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Medical staff insight, peer review analysis, and updates for health care organizations presented quarterly by the nation's health care law firm of the year[1]

A California Court Finds that Dishonesty and Unethical Conduct is a Basis for Denial of Reappointment

By Erin L. Muellenberg (emuellenberg@polsinelli.com) and Lauryn Anthony Pollard (lpollard@polsinelli.com)

In a recent opinion issued by the California Fourth District Court of Appeal, the court reaffirmed that dishonesty and unethical conduct can affect patient care and therefore is a basis to deny reappointment; the information in this article is derived from the opinion. In *Powell v. Bear Valley Community Hospital*, Dr. Robert Powell obtained provisional membership on the medical staff of Bear Valley Community Hospital ("Bear Valley") in Big Bear Lake, California, roughly 10 years after he had his clinical privileges and membership terminated by Brownwood Regional Medical Center ("Brownwood"), in Texas.

Brownwood terminated Dr. Powell's privileges based on findings that he failed to advise a young boy's parents that he severed the boy's vas deferens during a hernia procedure or of the complications post-surgery. Further, Brownwood found that Dr. Powell falsely represented to the medical staff, on at least two occasions, that he fully disclosed the circumstances to the parents. This behavior, which Brownwood considered to be dishonest and obstructive, prevented providing appropriate follow-up care to the patient. Based on the committee's findings, Brownwood terminated Dr. Powell's staff membership and clinical privileges. In 2001,

[1] Ranked #1 health care practice overall, *AHLA Connections*, June 2018

the Texas Board of Medical Examiners completed an investigation into Dr. Powell but closed the file after stating the evidence didn't indicate a violation of the Texas Medical Practice Act. Following the investigation, Dr. Powell received a letter from the Texas Board of Medical Examiners stating the conclusions he could use to inform other hospitals of the matter's closure.

When Dr. Powell applied for appointment at Bear Valley he was required to attest to whether his privileges had ever been revoked by any facility and provide details. While he replied yes, he did not provide the necessary details to explain his loss of privileges nor the letter from the Texas Board of Medical Examiners. Dr. Powell was granted provisional membership to the medical staff. Bear Valley's Board of Directors ("Board") determined that his application was incomplete based on the fact he had not fully explained his loss of privileges at Brownwood. The Board notified Dr. Powell that his provisional membership had expired, but encouraged him to reapply. Dr. Powell reapplied, submitting additional information regarding his loss of privileges in Texas. After the Board made a decision to deny Dr. Powell's renewed application, he requested a judicial review committee ("JRC") hearing regarding that decision.

The JRC found that the Board's action was reasonable and supported by substantial evidence showing Dr. Powell's dishonesty and deceitfulness based on (1) his repeated failure to produce the letter from the Texas Board of Medical Examiners regarding his earlier loss of privileges, (2) his attempt to mislead Bear Valley by producing a different letter from the Texas Board of Medical Examiners and (3) the misleading information he provided regarding the circumstances that led to his loss of privileges in Texas. The Board affirmed the JRC's findings after Dr. Powell waived his right to an administrative appeal. Then, Dr. Powell filed a petition for writ of administrative mandamus in the Superior Court, which was unsuccessful, followed by an appeal.

The Court of Appeal affirmed the decision of the Superior Court. First, the court affirmed that a physician does not have an absolute right to reappointment. The Court of Appeal affirmed that the failure of an applicant to provide the supporting information necessary for the medical staff to make a recommendation (or the governing body to make a decision) will render the application incomplete and does not transform the expiration of an appointment into a decision to deny or terminate the privileges. Second, the court explained that a lapse in provisional privileges while a physician submits a more complete application is not a reportable event under Business and Professions Code Section 805 and does not trigger the right to a JRC hearing. Thus, the court held that Dr. Powell was not entitled to a hearing relating to his initial provisional staff privileges. Third, the court held that the Board properly exercised independent judgment and after giving great weight to the medical staff's recommendation did not exceed its authority by denying Dr. Powell's reapplication. The continued misrepresentations and inability to produce relevant evidence by Dr. Powell showed a propensity for dishonesty and unethical conduct that could affect patients and their care. Lastly, the court provided additional insight into hospital peer review standards and the scope of duties provided to hearing officers. The court discussed that hearing officers have the power to determine the relevancy of evidence, rule on requests for information, and impose safeguards as necessary to protect the peer review process.

