The top six mistakes hospitals make when employing and contracting with physicians

As more physicians seek employment and contracting opportunities, hospitals are forced to navigate what can feel like uncharted waters. Some hospitals are still reeling from the mistakes they made in the ‘90s when they gobbled up physician practices only to cough them back up when they realized they had no idea what they had gotten themselves into.

But this decade presents a fresh start—and a whole new set of challenges than those faced 20 years ago. To help hospitals avoid the pitfalls inherent to the healthcare industry in the 2010s, MSB interviewed healthcare executives and uncovered the top six mistakes that hospitals make when employing and contracting with physicians. Whether you employ hospitalists or contract with a physician group, avoiding these pitfalls will ensure that your organization forges successful relationships with the people who make it tick.

Mistake #1: Being desperate

We all know what it’s like to go to the grocery store hungry: To meet your immediate need, you grab a bulk pack of potato chips without thinking, but when you get home, you wonder why on earth you bought it. The salty treat will only thwart your diet goals, and now you’re stuck with it. The same concept applies to hiring physicians. If hospital administration is desperate to hire a physician to fulfill an immediate patient care need, it may end up making poor choices,

"Not every doctor is meant to be employed, and you find that out through lots of conversations and as you negotiate."
—Chal Nunn, MD

Hospitals may be accustomed to employing every physician who shows up on their doorstep, but the
key is to filter out applicants for the right cultural fit, says Chal Nunn, MD, senior vice president and chief medical officer at Centra Health in Lynchburg, VA. “Not every doctor is meant to be employed, and you find that out through lots of conversations and as you negotiate,” Nunn says.

To avoid hiring the wrong individuals for your organization, Means suggests training everyone who interviews applicants—from the director of nursing to members of the board of trustees—in interview skills so they can evaluate each applicant objectively.

Asking behavior-based questions will help your organization determine whether an applicant is the right fit. For example, Means suggests that instead of asking, “How would you respond if you and a nurse butted heads over a patient’s care plan?” say, “Tell me about a time within the last two years that you and a nurse disagreed about a patient care plan and how you resolved it.” If the physician blames the entire incident on the nurse or becomes defensive, that’s a sign that this individual is not a team player.

Another way to avoid hiring the wrong physicians is to go above and beyond during the credentialing process. Call the operating room director at the applicant’s previous hospital to find out about his or her behavior during procedures. Also speak to the chief nursing officer (CNO) at the applicant’s previous facility to learn whether he or she got along well with nurses. “If the physician is a problem physician, the CNO will know,” says Means.

**Mistake #2: Assuming you can simply terminate a poor performer**

Hospitals that are desperate may overlook red flags and bring on a physician who turns out to be a patient safety risk, and many hospitals incorrectly think that they can simply terminate this individual. However, terminating a physician is never a quick fix, says William K. Cors, MD, MMM, FACPE, CMSL, senior vice president of Inpatient Medical Associates in Livingston, NJ.

The first thing to consider is the employment agreement. Most agreements stipulate that if a physician is fired, he or she can no longer serve on the hospital’s medical staff (the employment agreement trumps the medical staff bylaws). However, some employment agreements do not have this stipulation, meaning a fired physician who has been granted clinical privileges can still treat patients at the hospital, albeit as an independent practitioner. Additionally, the terminated physician would be entitled to any due process under the medical staff bylaws.

The second thing to consider is that terminating an individual never results in a clean break. “Most employment agreements call either for immediate termination with cause or termination without cause but generally requiring a notice period, usually 60–90 days.”
So if you have a physician with performance challenges, do you terminate them with cause and open the door to a wrongful termination suit, or do you terminate them without cause?” says Cors. If your organization chooses to terminate the physician with cause, labor laws enable employees to bring a wrongful termination suit against the organization. “The plaintiff may not prevail, but the lawsuit will eat up your organization’s capital, time, and resources,” adds Cors. “If termination without cause is chosen, do you allow them to continue working knowing that they have bad outcomes, or do you suck it up and pay them severance pay for three months?”

**Mistake #3: Not sticking to your organization’s business plan**

Before hiring a physician, a hospital generally establishes a business plan. It calculates how many physicians it requires to fulfill a particular need, how much revenue those physicians will produce, and how much it can afford to pay them. However, once again, desperation can cause the hospital to sway from this business plan.

