



# Credentialing & Peer Review

## LEGAL INSIDER

DECEMBER 2006

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### Consider medical staff membership options for low-volume providers

Does your hospital have medical staff physicians with privileges but who rarely—or never—admit patients or perform procedures at your facility? If so, you're not alone in facing a potential new problem. Now that the revised JCAHO standards clearly state that all hospitals are responsible for identifying competencies and extending privileges based on those competencies, many hospitals may need to reevaluate the status of low- or no-volume providers at their facility. That is because it is virtually impossible for a facility to independently assess the competency and professionalism of a physician who is rarely on-site, says **Michael Callahan, Esq.**, an attorney with Katten Muchin Rosenman in Chicago.

Low- or no-volume providers contribute little to a facility, yet the obligations and liabilities associated with them that may be burdensome. So why have hospitals been traditionally reluctant to deny privileges to physicians who rarely use the facility? There are several reasons, says **Christina W. Giles, CPMSM, MS**, principal at Medical Staff Solutions in Nashua, NH.

First, staff membership and privileges were synonymous at many institutions for years, notes **Jay Silverman, Esq.**, an attorney with the Long Island, NY-based firm of Ruskin Moscou Faltischek, PC. With this philosophy in mind, denying privileges to a physician was akin to denying the physician staff membership—a perceived slap in the face.

Giles says it's for this reason alone that many institutions preferred to extend privileges even to physicians who rarely used the facility, rather than risk offending the physician and the medical staff, and thus, in the eyes of the physician, calling into question his or her competence. This perception persists, she adds, even though most hospitals now have staff membership categories that do not require a physician to have privileges at the facility.

Family practitioners and internists also factor into the low- or no-volume equation. Many low- or no-volume providers are physicians in family practice or internal medicine who, although rarely admitting patients or using the hospital, frequently refer their patients to specialists there. Silverman notes that the specialist members of the medical staff—the high-volume physicians—may be reluctant to deny or limit the staff membership of their referral sources.

Additional reasons why a facility may extend staff membership and privileges to a low- or no-volume provider include the following:

- To keep an influential or well-known physician on staff for public relations reasons, even if he or she rarely uses the facility
- Because denying medical staff membership to a physician who has made

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**Credentialing & Peer Review Legal Insider** (ISSN 1542-1600) is published monthly by HCPro, Inc., 200 Hoods Lane, Marblehead, MA 01945. Subscription rate: \$239/year; back issues are available at \$25 each.

Postmaster: Send address changes to **Credentialing & Peer Review Legal Insider**, P.O. Box 1168, Marblehead, MA 01945.

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contributions to the institution or who is well-regarded in the community and among other physicians may be perceived as churlish

- To maintain its affiliation with a physician who is well-known and well-respected, as the reputation of the physician may reflect well on the hospital
- There are financial benefits of retaining an affiliation with a physician who has attracted research grants and other funding to the institution

Physicians often are eager to have an affiliation with a hospital even if they do not admit patients frequently and rarely perform procedures. Reasons for this include the following:

- Affiliation with a hospital—particularly a hospital with a good reputation—lends prestige to the physician
- Hospital staff membership offers educational opportunities that give physicians the chance to keep their skills and knowledge current
- Hospital staff membership gives physicians the chance to observe colleagues in other specialties, and thus to become familiar with specialists to whom they may refer patients
- Physicians may believe they need an affiliation with a hospital in order to gain or retain managed-care contracts
- Physicians may feel that a lack of medical staff membership reflects poorly on their competence or implies that colleagues do not wish to associate with them
- Hospital staff membership offers social opportunities and the chance to interact with colleagues, which can be especially important to older physicians and to physicians who are just entering practice and are eager to build a referral network

## JCAHO standards emphasize distinction

As the new JCAHO standards prepare to take effect on January 1, 2007, hospitals that have not yet done so should consider ways to respond to the needs of low- or no-volume admittees. One option that many hospitals are adopting is developing new categories of staff membership. These categories will simultaneously address physician concerns while permitting the hospital to assess the initial and ongoing competency of all members of its medical staff. Because the new standards require the hospital to make an independent judgment about the physician's level of skill, training, and clinical judgment, prudent hospitals will no longer risk extending clinical privileges to physicians who rarely use the facility.

"Hospitals can no longer allow practitioners to be granted privileges in name only," says Giles.

This means that the hospital's governing documents and medical staff bylaws may need to be revised, says Callahan. "The medical staff need to establish a clear standard that defines what a physician must do to be an 'active' staff member," he adds.

The 2007 JCAHO standards recommend a tiered medical staff structure to respond to the desire of low- and no-volume physicians to maintain a rela-

tionship with a facility and permitting hospitals to assess the competency of physicians who use the hospital on an ongoing basis. For example, the JCAHO's introduction to the medical staff standards notes the following:

*Membership on the medical staff is not synonymous with privileges. The medical staff may create categories of membership, as in active member, courtesy member, and so forth. These categories may be helpful in defining the roles and expectations for the various members of the medical staff.*

Giles suggests offering physicians medical staff membership without privileges. This may permit the physician most or all of the benefits of medical staff membership, with the exception of clinical privileges, and may be an appropriate alternative for physicians who no longer practice medicine full-time.

For the family practitioner, internist, or other low- or no-volume provider in active practice, a form of "refer-and-follow" privileges may be adequate, Giles says. This level of privileging permits the physician to refer his or her patients for admission to the hospital, where a hospitalist assumes responsibility for the patients' care. The referring physician may have the opportunity to visit the patient and provide follow-up care, but the hospitalist makes medical decisions for the duration of the patient's inpatient stay.