Powell was certified for publication April 16, 2018. To read the opinion visit http://www.courts.ca.gov/opinions/documents/D072616.PDF.

New Jersey Court Holds Hospital's MEC Can be Considered Separate Legal Entity for Suit

By Adam D. Chilton (adam.chilton@polsinelli.com)

A recent federal case from New Jersey, *Nahas v. Shore Medical Center*, 2018 WL 1981474, is making headlines due to its relatively novel ruling that medical executive committees can be considered legal entities separate and apart from the hospitals that they serve, and more importantly, its reliance on the Health Care Quality Improvement Act to support the ruling; the information in this article is derived from the case.

According to court documents, Dr. Nahas maintained privileges at Shore Medical Center ("Hospital") from 1978 to 2003. In 2003, Dr. Nahas was sentenced to one month of imprisonment for obstructing justice in a health care investigation. As a result of this sentence, the Hospital suspended Dr. Nahas' medical staff membership and privileges until December 31, 2005. In 2006, Dr. Nahas applied for reinstatement of his medical staff membership and privileges. The Credentials Committee recommended that Dr. Nahas' membership and privileges not be reinstated, and the Medical Executive Committee ("MEC") and Board of Trustees later accepted the Credentials Committee's recommendation.

After litigation at the state court level, some of Dr. Nahas' privileges were reinstated; however, Dr. Nahas' endovascular privileges were not. In 2013, Dr. Nahas sued the Hospital again, this time in federal court and joined its MEC as a defendant, on the premise that the two entities, along with several allegedly competitive doctors, conspired to deprive Dr. Nahas of his endovascular privileges.

The relevant opinion from the U.S. District Court for the District of New Jersey arises out of a motion for summary judgment filed by the Hospital that its MEC does not exist as a separate legal entity with the capacity to sue or be sued. The district court found the MEC could be sued as an unincorporated association under New Jersey state law.

New Jersey statutory law requires that for an unincorporated association to be sued it must (a) consist of seven or more persons, and (b) have a recognized name. N.J. Stat. Ann. Sec. 2A:64-1. Additionally, "fraternal, charitable or other organization[s]

not organized for pecuniary profit" are not able to be sued as unincorporated associations. N.J. Stat. Ann. 2A:64-6.

The court observed that the case law on whether an unincorporated association could be sued turned on two key factors: (a) whether such association is voluntarily organized for a common purpose, and (b) whether such association is separate and distinct from another entity or its own members. *Nahas* at 6. The court found that it was undisputed that the MEC is an aggregate of persons organized for a common purpose, therefore satisfying the first criteria of an unincorporated association. *Id*.

The majority of the court's analysis focused on the second factor, whether the MEC is separate and distinct from the Hospital. The court largely relied on a New Jersey state court case which held that a hospital's medical staff is a distinct and separate entity from the hospital itself, with the capacity to sue and be sued. *Id* at 7 (citing *Corleto v. Shore Memorial Hospital*, 350 A.2d 534 (Law Div. 1975)). The *Coleto* case relied on precedent from New Jersey state court cases that treated the hospital's relationship with its medical staff, as stated in the medical staff bylaws, one of contract. *Id* at 8. The court then determined because the MEC is a subgroup of the medical staff, the court was required to allow the plaintiff to sue a subgroup of an unincorporated association, which is typically not allowed. *Id* at 9 (noting that the case *Simrin v. Corr. Med. Servs*., 2006 WL 469677 (D.N.J. 2006) disallowed suit against a prison's nursing staff as an unincorporated association separate and apart from the prison itself).