“If you are recruiting a physician who has a track record of being an excellent physician, great teacher, and great researcher, you can be tempted to go above and beyond your business plan and offer them more than the business plan allows,” says Means.

This isn’t to say that hospitals shouldn’t aim to hire the best physicians, but they should consider whether they can truly afford a physician whom several other hospitals are also recruiting, especially hospitals in less-than-desirable locations.

**Mistake #4: Employing, rather than engaging, physicians**

Before a hospital employs or contracts with a single physician, it must establish a mechanism for engaging physicians. If a hospital starts employing or contracting physicians without such a plan in place, it risks losing money down the road.

Some hospitals mistakenly believe that offering physicians a competitive compensation package is enough to motivate physicians to do what is right for the hospital, rather than for themselves. But it isn’t enough to simply incentivize physicians—hospitals must do so wisely, says Ronald May, MD, FAAP, CPE, vice president of medical affairs at Carolina East Health System in New Bern, NC.

Granted, hospitals must provide physicians with an appropriate base salary. “The main reason physicians are coming to hospitals is security, and they need to know that a significant portion of their income is secure, provided they do a good job,” says May.

Bonus structures, however, are a different story. It’s probably better if the bonuses are not secure, meaning they are dependent on a physician’s productivity, ability to improve quality, or other goals your organization might have. However, hospitals must be careful how they incentivize physicians because the wrong incentive might unintentionally entice physicians into putting the hospital out of business.

Consider the following scenario: A hospital employs all of its primary care physicians and includes in its contract a productivity incentive based on relative value-based units. The physicians quickly figure out that if they stay in their offices and refuse to see patients in the ED, they can make more money. Although they are employees of the hospital, they are effectively putting the hospital out of business by not seeing patients in the ED.

“I can’t tell you how many hospitals I see that assume that physicians are going to align with their employers simply because they are employees,” says Cors. “Clearly, physicians don’t take well to having a boss.”

Incentivizing physicians based on productivity isn’t a bad idea; in fact, it’s one way to guarantee that physicians don’t join your facility only to “semi-retire,” says Cors. However, think through all of the possible unintended consequences and speak with leaders at other organizations to learn from their experiences before committing anything to writing.

Another way to engage physicians is to make sure they have a seat at the governance table, says May. Hospitals sometimes make the mistake of making
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decisions about physicians’ practices without asking the affected physicians for their input. Doing so can turn a promising physician-hospital relationship sour if it means that physicians lose control of their practices’ finances.

“If you want to hold them responsible for their expenses and revenue, they have to have ability to control those things. If you take the control of the office away from the doctors but still hold them responsible for the costs, that won’t work,” says May.

If the physicians you hire have privileges at your hospital, they are members of the medical staff. Thus, they should be allowed to have a say not only in decisions that affect their practices, but also in decisions that affect the medical staff as a whole.

Keep in mind that a physician’s level of involvement depends on his or her personality. Some physicians are happy to let go of some decision-making abilities to focus more on their patients, while others can’t imagine practicing medicine unless they have a say in every decision.

Mistake #5: Treating physician practices like a hospital department

When hospitals employ private practices, they often make the mistake of running their newly acquired outpatient facility as though it is part of the hospital. However, when it comes to running a business, the outpatient and inpatient settings couldn’t be more different, says Cors.

“I’ve seen too many hospitals and health systems say, ‘We already have a finance department, so we will let them do the billing; we already have an HR department, so we will let them handle human resources; and we already have a nursing department, so we will let them do the nursing.’ You end up with all of this extremely unnecessary and expensive overhead, and at the end of the year, you’ve lost your shirt,” he says.

Hospitals think in terms of individuals with specific skill sets assigned to specific tasks, whereas most physician practices assign multiple tasks to fewer people. Most physician practices run quite efficiently, for example, by employing a nurse who can give injections and draw blood, rather than employing an RN and a phlebotomist.

Hospitals also differ by tending to write off the inconsequential bills that physician practices chase, says Nunn. If hospitals impose their own infrastructure on physician practices, they could end up putting those practices out of business. Hospitals may be wise to allow physician practices to continue running as they always have.

Mistake #6: Neglecting to lay out expectations

Before you sign a contract with a physician or physician group, make sure everyone understands the contract. “I’ve seen situations where the lawyers understand the contract, but the doctor doesn’t,” says May.

