Medical Staff Challenges: Best Practices for Peer Review, Governing Documents, and Board Governance

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Today’s faculty features:

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Medical Staff Challenges:
Best Practices for Peer Review,
Governing Documents, and Board Governance

December 4, 2013

Catherine M. Ballard, Esq.
Steve Kleinman, Esq.
Jeremy Morris, Esq.

100 South Third
Columbus, Ohio 43215
EFFECTIVE PEER REVIEW
EFFECTIVE PEER REVIEW

- What is peer review and why we do it
- Important considerations in conducting peer review
- Avoiding common pitfalls
WHAT IS IT

Peer review is the process by which a professional review body considers a practitioner’s professional competence and/or professional behavior to determine whether the practitioner meets acceptable standards.
WHY BOTHER

- It’s an accreditation requirement
- Avoid liability
  - Negligent Credentialing
  - Vicarious Liability
- Protect patients
IMPORTANT CONSIDERATIONS

Process Objectivity:

- Clearly Defined Process
  - Set forth in governing documents
  - Investigate the facts
  - Fair to each side
  - Mechanism to challenge action
IMPORTANT CONSIDERATIONS

Process Objectivity:

- Consistent Application

- No Conflicts of Interest
  - Involvement with practitioner/case
  - Economic
IMPORTANT CONSIDERATIONS

Process Objectivity:

- Tips
  - Broad and flexible membership of peer review committees
  - Training for members of peer review committees
IMPORTANT CONSIDERATIONS

Substantive Objectivity:

- Clearly defined expectations
  - Clinical
  - Behavioral
  - Be sure can point to facts/data to support action
IMPORTANT CONSIDERATIONS

Substantive Objectivity:

- Tips
  - Utilization of external reviews
  - Documentation
COMMON PITFALLS

- Breaches of Confidentiality
  - All states recognize (to some extent) peer review privilege
  - Privilege must be respected or it will be lost
  - Causes problems in process
  - Can result in litigation
COMMON PITFALLS

- Breaches of Confidentiality – Fixes
  - Must be explicitly and clearly explained
  - Explain consequences
  - Must be sacrosanct
  - Collect all documents
COMMON PITFALLS

- Failure to Follow Process
  - Where claims are born
  - Proceed with end in sight
  - Try to craft own “fair” process
  - Failure to review governing documents
COMMON PITFALLS

- Failure to Follow Process – Fixes
  - Review governing documents
  - Apply governing documents
  - Consult with counsel
COMMON PITFALLS

- Rush to Judgment
  - Fail to get all information
  - Rely upon “hearsay”
  - Make up mind too early
COMMON PITFALLS

- Rush to Judgment – Fixes
  - Methods to keep status quo
  - Pump the brake and slow down
Effective Medical Staff Governing Documents
Medical Staff Documents

- Medical Staff Governing Documents
  - **The Bylaws.** Trump manuals, Policies, Rules and Regulations. Must be voted on by the active medical staff and approved by the Board.
  - **Policies.** The details (credentialing, fair hearing procedures, allied health professionals etc.). Vote may be delegated by the medical staff to the MEC. Policies must be approved by the Board.
  - **Rules and Regulations.** Generally cover practice within the hospital (i.e. admission criteria etc.). Vote may be delegated by the medical staff to the MEC.

- Medical Staff documents should meet the 3 C’s (Compliance, Clarity, Consistency).
CONTENT/COMPLIANCE

The information in the next several slides is required to be in the medical staff bylaws according to applicable medical staff standards.
# Medical Staff Documents

<table>
<thead>
<tr>
<th>Section</th>
<th>TJC</th>
<th>HFAP</th>
<th>DNV</th>
<th>CIHQ</th>
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<tbody>
<tr>
<td>Duties and privileges (prerogatives) of each Medical Staff category</td>
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<td>Medical staff organization/structure</td>
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<td>Physician adherence to Code of Ethics</td>
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<td>Criteria/qualifications for medical staff appointment and clinical privileges</td>
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<td>History and physical</td>
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<tr>
<td>Requirements for meeting frequency and attendance (including definition of quorum)</td>
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<tr>
<td>Specified information regarding departments or services (if Medical Staff is departmentalized)</td>
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# Medical Staff Documents