Finally and most notably, the district court relied upon the presumed immunity for a professional review body of a hospital under the Health Care Quality Improvement Act, 42 U.S.C. § 11111(a) ("HCQIA"), to support its decision. The court found that the presumed immunity for a professional review body, like the MEC, was persuasive evidence that HCQIA contemplated, (1) the ability of the MEC to be sued, and (2) its separate and distinct nature from the Hospital, as well as the individual members that comprise the MEC. *Id*. Therefore, the court ruled that the MEC could be sued as an unincorporated association under New Jersey state law; however, the court expressed no opinion as to what claims may be brought against the MEC. *Id* at 9.

Most of the analysis in this case can be attributed to New Jersey's unique laws concerning unincorporated associations. We may see, however, portions of the Court's opinion concerning HCQIA used by parties in litigation to urge courts to treat professional review committees as separate and distinct legal entities from the hospitals they serve. As such, we will be monitoring future developments in this case, as well as national trends regarding this matter.

If you would like to read the district court's ruling in this matter, it can be found at: https://law.justia.com/cases/federal/district-courts/new-jersey/njdce/1:2013cv06537/296104/159/

National Practitioner Data Bank Q and A

If a hospital summarily suspends a physician but the physician resigns his or her clinical privileges, or takes a leave of absence, before the suspension has been in effect for more than 30 days, does the hospital have to report that suspension or leave?

The Basics – Hospitals and other healthcare entities must report adverse clinical privileges actions that adversely affect the clinical privileges of a physician for a period of more than 30 days. Hospitals and other healthcare entities must also report the surrender of clinical privileges or any restriction on such privileges while the physician is under investigation relating to professional competence or conduct. The types of actions against clinical privileges that require a report are those which reduce, restrict, suspend, revoke or deny clinical privileges based on professional competence or professional conduct. Clinical privileges actions are reportable once they are made final, except that summary suspensions or summary restrictions lasting more than 30 days are reportable even if they are not yet final.

Question – If a hospital summarily suspends a physician but the physician resigns his or her clinical privileges, or takes a leave of absence, before the suspension has been in effect for more than 30 days, does the hospital have to report that suspension or leave?

Answer – Yes. The NPDB Guidebook (April 2015) considers resignations and leaves of absence taken while the physician is under investigation, or on summary suspension for longer than 30 days, events which must be reported. Consider the following statement and an example from the Guidebook:

- "If the physician, dentist, or other health care practitioner surrenders his or her clinical privileges during a summary suspension, regardless of whether the suspension has been confirmed by a hospital review body, that action must be reported to the NPDB. The action must be reported because the practitioner is surrendering the privileges either while under investigation . . . or in return for not conducting an investigation . . . ." (NPDB Guidebook at E–36)
- Example 42, NPDB Guidebook at E-52:
  - "**Question**: A hospital summarily suspended a physician's clinical privileges to allow sufficient time for allegations of gross negligence to be fully investigated. The day after the summary suspension was imposed, the physician requested an educational leave of absence. If the hospital grants the leave of absence, must the summary suspension be reported to the NPDB?

- **Answer**: If the summary suspension is not lifted within 30 days, it must be reported to the NPDB, regardless of when the leave of absence begins or if it ever occurs."

42 CFR Part 2 Substance and Alcohol Abuse Information Restrictions and Concerns during the Credentialing and Peer Review Processes

By Jessica D. Schmit (jschmit@polsinelli.com) and Stephen M. Angelette (sangelette@polsinelli.com)

Hospitals and other medical providers are becoming increasingly concerned with the issue of substance and alcohol abuse reporting during physician credentialing and peer review processes. If a physician discloses a history of such abuse during the credentialing process or is reported by a colleague before or during the peer review process, the credentialing entity's board or peer-review committee is likely to request the disclosure of any records pertaining to the diagnosis or treatment relating to the individual's substance or alcohol abuse. The disclosure of medical records pertaining to the treatment of alcohol and substance abuse are often restricted by 42 CFR Part 2 ("Part 2"), which offers a higher level of protection and privacy than is afforded most other types of records. However, with a constant changing landscape of federal and state confidentiality and privacy laws, there is often confusion regarding what is permitted to be disclosed under these restrictions.