Making sure everyone understands the contract and job responsibilities before signing will save both parties headaches down the road. “The truth is, the only time you pull out a contract is when someone is unhappy. The people who are going to be doing the supervising and the people who will be supervised need to have a chance to ask their questions,” says May.

Within that contract should be a detailed job description. Consider this scenario: You’ve hired a hospitalist and assume that this physician will take care of all medical issues relating to inpatients. However, you get a call from the CNO, who says that the hospitalist refused to see an OB/GYN patient because the hospitalist “doesn’t do” GYN.

“What it comes down to is that no one sat down and articulated the duties of the hospitalist in addition to admitting and caring for unassigned patients that require medical services,” says Cors. “I can’t tell you how many times I’ve seen hospitalists get hired without a job description. You would think that there is a job description that clearly lays out the duties, but often it is incomplete and does not cover a lot of the scenarios that exist in real life.”

With a detailed job description in place, both the hospital and the physicians it hires will be saved from frustration down the road.
Do faith-based healthcare organizations violate EMTALA?

Drawing the line between religion and the law

The story of Margaret McBride, a nun who was recently excommunicated for allowing an abortion to occur at Arizona-based St. Joseph’s Hospital and Medical Center, has made headlines during the past few months. The case prompted the American Civil Liberties Union (ACLU) to write two letters to the Centers for Medicare & Medicaid Services (CMS), urging it to investigate cases where women are denied emergency obstetrical care (or receive delayed care) at Catholic hospitals.

In its letter, the ACLU claimed that Catholic hospitals that do not provide emergency abortions to women with a medical need for them violate the Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA). The scenario sparks numerous questions, including where exactly the line is drawn between religion and the law.

The backstory

A physician at St. Joseph’s determined that an 11-week-pregnant woman with a potentially fatal case of pulmonary hypertension would likely die if she did not have an abortion, according to a May 19, 2010, Arizona Republic article and a June 1, 2010, Huffington Post article. The hospital’s ethics committee, of which McBride was a member, consented to an abortion. McBride later received harsh criticism from Bishop Thomas J. Olmsted, head of the Phoenix Diocese, and was excommunicated. According to the Arizona Republic, a team of physicians, the patient, and her family made the decision to abort the fetus, and the hospital’s ethics committee reviewed the decision.

Subsequently, the ACLU wrote two letters to CMS alerting the agency that the bishop’s actions might be sending the wrong message to physicians and employees of Catholic hospitals; namely, that providing women with necessary obstetrical care can land you in hot water.

The ACLU’s case

The ACLU, in its two letters to CMS, applauded St. Joseph’s for standing up for women’s rights and complying with federal law. In its second letter, dated December 22, 2010, it noted, “But this confrontation never should have happened in the first place because no hospital—religious or otherwise—should be prohibited from saving women’s lives and from following federal law. Indeed, the Bishop’s drastic and heavy-handed actions send a chilling message to Catholic hospitals throughout the country, as well as their employees.”

The ACLU summarized a variety of health problems that may jeopardize a woman’s life during pregnancy and require emergency abortions. It also stated that because Catholic hospitals are sometimes the only hospitals in certain communities, Catholic beliefs are often forced on women who do not share them. Further, the ACLU stated that religious-based hospitals should not be able to invoke their religious status to avoid complying with federal law, including EMTALA and CMS’ Conditions of Participation.

But does refusing to provide emergency abortions really break the law? There is no simple answer.

Two sides to the same coin

Some say that if a faith-based hospital refuses to perform an emergency abortion, it violates EMTALA. “Clearly, there are situations where in order to stabilize a pregnant woman’s condition, there may be a need for an emergency abortion. If that is the case, then I think that EMTALA requires that to be performed. There is no exception in the law that provides for religious-based facilities,” states an attorney who wishes to remain anonymous.

Others say that faith-based hospitals are simply providing the services that are available to them, which does not violate EMTALA. For example, if a hospital does not provide stroke care, it would not be cited for an EMTALA violation if it screens and stabilizes a stroke patient and then transfers that patient to a facility that can provide the necessary services.

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“Basically, it is a decision that this is not a service that is available at this hospital. There is no real difference between saying, ‘This service is not available at our hospital’ and, ‘Our CT scanner is down and not available at our hospital,’ ” says M. Sean Fosmire, Esq., an attorney at Garan Lucow Miller, PC, in Marquette, MI.