<table>
<thead>
<tr>
<th>Grounds for automatic suspension</th>
<th>TJC</th>
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<th>CIHQ</th>
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<tbody>
<tr>
<td>Process/procedure for automatic suspension</td>
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<td>✔️</td>
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<tr>
<td>Grounds for summary suspension</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
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<tr>
<td>Process/procedure for summary suspension</td>
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<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
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<tr>
<td>Process/procedure for privileging</td>
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<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
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<tr>
<td>Medical staff members eligible to vote</td>
<td>✔️</td>
<td>✔️</td>
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</tr>
<tr>
<td>Process for electing/selecting and removing medical staff officers</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
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<tr>
<td>Medical staff officer positions</td>
<td>✔️</td>
<td>✔️</td>
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<tr>
<td>Criteria/process for periodic performance appraisal</td>
<td>✔️</td>
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<td>✔️</td>
</tr>
</tbody>
</table>
# Medical Staff Documents

| Function, size, composition of the MEC | TJC | HFAP |
| Authority delegated to MEC to act on medical staff’s behalf /how such authority is delegated or removed | ✓ | ✓ |
| Process for electing/selecting and removing MEC members | ✓ |
| MEC includes physicians/other practitioners and any other individuals as determined by the medical staff | ✓ |
| MEC acts on behalf of medical staff between meetings | ✓ | ✓ |
| Process for adopting/amending medical staff bylaws | ✓ | ✓ | ✓ |
| Process for adopting/amending medical staff rules and regulations and policies | ✓ | ✓ | ✓ |
| Process for credentialing/recredentialing | ✓ | ✓ | ✓ |
| Process for appointment/reappointment | ✓ | ✓ | ✓ |
# Medical Staff Documents

<table>
<thead>
<tr>
<th>Requirement</th>
<th>TJC</th>
<th>HFAP</th>
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<th>CIHQ</th>
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</thead>
<tbody>
<tr>
<td>Grounds for corrective action (recommending termination or suspension of medical staff appointment/privileges or reduction of privileges)</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Process for corrective action</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Fair hearing and appeal process</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
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<tr>
<td>Composition of fair hearing committee</td>
<td>✔️</td>
<td></td>
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<tr>
<td>Requirement for complete and accurate medical record</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Procedures for medical record delinquencies</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Requirement that medical staff have periodic meetings at regular intervals to review and analyze patient medical records</td>
<td>✔️</td>
<td>✔️</td>
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<tr>
<td>Circumstances and criteria under which consultation or management by a physician or other LIP is required</td>
<td>✔️</td>
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## Medical Staff Documents

<table>
<thead>
<tr>
<th>Description</th>
<th>TJC</th>
<th>HFAP</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Mechanism for enforcement of bylaws and rules</td>
<td></td>
<td></td>
<td>✔️</td>
</tr>
<tr>
<td>Description of who is responsible for review and evaluation of clinical work of medical staff members</td>
<td></td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Statement regarding congruency of policies/rules</td>
<td></td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Provision for periodic review</td>
<td></td>
<td>✔️</td>
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</tbody>
</table>
Medical Staff Documents

- **Best Practice**
- Checklist provides summary of type of information that should be considered and addressed in medical staff documents even if CMS and/or accrediting entity does not require information to be located in the medical staff bylaws.
Medical Staff Documents

- Credentialing Process
- Hospital credentials applicant using clearly defined process/mechanism
- Credentialing process is based on review and recommendation by the medical staff and approval by the governing body
- Credentials process includes collecting and verifying (in writing and from the primary sources when feasible or from a CVO) specified information.
## Credentialing Process