Only certain treatment programs are covered by Part 2, limited to individuals or entities that are federally regulated or assisted, and hold themselves out as "providing education, treatment or prevention to individuals in need of alcohol or drug abuse treatment." General medical facilities as a whole are not considered programs; however, a unit within a larger facility that provides substance abuse or treatment services may qualify as a "program" under Part 2. A program is considered federally assisted if it is (i) operated by a department or agency of the United States; (ii) operating based on the authorization of a department of the United States; (iii) receiving or part of an organization receiving federal financial assistance; or (iv) receiving tax deductions or is operating under tax exempt status. Thus, the definition of a "program" is relatively broad, and the majority of substance and alcohol abuse treatment programs, providing care to physicians under a committee's review, are likely impacted by the Part 2 disclosure restrictions.

Part 2 only permits the disclosure of substance abuse records pursuant to the patient's voluntary, written authorization.[1] If a credentialing or peer review process requests the disclosure of a physician's treatment records, the reviewing board or committee should ensure that proper authorization is obtained. Proper authorization is only obtained if the underlying form meets ten elements outlined in the regulations, including to which entity such disclosure may be made; the purpose of the disclosure; and the date or condition upon which the consent expires. It is advisable for a credentialing or peer review committee to adopt an authorization form that is compliant with the requirements under both the Health Insurance Portability and Accountability Act ("HIPAA"), Part 2, and any additional requirements imposed by applicable state law. This provides a baseline framework under which the credentialing or peer review committee can avoid issues in determining whether a program is covered by Part 2 or inadvertently seeking disclosure of a physician's records with a form that does not meet the regulatory requirements.

Upon receipt, the disclosed substance or alcohol abuse treatment records, pursuant to the physician's authorization, should be accompanied by a statement notifying the receiving credentialing or peer review committee that redisclosure of such records is prohibited without the express written consent of the person to whom the records pertain or as otherwise permitted by Part 2. If the received records contain this language, the receiving entity is generally precluded from disclosing the information to any contractors or other third parties. Thus, hospitals and other entities should be cautious in how such records are maintained to avoid inadvertent redisclosure, and could consider adopting a policy that would govern how such records are maintained.

However, effective February 2, 2018, the Substance Abuse and Mental Health Services Administration ("SAMHSA") issued new regulations to Part 2 that carve out an exception to this redisclosure restriction. The recipient of Part 2 information, sometimes referred to as a "lawful holder", may further use and disclose Part 2 information for certain purposes, such as health care operations, without the patient's written consent if specific conditions are met. "Healthcare Operations", which is a defined term under HIPAA, is an exception to the HIPAA requirement that allows a healthcare provider to disclose patient medical records without patient authorization. As articulated by SAMHSA, "Healthcare Operations" would encompass credentialing and peer review related activities, as it includes, among other things, the assessment of practitioner competencies, credentialing activities, activities related to addressing fraud, waste, and abuse, conducting or arranging for medical review, and review of health care services with respect to medical necessity, appropriateness of care, or justification of charges.[2] Because the credentialing and peer-review process fits under the broad definition of Health Care Operations, these committees may redisclose records to a third party entity involved with these processes, such as an external expert retained for second opinion of certain records, a law firm representing the peer

[1] There are other narrow exceptions, but they are very limited and require the receiving entity to obtain a Court Order requiring the disclosure of such records.

[2] Confidentiality of Substance Use Disorder Patient Records, 83 Fed. Reg. 239, p.247-48.

review committee, or other outside experts if the aforementioned conditions are met. Under the new rule, the lawful holder and the receiving third party must enter into a written contract establishing that both parties: (1) are fully bound by Part 2; (2) must implement appropriate safeguards to prevent the records' redisclosure; and (3) are required to report any unauthorized uses, disclosures or breaches of patient-identifying information. The lawful holder must ensure that any disclosed medical records are accompanied by a re-disclosure notice; however, the new rule permits an abbreviated notice to promote ease and convenience when disclosing via electronic means. Again, if any third parties are regularly involved with the credentialing or peer-review process, it is likely advisable for a reviewing entity to implement policies and procedures that outline the necessary requirements preceding disclosure of such records to any third parties.