But there are other factors that play into whether Catholic hospitals violate EMTALA by not offering certain procedures. One of those factors is that the vast majority of patients are eventually treated. Often, ethics boards of Catholic hospitals tell physicians not to proceed with an abortion until the fetal heartbeat has stopped naturally, unless the mother’s life is jeopardized. “That is the big exception,” says Fosmire.

In rare instances, such as in the St. Joseph’s case, hospitals allow physicians to proceed with an emergency abortion while the fetal heart is still beating because the physicians determine that the mother may die if she continues with her pregnancy. Either way, patients are screened, stabilized, and treated, which is the baseline requirement for EMTALA.

In the St. Joseph’s case, the treatment was provided in a timely manner, and thus the hospital did not violate EMTALA, says Fosmire.

Another factor to consider is that EMTALA does not stipulate how physicians should practice, only that they screen, stabilize, and provide the best possible treatment to all patients who arrive at the hospital with emergent conditions, even if that means transferring a patient to another facility.

“The doctor has to decide whether this is a situation that presents a significant risk to the mother, and far be it for me and far be it for any government official to tell a doctor when and where that decision needs to be made,” says Fosmire.

Thus, if a physician practicing at a faith-based hospital determines an emergency abortion—and thus a transfer to another facility that offers that service—is necessary, it likely does not constitute an EMTALA violation, as long as the patient consents to the transfer. If the hospital does not obtain consent from the patient, the benefits of the transfer must outweigh the burden and risk that the transfer presents to the patient. “That does not include the benefit that [the Catholic hospital] can ship you down to ABC hospital for an abortion because that would just be a way to avoid the obligations of law,” says the anonymous source.

A third factor to consider is that physicians who practice in Catholic hospitals, regardless of whether they are Catholic, must adhere to Catholic tenets. One of the major tenets is that abortion, under any circumstance, is unacceptable. At the same time, however, physicians must also adhere to state and federal law and do what is necessary to save life and limb. “That does not include the benefit that [the Catholic hospital] can ship you down to ABC hospital for an abortion because that would just be a way to avoid the obligations of law,” says the anonymous source.

Thus, if a physician practicing at a faith-based hospital determines an emergency abortion—and thus a transfer to another facility that offers that service—is necessary, it likely does not constitute an EMTALA violation, as long as the patient consents to the transfer. If the hospital does not obtain consent from the patient, the benefits of the transfer must outweigh the burden and risk that the transfer presents to the patient. “That does not include the benefit that [the Catholic hospital] can ship you down to ABC hospital for an abortion because that would just be a way to avoid the obligations of law,” says the anonymous source.

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The bottom line

“It is a very rare situation where a patient comes in with something that would truly constitute an emergency medical condition where an abortion is considered the treatment of choice,” says Fosmire. In addition, as long as a Catholic hospital screens, stabilizes, and treats a patient with an emergency condition, even if the treatment requires transferring the patient to another facility, the argument that the facility violated EMTALA is weak, he says. However, it is important to keep in mind that every case is dependent on the medical facts involved, and in some rare cases, a Catholic hospital—like any other hospital—may indeed violate the law.
Get hospitalists off on the right foot with a solid orientation process, clear expectations, and mentorship

Tips for medical directors to ease new hires into practice

Orienting hospitalists involves more than just providing new hires with a badge, showing them where the ED is, and sending them on their merry way. As employees of the hospital, hospitalists require a more comprehensive orientation than independent physicians who practice primarily in the outpatient setting and only visit the hospital on occasion.

The typical orientation for hospitalists involves two parts. The first is conducted by HR and focuses on reviewing pay, benefits, and a basic orientation of how to operate the hospital’s or network’s computer systems. The second part is conducted by the hospitalist medical director and focuses on teaching new hospitalists the work flow within the program.

One of the biggest mistakes that medical directors can make is to throw new hires into the lion’s den, says Evangeline Gutierrez, MD, hospitalist medical director at Overlook Hospital in Summit, NJ, which contracts with Hospitalist EMO, a New Jersey–based physician-owned practice management group.

If medical directors fail to get hospitalists off on the right foot, they risk those hospitalists failing to practice up to par within the expected time frame, which can drag the entire program down. A shaky start may even contribute to hospitalist turnover.