<table>
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<th>CIHQ</th>
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</thead>
<tbody>
<tr>
<td>Current licensure (certification and/or registration)</td>
<td>☑️</td>
<td>☑️</td>
<td>☑️</td>
<td>☑️</td>
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<tr>
<td>Relevant training</td>
<td>☑️</td>
<td>☑️</td>
<td>☑️</td>
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<tr>
<td>Current competence</td>
<td>☑️</td>
<td>☑️</td>
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<tr>
<td>Photo identification</td>
<td>☑️</td>
<td>☑️</td>
<td>☑️</td>
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</tr>
<tr>
<td>Professional education (medical education and postgraduate training)</td>
<td>☑️</td>
<td>☑️</td>
<td>☑️</td>
<td>☑️</td>
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<tr>
<td>Documented experience</td>
<td>☑️</td>
<td>☑️</td>
<td>☑️</td>
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<tr>
<td>Ability to perform requested privilege</td>
<td>☑️</td>
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<tbody>
<tr>
<td>Malpractice Insurance History</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
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<tr>
<td>Specialty board status (if applicable)</td>
<td></td>
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<tr>
<td>Sanctions or disciplinary actions</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
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<tr>
<td>Criminal history</td>
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<tr>
<td>Healthcare employment (work) history</td>
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<tr>
<td>Professional references</td>
<td>✅</td>
<td>✅</td>
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<tr>
<td>Clinical activity</td>
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# Credentialing Process

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<tbody>
<tr>
<td>Compliance with meeting attendance requirements as set forth in Bylaws</td>
<td>🟢</td>
<td>🟢</td>
<td>🟢</td>
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<tr>
<td>Performance within hospital (upon regrant)</td>
<td>🟢</td>
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<tr>
<td>NPDB query (other database profiles)</td>
<td>🟢</td>
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<tr>
<td>DEA</td>
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<td>🟢</td>
<td>🟢</td>
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<tr>
<td>Data from professional practice review by organization that currently privileges applicant, if available</td>
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</table>
Medical Staff Documents

- Avoid processing unnecessary applications.
- Use appropriate base line criteria.
- Because nothing is absolute, have an appropriate waiver provision in the Bylaws and/or credentials policy applicable to extraordinary circumstances.
- Restrict reapplication for a reasonable period of time after a physician has received a final adverse decision regarding appointment, reappointment or clinical privileges.
Medical Staff Documents
Disruptive Physicians

- Pre-2009: Not a “big issue for the purposes of The Joint Commission.
- 2009: TJC came out with need for a disruptive practitioner policy (How one is expected to act).
- TJC included “interpersonal and communication skills” and “professionalism as bases for credentialing.
Medical Staff Documents

- 2010: TJC came out with need for a code of conduct.
- Hospitals must provide a culture of safety and quality
Medical Staff Documents

- Policies should address disruptive behavior progressively if possible and immediately if necessary.
- Progressive steps may include: informal intervention, formal workplace assessment, remedial plan, monitoring compliance, corrective action.
- All progressive steps should be documented.
Medical Staff Documents

- Fair hearing process and procedures.
- Clearly defined process and procedure for initiating a formal investigation- Do your medical staff documents define when a formal investigation begins?
- Attorney representation- When is a physician entitled to representation at meetings/hearings?
- Do you want your medical staff conducting the hearing or counsel?
Inter-Relationship Of The Board, Administration And Medical Staff Leaders
Inter-Relationship of the Board, Administration and Medical Staff Leaders

The evolution of the relationship:

- Florence Nightingale (May 1820 – August 1910)

- Ernest Amory Codman, M.D. (Dec. 30, 1869 – Nov. 23, 1940): 1918: A study in hospital efficiency: as demonstrated by the case report of the first five years of a private hospital
1916: A Study in Hospital Efficiency published by Codman; challenged hospitals to:
(a) release quality data to affect comparisons
(b) be more critical in services offered
(c) recognize responsibility to oversee medical staff
(d) be accountable to the public
(e) recognize that the entity (board and staff) transcended the individual physician
1951: JCAHO-CMA established

- Ban on Corporate Practice of Medicine: It is a fundamental rule of law that only an individual properly educated and licensed, and not a corporation, may practice medicine. * * * * Accordingly, a hospital is powerless under the law to forbid or command any act by a physician or surgeon in the practice of his profession. [quote from Darling case]
Inter-Relationship of the Board, Administration and Medical Staff Leaders