### Promoting alternate status where appropriate

The medical staff bylaws of many hospitals already permit some form of staff membership that does not confer full clinical privileges (e.g., courtesy membership), an option that may, in fact, be underused. A successful

transition to stricter privileging standards will respond to the low- or no-volume physician's emotional and social needs for medical staff membership, as well as the physician's financial and professional needs, says Silverman. Making greater use of options such as courtesy staff membership will benefit the hospital, as well. Giles points out that the new JCAHO standards will require that a hospital conduct a focused evaluation to determine the competency of a practitioner who is unknown to the institution. If the new practitioner only requests membership, not privileges, the competency determination is not an issue, she explains.

The new JCAHO standards will require hospitals to educate physicians about the rights and obligations associated with the various forms of staff membership. When a low- or no-volume provider seeks privileges at a hospital, it's important for someone to discuss the request with the provider to determine the reason he or she requested privileges.

Medical staff bylaws should offer low- or no-volume physicians a means to gaining or maintaining affiliation with the facility without having admitting or surgical privileges. The use of membership without clinical privileges where appropriate will allow the hospital to preserve existing relationships with physicians in the community and appease the active medical staff, without forcing the hospital to perform the extensive competency evaluation involved in privileging a medical staffer.

Hospitals may need to educate the medical staff in general, and low- or no-volume providers in particular, that extending clinical privileges to low- or no-volume providers may not be appropriate in some cases. Silverman advises

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## JCAHO 2007 medical staff standards: Privileges not a right, but a privilege

The JCAHO standards emphasize that membership on hospital medical staff should not automatically confer the right to privileges at the facility, notes **Michael Callahan, Esq.**, an attorney with the Chicago-based firm Katten Muchin Rosenman.

Instead, hospitals may only extend privileges to a physician if the facility has objective data indicating the physician's current competence to perform all of the procedures that he or she requests privileges to perform. If the hospital lacks such data—as it will if the physician is new to practice or has recently relocated—

it must engage in a focused practice evaluation to determine the physician's competence.

Once the facility has made an initial finding that a physician is competent to perform those procedures within the scope of the privilege granted, the hospital must conduct ongoing evaluation of the physician's skill, professionalism, and clinical judgment. The new standard also requires the facility to respond swiftly if the data it collects or its experience with the physician indicate that the physician may not be performing up to standard, Callahan explains.

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hospitals to ensure that all physicians understand the new JCAHO standards and recognize the additional time, effort, and expense that compliance with the new credentialing standards will require. With the new standards pending, this process should be well underway by now, says Silverman. If not, hospital administration and the credentialing staff should focus on it immediately.

In addition, hospital credentialing staff should try to alleviate some of the common economic and professional concerns of low- or no-volume providers, Silverman adds. Giles points out that although in the past many managed care panels required hospital admitting privileges for their physicians, this often is no longer the case, particularly for family or internal medicine practitioners. Confirming with the managed care plan that admitting or other clinical privileges are not required for participation with the plan may reassure the physician requesting privileges for this reason.

It is also crucial that physicians understand that relinquishing privileges is not a smudge on their professional reputation or a mark of impropriety or incompetence, Giles says. Many physicians believe that because they will have to

report the relinquishment of privileges in future applications, they should keep privileges they do not use, she explains. However, Silverman points out that a voluntary resignation of privileges that is not related to peer review activities is not reportable to the National Practitioner Data Bank or a state licensing board. Instead, physicians who drop privileges because they no longer provide services at the facility can simply note that fact in any document that asks about privileging history without fear that the admission will reflect poorly on their professionalism or competence.

Opening educational and social opportunities to non-privileged members of the medical staff may also help a hospital to encourage low- or no-volume providers to accept nonprivileged status.

The hospital should be cognizant of the need to offer a forum for low-volume providers (e.g., family practitioners and internists) to interact with their specialist colleagues and develop referral relationships. The hospital also should enable older physicians to maintain collegial professional connections and wind down their practices with dignity. Fully including low- or no-volume providers in the hospital's social events and educational programs can accomplish this. ■

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## Review your disciplinary procedures for student physicians

Hospitals with teaching programs employing interns, residents, and fellows must at times impose disciplinary action on a student physician or opt not to renew a student physician's contract. In many cases, hospitals are inadequately prepared for this eventuality and, therefore, find it difficult to respond appropriately and in a manner that equally protects the rights of the student physician, the accreditation of the residency program, and the hospital.

Hospitals with teaching programs would do well to review their disciplinary procedures for student physicians periodically to ensure that they are fair, effective, and appropriate, advises **Michael Schaff**, an attorney with Wilentz Spitzer & Goldman in Woodbridge, NJ.

### ACGME requires written disciplinary procedures

The Accreditation Committee on Graduate Medical Education (ACGME) publishes guidelines for institutions employing interns, residents, and fellows. These guidelines include provisions that afford certain due

process rights to student physicians, although these rights are far less extensive than those that the law requires hospitals extend to attending or full members of a medical staff. Specifically, ACGME institutional requirements call for organizations with physician training programs to have written policies that

- provide for written notification to an intern, resident, or fellow at least four months prior to the termination of his or her contract that the contract will not be renewed, unless the decision not to renew is made within four months of the termination date of the agreement. In that case, the institution must make the written notification as soon as the circumstances reasonably allow prior to the termination of the agreement.
- establish fair and reasonable procedures for grievance and due process. These must encompass a procedure for a student physician to challenge "academic or other disciplinary actions taken against residents that could result in dismissal, nonrenewal of a resident's agreement or other actions that could significantly threaten a resident's intended career development," according to