To give every new hospitalist the best possible start, medical directors must dedicate time to orienting new hires and ensuring that the orientation is a comprehensive one. The following are some tips to help you along the way.

Set clear expectations

Medical directors must ensure that they make their expectations for performance clear to the hospitalists. For example, Gutierrez expects all hospitalists that she works with to call the primary care physician on the day a patient is admitted to the hospital and call again when discharged, explain to patients their role as hospitalists, and communicate clearly with consulting practitioners.

“My expectations are for them to make their phone calls or to communicate [well], but if they don’t know that, I’m the one who hasfallen short because I didn’t tell them they are expected to do that,” says Gutierrez.

Hospitalist programs should also set expectations around documentation (e.g., medical records should be completed within a certain number of days after a patient is discharged), patient volume (e.g., hospitalists are expected to see X patients per day), and work hours (e.g., some shifts may last longer than 12 hours if an emergency arises). Hospitalists should not be surprised to learn that they may not get to leave at 4 p.m. every day.

“It is a very stressful job, so you cannot tell them that it is going to be a breeze and they are going to see 10 patients if the reality is that they will see 20. Honesty from the program is so important when you give orientation so you don’t shock your new colleagues,” says Gutierrez. “There will be good days and bad days, but I’m not going to lie and say you’ll be home every day by 4:00 when you know that if you have a crashing patient, you are going to have to stay.”

The clearer the picture you can paint for new hires, the better prepared they will be to meet your expectations and, therefore, help meet program goals. Medical directors should determine the goals for the program and then set expectations around them.

“What are the outcomes that I want, and how can I make sure that [new hospitalists] are successful? Lack of their success means I don’t get the outcomes that I want,” says Alpesh N. Amin, MD, MBA, FACP, executive director of hospitalist programs and vice chair. 

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for clinical affairs and quality at the University of California, Irvine.

Step it up gradually

Those first few days and weeks are critical, so it’s important to plan your orientation such that new hospitalists aren’t forced to dive headfirst into the deep end on their first day.

Gutierrez plans for a three- to four-day transition period as follows:

➤ Day 1: The new hire shadows the medical director. The medical director addresses the daily work flow: how to handle phone calls and pages, use the computerized physician order entry system, read medical charts (chart setup differs from hospital to hospital), and process bills.

➤ Day 2: The new hire takes on a handful of patients—about half the typical census. The medical director observes the new hire in action and answers any questions he or she may have.

➤ Day 3: The new hire takes on a full load of patients during the same shift that the medical director works so that the medical director is available to answer questions and provide mentoring. “I don’t like that experience of saying to them, ‘Welcome to your first day. Here are your patients, go and see them.’ The whole time they are thinking, ‘Who is Dr. Smith? Where do I go? Who do I call? What is the extension for radiology?’ ” says Gutierrez.

Throughout this process, Gutierrez makes sure to introduce the new hire to the patient care team. That includes not just other hospitalists, but also the attending physician in the ED, social workers, nurses, and anyone else the hospitalist may work with regularly.

Maninder Abraham, MD, hospitalist medical director at Saint Barnabas Medical Center in Livingston, NJ, takes a slightly different but equally effective approach. Prior to their start date, she asks new hires to come in for a few days to meet the staff and observe them in action, familiarize themselves with the computer system, and get to know the lay of the land. Once they start, the new hires see a reduced number of patients for approximately the first week. If the average patient census is 10, for example, Abraham may assign the new hires four or five. She is always sure to schedule new hires during one of her shifts so she is available to assist. If Abraham is unavailable, the new hires will work closely with a veteran of the program.

To provide a greater support system, Abraham allows for a longer orientation period for more challenging situations. Although St. Barnabas has a teaching program, she does not throw hospitalists into their teaching
responsibilities right away. She also does not schedule new hospitalists for a night shift, which is generally staffed by only one person. “I save that for the end of the first month or the beginning of the second month so they have at least three to four weeks to get oriented to the place.”

Create an orientation package

Abraham provides each new hospitalist with an orientation package that includes:

➤ Names and contact information of referring physicians
➤ Names and contact information of consulting physicians
➤ A summary of each referring physician’s practice patterns
➤ Essential phone numbers, such as the answering service and various departments in the hospital

“A lot of [hospitalists] carry that around for the first month or so until they get familiar with the names and numbers,” says Abraham. Update the list as physicians come and go so that new hires don’t attempt to call a physician who no longer works at your facility.