1965: *Darling v. Charleston Community Hospital*

- Present day hospitals do more than furnish facilities. The person who avails himself of hospital facilities expects that the hospital will attempt to cure him, not that its nurses or other employees will act on their own responsibility… The protection of the public must come from some … authority, and that, in this case, is the hospital board of trustees.
Inter-Relationship of the Board, Administration and Medical Staff Leaders

1980: *Johnson v. Misericordia Hospital*

- The failure of a hospital to scrutinize the credentials of its medical staff applicants could foreseeably result in the appointment of unqualified physicians and surgeons to its staff. Thus, the granting of staff privileges to these doctors would undoubtedly create an unreasonable risk of harm or injury to their patients. Therefore, the failure to investigate a medical staff applicant's qualifications for the privileges requested gives rise to a foreseeable risk of unreasonable harm and we hold that a hospital has a duty to exercise due care in the selection of its medical staff.
Role of Board

The Board is responsible for oversight of the business and affairs of the corporation:

- Decision making regarding matters of policy, direction, strategy, and governance
- Oversight of matters critical to the health of the company on behalf of its stakeholders (community served by the hospital’s mission statement)
- Mentorship to the CEO and senior officers
Inter-Relationship of the Board, Administration and Medical Staff Leaders

Role of Board

The Board’s job is to DIRECT rather than to MANAGE.

MANAGEMENT manages under that DIRECTION.

Board must determine RELIABILITY and COMPETENCY in order to rely.
Inter-Relationship of the Board, Administration and Medical Staff Leaders

Role of Board

- Board can only act as a board (i.e., through its minutes).
  Minutes serve to:
  - Inform the intended audience
  - Give enough detail to show compliance with notice provisions and entitle reliance
  - Reflect the decisions made (to take or not to take).
  - Protect against giving a cause of action to another
Inter-Relationship of the Board, Administration and Medical Staff Leaders

Role of CEO

- Highest fiduciary duty – must always act in a manner the officer reasonably believes to be “in” the best interests of the hospital
- May also have contractual obligations
- Does not have protection of “reliance” because accountable for execution of business and operations of hospital
Inter-Relationship of the Board, Administration and Medical Staff Leaders

Medical Staff responsibility

- Board delegates overall responsibility (and accountability to Board) for quality to Medical Staff
- Medical Staff delegates responsibility to its Medical Staff leadership
Inter-Relationship of the Board, Administration and Medical Staff Leaders

Distinguishing between a private practitioner and a medical staff member

Private practitioner: Acting in your own best interest. Responsible for your own acts.

Medical Staff member: Acting in the best interest of the Hospital. May be entitled to protection by hospital.
Inter-Relationship of the Board, Administration and Medical Staff Leaders

The Role Of A Medical Staff Committee

A Medical Staff committee properly established pursuant to the Medical Staff Bylaws is, in effect, an administrative arm of the Board of Directors

- Covered by general liability and/or directors/officers insurance for acts within the scope of that committee done in good faith and without malice
- A committee only speaks through its minutes and its approved motions.
- Minority view is not committee position
Decision-Making Issues When Dealing With A “Hospital Employed” Physician
Decision-Making Issues When Dealing With A “Hospital Employed” Physician

Where We Were
Independent Physician
Medical Staff documents
Limited liability
Protected Information

Where We Are Going
Employed physician
Contract/Employee Handbook
Vicarious liability
Discoverable Information
Decision-Making Issues When Dealing With A “Hospital Employed” Physician

- **Internal System Issues:**

Dr. Cardio is employed by Heart Hospital. A number of complaints have been coming in that his documentation is very poor, he is constantly making mistakes in the electronic medical record, the lack of documentation is raising questions as to the appropriateness of a number of his procedures, and he gets so mad when people try to work with him that he screams obscenities and has even drop kicked a monitor.
Decision-Making Issues When Dealing With A “Hospital Employed” Physician

- **Internal System Issues:**
  - Documentation/appropriateness of procedures — Medical Staff? Compliance? Concurrent?
  - EMR mistakes — Human Resources?
  - Disruptive behavior — Medical Staff? Human Resources? Both?
  - Contract — Can you just terminate him?