While the restrictions surrounding the use and disclosure of substance and alcohol abuse treatment records may seem arduous and complicated, a reviewing body may streamline their procedures by implementing universal policies that meet HIPAA, Part 2, and additional state privacy and confidentiality laws. Such committees are challenged to balance protecting patients' rights and the reviewing entity's potential future liability, with the privacy and confidentiality rights of the physicians.

The Benefits and Complications of Peer Reviewing Employed Physicians

By John T. Synowicki (jsynowicki@polsinelli.com)

A growing trend for hospitals and other health care providers is entering arrangements with physicians and physician groups which extend beyond solely credentialing the physicians. In an effort to streamline both the services provided and continuity of care, hospitals are now engaging in more intertwined relationships with physicians that often include employment requirements or separate employment agreements. Inevitably, peer review concerns arise for physicians who are involved in these types of relationships with a hospital, often resulting in separate employment and peer review evaluations of the physician. Depending on the type of employment relationship with the physician, the result can either complicate or streamline how the hospital handles the underlying situation.

What kinds of employment relationships arise?

There are three primary situations in which the physician's employment arrangement can impact the peer review process at a hospital where the physician holds credentials.

First, some states permit hospitals to directly employ physicians. In this scenario, there is usually a mixture of physicians who are employed, and others who are only credentialed on the hospital's medical staff. In these situations, it is not uncommon – and could be advisable – for the employment agreement to contain a provision that the loss of employment by the physician will result in the automatic loss of membership and privileges at the hospital through immediate termination.[3]

Second, a physician could be employed through a physician group that is affiliated with the hospital. In this situation, it is not uncommon for the physician group to directly employ the physician, and for the employment agreement to contain a provision that the loss of employment by the physician would require the physician to immediately resign from any affiliated hospitals or other affiliated credentialing entities. This provision could exist in the employment agreement, or could be included directly in the medical staff bylaws.[4] Under these circumstances, the loss of employment could trigger an automatic termination[5] of privileges and membership, or require the physician to voluntarily resign his/her privileges and membership at affiliated entities.

Third, a physician could be part of an exclusive provider who has a professional services agreement with the hospital. When a hospital enters into an exclusive provider agreement or a professional services agreement with a physician group, there is a written agreement between the physician group and the hospital. In this agreement, there are two types of provisions that may affect a physician's privileges and membership at the hospital: there may be a provision that states that the physician's loss of employment with the physician group results in an automatic resignation or termination of privileges and membership at the hospital; there may also be a stipulation that the hospital can notify the physician group that it does not want a particular physician included as part of the agreement.

Although each of these arrangements differ in structure, hospitals should be aware of both the possibilities and complications that can arise under each scenario.

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[3] In California, this would not be applicable, as the state peer review procedure relates to the review of employment as well. See Cal. Bus. & Prof. Code § 805 (West) ("Peer Review" is defined to include "[a] process in which a peer review body reviews the basic qualifications, staff privileges, employment, medical outcomes, or professional conduct of licentiates to make recommendations for quality improvement and education."). As a result, although there may not be reporting requirements to the NPDB, California may have separate state reporting requirements related to adverse actions against employment.

[4] It would be unusual for this type of provision to appear in the medical staff bylaws unless the hospital had a closed medical staff, where membership was limited to physicians employed by a specific entity. If the medical staff is open, the automatic resignation or similar language would most likely appear in an employment agreement.

[5] The term "termination" is used throughout this article because this is the language used by the NPDB in its formal Publication. The bylaws for any specific entity could reference automatic termination, automatic relinquishment, or automatic resignation, which would likely result in the same analysis as termination.