Review billing processes

Abraham, who is also part of the Hospitalist EMO group, says that when she first started practicing hospital medicine, she wished someone had taught her more about billing. Residents often enter practice not having a clue how to bill, she says, so medical directors will need to spend extra time with new grads.

Even if a hospitalist has been practicing medicine for many years, the billing process differs from hospital to hospital, so it’s still worth walking new hires through how it works.

When teaching new hires about the billing system, it’s important to not throw too much information at them at once, says Amin. Think of it as a learning cycle. “We first give them the nuts and bolts, and then we do an assessment of how they are doing, and we go back to them and give them further education.”

Enlist existing hospitalists as mentors

Although the job of orienting new hospitalists often falls to the medical director, sometimes it is necessary to enlist other physicians in the orientation process. According to Tools and Strategies for an Effective Hospitalist Program, published by HCPro, Inc., to facilitate a strong match, gather information about the new hospitalist and pair him or her with a mentor who shares a similar personality, background, and work style. You may wish to train mentors to ensure that they know what material to cover with new hires; if time is tight, a checklist may suffice. Mentors should check in with their mentees regularly throughout the first six months.

Don’t set an orientation time limit

Residents may take a couple of months to get up to speed, while experienced hospitalists may take a couple of weeks. Even after hospitalists are fully immersed, don’t consider your job as a medical director done.

“Sometimes I feel like I’m continuously orienting because even if they are already working, they are not going to absorb everything in one sitting during that period. It is a continuous learning process because as they are working, new things come up and then they call you and you have to teach them as they go along,” says Gutierrez.

Abraham notes that the length of the orientation may depend on how short-staffed the hospitalist program is. “When you are desperate for staffing, which I used to be in the past, it was never too soon. The moment they started, we could not wait to fill up their schedule,” she says. If your program is well staffed, it’s smart to take your time with the orientation to ensure that the hospitalists you hire today stay on for the long term.

Providing a thorough orientation ensures that hospitalists start their tenure with your facility on a high note, and it will help keep their job satisfaction elevated throughout their career with you. It’s no secret that employee retention starts during the hiring and orientation process, so make sure it’s a good one.
Is your medical staff compliant with MS.01.01.01?
As March 31 deadline approaches, medical staffs must be prepared

As the March 31 deadline approaches for implementing the changes brought about by the final version of Joint Commission standard MS.01.01.01, one question hangs in the air: Are you ready?

Eight elements of performance (EP) have undergone significant changes with the final revision to MS.01.01.01, according to MS.01.01.01 Solutions Package: Strategies, Tools, and Analysis for Compliance, published by The Greeley Company, a division of HCPro, Inc., in Danvers, MA. Those updated EPs are:

- EP 1: The medical staff determines how much authority to delegate to the medical executive committee (MEC) regarding rules, regulations, and policies
- EP 2: The amendment of bylaws cannot be delegated
- EP 3: Major processes must be outlined in the bylaws, but details concerning those processes can be in accompanying documents
- EP 8: The medical staff can propose bylaws amendments directly to the board
- EP 9: There must be a communication mechanism between the medical staff and MEC
- EP 10: There must be a conflict resolution mechanism between the medical staff and MEC
- EP 11: The MEC and board are able to enact urgent temporary amendments to the bylaws
- EP 20: The medical staff determines how much authority to delegate to the MEC and how that authority is delegated or removed

Although many of these changes have caused medical staffs to rework their current processes, many are pretty straightforward, says Mary Hoppa, MD, MBA, CMSL, senior consultant with The Greeley Company.

For example, the debate regarding whether process details should be contained in the bylaws or in associated documents has been raging for years, so medical staffs knew it was coming down the pike. In addition, for many medical staffs, the change simply required moving text from one document to another and voting to approve it.

However, two sticky areas remain: developing a conflict resolution mechanism and creating a bylaws amendment process that allows amendments proposed by the medical staff to not be stifled by medical staff leadership.

Understanding the challenges that these two changes pose and developing appropriate language will ensure that your organization passes its next Joint Commission survey with flying colors.