  - Regardless, how do you first capture the matter in order to make an intelligent decision on how the issues should be triaged?
Decision-Making Issues When Dealing With A “Hospital Employed” Physician

- **Internal System Issues:**

Questions to ask:

- Can any of this be protected under attorney client privilege?
- Can any of this be protected under peer review privilege?
- Who is the most qualified to deal with (can be most effective in dealing with) the issue?
- Should it be divvied up or handled by one person/group?
- Who needs to know what decisions are reached?
Decision-Making Issues When Dealing With A “Hospital Employed” Physician

- **Internal System Issues:**
  - If you can put everything under attorney client privilege, problem is solved.
  - But assuming you cannot:
  - Can you start out with peer review protection until you decide what to do?
    - Can you work from a Board quality committee?
    - Can you designate individuals to act as designated peer review agents (i.e., individuals who will receive and review issues at all levels of the organization and decide the appropriate place to “house” the investigation).
Employment Challenges:
If the location is provider-based, the physician is subject to the same peer review process as the main hospital campus.

- Consider creating a peer review committee of physicians who only work (or primarily work) at provider-based locations that is on the same level as other peer review committees.
- This information must be treated the same as peer review information at the hospital.
Employment Challenges:

- If the location is not provider-based, is there value in creating a peer review process?
- Can it be done and be protected under State or Federal law?
Decision-Making Issues When Dealing With A “Hospital Employed” Physician

- **Contract Issues (Employment):**

  If the physician is on the medical staff:
  - Does termination of employment automatically terminate appointment/clinical privileges?
  - Does termination of employment impact any other relationships with the Hospital or its affiliated entities?
  - What is the impact of a limitation on clinical privileges?
  - Can action be taken on the employment side without losing peer review protection?
  - Will the hospital be alienating the medical staff if the hospital terminates employment in situations where the medical staff believes corrective action is more appropriate?
The Future
The Future

- **The Past**
  - 45 years ago the required skills for a medical staff professional were secretarial and clerical skills (i.e. shorthand and typing).
  - Minimal use of technology (typewriters, telephones but no voice mail)
The Future

- **Today**
  - Skills required include knowledge of regulatory and accreditation requirements
  - Understanding of medical staff organization
  - Expertise in the use of technology to manage information
  - Ability to identify red flags in applications
  - Expertise in OPPE and FPPE
The Future

- Increasing use of technology (use of the internet to verify licensure, DEA, Board Certification, Exclusions, hospital affiliations).
- Electronic files instead of paper files
- Electronic communication for evaluations (Credentials Committee and MEC to review files online)
The Future

- CMS continues to take the position that a system with several distinct hospitals is not permitted to combine the medical staff into a single entity.
  - More sharing of information (credentialing decisions, peer review materials) is necessary to avoid duplicative process and procedures and the risk of negligent credentialing claims.
  - As technology improves, more telemedicine practitioners to credential (remember you must have appropriate agreements in place with the distant entity if you elect to credential by proxy).
The Future

- Continued trend towards hospital employment of physicians.
- Medical staff and hospital leadership need to triage of matters to determine whether they are medical staff or HR matters.
The Future

- National Practitioner Data Bank Guidebook. The much awaited NPDB rewrite has been in the works for several years.

- Look for changes in requirements regarding the reportability of certain processes and procedures frequently used by hospitals (i.e. voluntary agreements to refrain from exercising privileges).
The Future

- 2 year credentialing cycle or continuous credentialing?
COMMON CHALLENGES
MANAGING PEOPLE

- Used to being “Captain of the Ship”
- Used to Fixing Problems
- Used to Resolving Issues Quickly
MANAGING PROCESS

- Staying Informed
- Using the Right Process
- Managing Expectations
LESSONS FROM LITIGATION

- Recent Ohio Verdict
  - Medical staff action against privileges
  - Discrimination claims in federal court
  - $3.7 million jury verdict
LESSONS FROM LITIGATION

- No Privilege in Federal Court
- Discrimination Claims often Driving Force
- Potential for Large Damage Awards
LESSONS FROM LITIGATION

- Process Matters
- Fairness Matters
- Consistency Matters
QUESTIONS