NPDB Formal Guidance States That Loss of Privileges Through Termination of Employment is Not Reportable

In April 2017, the National Practitioner Data Bank (NPDB) issued a publication ("NPDB Publication" or "Publication") to provide additional public guidance on the issues surrounding loss of employment in relation to privileging issues. In the Publication, the NPDB clarified that where a physician was under peer review, but automatically lost his/her privileges and membership through an employment termination procedure, no report was required with the NPDB. The NPDB stated the "termination [of privileges and membership] was not a result of a professional review action and, therefore, was not reportable. It does not matter that the employment termination ***automatically resulted in the end of the practitioner's clinical privileges." *National Practitioner Data Bank Insights Publication, April 2017*.[6]

There are several important takeaways from the NPDB Publication. First, the NPDB confirms that when the loss of privileges is automatic, it is considered an administrative action, rather than a medical staff adverse action, and thus the loss of privileges is not reportable. Thus, according to the NPDB Publication, even if there is a parallel peer review investigation underway at the hospital when the employment terminates, there is no independent reporting requirement related to the loss of privileges, provided the action is *automatic*.

Second, the NPDB Publication focuses on the *result* that terminated the physician's privileges, not whether the review began due to a peer review investigation or an employment concern. Thus, regardless of whether the underlying issue starts as an employment concern or a peer review concern, if the physician's employment terminates, and there is a provision for an automatic termination of privileges and membership, the NPDB Publication indicates this termination is not reportable to the NPDB.

Important Takeaways and Outstanding Questions for Health Care Providers

The NPDB Publication is an important clarification for health care providers, because it illustrates how to approach employment arrangements in a way that provides options to the providers when concerns arise about a particular physician. While each situation is unique, and requires a careful review of the particular medical staff bylaws, contract, and facts involved in each matter, there are several considerations that should guide providers.

Does the employment agreement permit the disclosure of information? This is a potential issue that has to be considered for affiliated-entity agreements, and possibly for exclusive provider agreements. If the physician's employment is terminated by an entity different than the hospital, does the employment agreement permit the employer to notify the affiliated hospital? If not, can the hospital properly receive notice of the employment termination decision to implement the automatic termination provision? If the employment agreement requires the physician to submit a letter to the hospital, resigning privileges and membership following employment termination, what happens if the physician refuses or fails to do so? Unless there is an appropriate avenue to share information, it may be difficult to automatically terminate a physician's privileges and membership, even if permitted or required by the medical staff bylaws or employment agreement.

Is the termination/relinquishment/resignation automatic? The NPDB Publication does not directly address this issue, and it raises a source of ambiguity for hospitals. What if the employment agreement provides that the physician is required to submit his resignation of privileges and membership to the hospital upon termination or loss of employment, and the physician does so while a peer review investigation is ongoing at the hospital – is the resignation considered "automatic," or did the physician resign while under investigation? This likely requires a close look at the NPDB Publication, the particular employment termination and whether it was initiated and/or negotiated by the physician while under investigation at the hospital, and the terms of the hospital's medical staff bylaws to determine whether the resignation of privileges and membership was automatic. The hospital or its counsel could also contact the NPDB, on an anonymous basis, for assistance regarding whether the specific scenario is reportable.

Even if the physician's privileges are automatically terminated, is it still advisable for the hospital to move forward with a peer review proceeding? The Health Care Quality Improvement Act (HCQIA) provides immunity to hospitals that take action under a professional review action "after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures are fair to the physician under the circumstances." 42 U.S.C. § 11112(a)(3) (1986). In the event a physician loses privileges and membership due to loss of employment through automatic termination, there is a strong argument that HCQIA immunity would not apply in the event the physician sues the hospital. Therefore, the hospital may decide not to utilize the automatic termination option and, instead, pursue formal peer review when the investigation concerns the physician's conduct or competence, and offer a hearing if appropriate, in order to squarely fall within the protections of HCQIA.

