initially closes a department or service-line and enters into an exclusive contract; 2) when a practitioner loses their employment or contract/sub-contract with the group or individual who holds the existing exclusive contract; or 3) when the hospital terminates an existing contract and enters into an exclusive contract with a new group or individual.

TJC requires that the medical staff bylaws include, "indications for automatic suspension of a practitioner's medical staff membership

1 This review does not discuss the legal and administrative challenges associated with developing exclusive contracts or creating closed departments.
2 42 CFR § 482.22(c)(4), TJC, MS.01.01.01, EP 13, DNV-NIAHO, MS.8.

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or clinical privileges."[3] Likewise, DNV standards require the medical staff bylaws to include, "procedures that define the process for automatic and summary suspension of the medical staff as it relates to membership and clinical privileges."[4] The hospital's medical staff bylaws should include provisions permitting the automatic suspension and/or termination of a practitioner's medical staff membership and clinical privileges in these three scenarios. By building such a provision into its bylaws, the medical staff has created an effective mechanism for removing practitioners for a failure to meet this objective criteria—generally without creating an obligation for the medical staff or hospital to report the practitioner to the National Practitioner Data Bank or provide the physician with a long, drawn out hearing and appeal process to challenge the decision. However, medical staffs should familiarize themselves with states laws and consult with legal counsel, as hearing rights and reporting obligations may still apply in certain situations under the common law or state statutes, such as when issues with the practitioner's competency or professionalism formed the basis for the terminating the contract or sub-contact.

Furthermore, as a best practice to address the practical realities of Scenarios 1 and 3 above, the bylaws may include, in addition to the automatic suspension and termination provisions, a grace period to allow a practitioner to become a member, employee, or subcontractor of the newly contracted group before automatically suspending or terminating their clinical privileges or membership.

Oversight of Patient Quality, Treatment, and Services

The last key section of the bylaws implicated by exclusive contracts and closed departments involves the medical staff's responsibilities for overseeing the quality of patient care and the organized medical staff's structure.

The CoPs require the medical staff to be responsible for the quality of medical care provided to patients at the hospital.[5] The DNV standards mirror the requirements of the CoPs,[6] while the TJC standards similarly require that the medical staff oversee, "the quality of patient care, treatment, and services provided by practitioners privileged through the medical staff process."[7] TJC standards additionally impart upon the medical executive committee the responsibility for making recommendations to the governing body regarding the organized medical staff's structure.[8] At the same time, TJC standards require that the governing body retain authority to approve and terminate any contracts for clinical services entered into by the hospital.[9]

Even though the governing body retains ultimate authority over the conduct of the hospital as a whole and holds the responsibility of making the business decisions, the medical staff's responsibility to oversee the quality of care provided at the hospital does not cease when the hospital decides to execute an exclusive contract. The medical staff bylaws should recognize this ongoing obligation and include a bylaws provision requiring the medical staff to be involved in the decisions to close a department, service line, or call panel, and to also provide input into the selection or retention of the group or individual providing the contracted services. The bylaws should also clearly grant the medical staff with oversight of the quality of care, efficiency, and professional performance of the group or individual that holds the exclusive contract, and recognize that the medical staff establishes its own clinical performance standards to which those in the closed department or service-line will be held as members of the medical staff.

Conclusion

While Medicare CoPs, and TJC and DNV standards do not directly require the medical staff bylaws to address exclusive contracts, they do require that the qualifications for medical staff membership, and the indications for automatic suspension or termination of medical staff membership or clinical privileges, be included in the medical staff bylaws. As a result of their nature, if a hospital has an exclusive contract or closed department, then membership, employment, or subcontracting with the group or individual who holds the exclusive contract naturally becomes a qualification for medical staff membership and as such must be included in the medical staff bylaws. By inverse, as soon as a hospital enters into an exclusive contract, the failure of a practitioner to do so must also be included in the bylaws as an indicator for automatic suspension or termination of the practitioner's medical staff membership and clinical privileges.

Finally, provisions must be included in the medical staff bylaws that (i) give the medical staff authority to provide recommendations on the quality and performance standards of the closed department or service-line (though not necessarily the power to approve or disapprove of the exclusive contract itself, which should be reserved to the governing body or administrator), and (ii) ensure the medical staff's responsibility to oversee the quality of patient care, treatment, and services provided by practitioners under the exclusive contract.

By addressing exclusive contracts in the three key areas of the medical staff bylaws discussed above, hospitals and their medical staff establish clear mechanisms for managing medical staff membership and clinical privileges, and overseeing the quality and safety of patient care, in the closed department or service-line, and prevent numerous uncertainties and administrative hurdles that could otherwise be avoided.

3 MS.01.01.01, EP 26.
4 DNV-NIAHO, MS.7, SR.4.
5 42 C.F.R. § 482.22.
6 DNV-NIAHO, MS.1 and MS.3.
7 TJC, MS.03.01.01.
8 TJC, MS.02.01.01, EP 9, and LD.04.03.09, EP 1.
9 TJC, LD.04.03.09, EP 3.

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John Synowicki is a member of the NAMSS Ethics Committee | Erin Muellenberg is the Immediate Past Chair of the Education Committee

About Polsinelli's Medical Staff Practice

Polsinelli's Health Care attorneys guide hospitals and health systems through the medical staff governance process including credentialing, peer review, bylaws and medical staff and governing body relationships. From practitioner credentialing to hearings and appeals, and defense of litigation, our attorneys are versed in the intricacies involved in the life cycle of hospital-medical staff relationships.

Polsinelli has handled almost every type of matter involving medical staff and mid-level practitioners and has advised client on compliance with accreditation standards, hospital licensing laws, peer review laws, and federal laws governing the conduct of medical staff fair hearings. Specifically, we have extensive experience counseling hospitals on medical staff bylaws and related rules, regulations, policies and procedures, and codes of conduct. We have been active helping clients in implementing processes for effectively managing disruptive and inappropriate behaviors and in developing processes for empowering the well-being committee and managing impaired and aging providers.

Our team has experience advising through the credentialing process, advising peer review committees, representing medical executive committees in hearings and appeals, and interfacing with government entities. We also have defended hospitals and surgical centers in lawsuits filed by affected practitioners, during and after peer review.

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