Conclusion

In certain circumstances, the physician's loss of employment could result in an automatic termination of his/her privileges and membership at a hospital if automatic termination is properly

[6] It is worth noting that even though the NPDB Publication was issued by the NPDB, it is not part of the NPDB Guidebook

documented in the employment agreement, professional services agreement with the hospital and/or in the hospital's medical staff bylaws. If proper provisions are available and the physician's employment is terminated during a hospital peer review investigation, the automatic termination provision allows the hospital to stop the peer review, and forego the expense and time necessary to complete the peer review. 5 The NPDB Publication also permits the hospital to forego reporting to the NPDB that the physician resigned while under investigation. In this event, the hospital should still evaluate applicable state law to determine if the automatic termination is reportable to its state licensing board.

Upcoming Webinars

National Association of Medical Staff Services

Tuesday, September 25, 2018

Erin Muellenberg is speaking on the Christopher Dutch Story "*A Credentialing Nightmare*"

More info on the NAMSS Webinar here.

Medical Staff, Credentialing and Peer Review

Thursday, September 20, 2018 | 1:00-2:30 PM CST

John Synowicki will present a webinar through AYLA titled "Medical Staff, Credentialing and Peer Review". The webinar is presented by AYLA's Medical Staff, Credentialing, and Peer Review Group, and will be live from 1:00-2:30 CST. Mr. Synowicki will present with Dr. Vanessa Brown of Stamford Hospital and Mr. Jeffrey Frost of Sutter Health.

Email smcguire@polsinelli.com for more information.

Upcoming Events

National Association of Medical Staff Services Educational Conference and Exhibition 2018

September 29 - October 3, 2018

Long Beach, CA

Polsinelli Reception on 9/30

Email smcguire@polsinelli.com for more information.

Texas Health Law Conference

Monday, October 8, 2018

Austin, TX

Sherri Alexander will be speaking on the topic of "Advising Hospitals and Physician Clients Regarding Medical Staff Issues After Gomez v. Memorial Hermann - Stay Tuned for the Appeal." Ms. Alexander represents hospitals and Karin Zaner of Zaner Law PC, who also will be speaking, represents physicians.

Email smcguire@polsinelli.com for more information.

Seattle Health Care and Labor and Employment Briefing

Tuesday, October 16, 2018 | 5:00 to 7:00 PM PST

Four Seasons | Seattle, WA

Email smcguire@polsinelli.com for more information.

2018 NIC Fall Conference Reception

Wednesday, October 17, 2018 | 6:30 - 8:30 PM

Loews Hotel | Chicago

Email smcguire@polsinelli.com for more information.

View invitation online here.

Save-The-Date: Reimbursement Institute 2019

February 26, 2019 | 8:00 – 4:15 PM

Omni Hotel | Nashville, TN

Email smcguire@polsinelli.com for more information.

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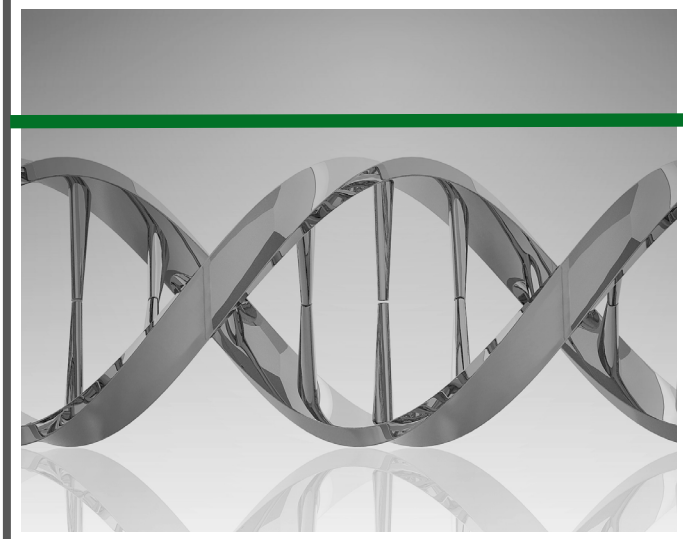

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