Conflict resolution

One thing medical staffs may not realize is that the basic rights afforded to medical staff members may serve as the foundation for any conflict resolution mechanism, says Hoppa. “A set of member rights in the bylaws ensures a set of checks and balances so that you just don’t let your medical staff leaders do things for you unchecked,” she says.

According to The Greeley Guide to Medical Staff Bylaws, Third Edition, published by HCPro in conjunction with The Greeley Company, members of the medical staff are afforded the right to:

- Meet with the MEC on matters relevant to the responsibilities of the MEC that may affect patient care or safety if the medical staff is unable to resolve the issue with the department/clinical service chair
- Have a fair hearing and appeal

The medical staff as a whole has the right to:

- Initiate a recall after an election of officers
- Initiate a recall after an election of department/clinical service chairs
- Initiate a call for a general staff meeting
➤ Initiate a call for a department/clinical service meeting
➤ Challenge any rule or policy adopted by the MEC

However, some medical staff bylaws do not include a section on member rights, which may make meeting this requirement difficult. If your medical staff does not have a section in its bylaws on medical staff member rights, consider the following sample bylaws from The Greeley Company, which incorporate the above rights:

Any conflict between the medical staff and the MEC will be resolved using the mechanisms noted below:
➤ Each staff member in the active category has the right to initiate a recall election of a medical staff officer by following the procedure outlined in Section X of these bylaws regarding removal and resignation from office.
➤ Each staff member in the active category may initiate a call for a general staff meeting to discuss a matter relevant to the medical staff. Upon presentation of a petition signed by n% of the members of the active category, the MEC shall schedule a general staff meeting for the specific purposes addressed by the petitioners. No business other than that detailed in the petition may be transacted.
➤ Each staff member in the active category may initiate a challenge to any rule or policy established by the MEC. In the event that a rule, regulation, or policy is thought to be inappropriate, any medical staff member may submit a petition signed by n% of the members of the active category. Upon presentation of such a petition, the adoption procedure outlined in Section X will be followed.
➤ Each staff member in the active category may initiate a call for a clinical service meeting by presenting a petition signed by n% of the members of the clinical service. To present such a petition, the [department chair] will schedule a clinical service meeting.

When deciding what percentage of the medical staff must sign a petition, “you want a number big enough so that not just one person or a small cadre of people can bog down the entire medical staff, but you don’t want it to appear so high that you’re stifling the medical staff and not allowing change to occur,” says Hoppa.

Creating a bylaws amendment process

MS.01.01.01 indicates that the MEC and the bylaws committee cannot be the only entities that can propose bylaws amendments.

According to Hoppa, medical staffs have struggled to come up with bylaws language to meet this change and to determine a reasonable percentage of the medical staff that must sign a petition to amend the bylaws.

Similar to the conflict resolution mechanism, the medical staff can ask that a certain percentage of members sign a petition before considering the bylaws amendment. Adding the following bylaws language from the MS.01.01.01 Solutions Package to your bylaws may do the trick:

Proposed amendments to these bylaws or rules and regulations may be originated by the MEC or by a petition signed by n% of the voting members of the medical staff.

After the proposal, the medical staff must consider the original bylaws and the amendment and then vote on the change following its existing bylaws approval process.

What to expect when you’re expecting a survey

Although it is impossible to predict how surveyors will respond come March 31, it’s safe to assume that surveyors will be expecting medical staffs to have made significant progress toward compliance, says Hoppa.

On the flip side, surveyors often understand that making changes to medical staff processes can move at a snail’s pace, so they may grant some leniency toward facilities that are still in the process of becoming compliant, she notes. “I don’t want to guarantee anything; I think we have to stick to the letter that it has been out a while, and therefore it is expected.”
Democracy is messy

What your medical staff can do when self-governance gets political

by Richard A. Sheff, MD, CMSL, chair and executive director of The Greeley Company, a division of HCPro, Inc., in Danvers, MA

For more than a century, the primary responsibilities of credentialing and peer review have been delegated to the medical staff. To fulfill this responsibility, medical staffs organized themselves under the principles of democratic self-governance. Early on, this meant direct democracy. The entire medical staff met monthly to make decisions that concerned credentialing and peer review. The same physicians typically constituted the county medical society, so they established the local standards of care and were responsible for holding their peers accountable for meeting those standards.

As hospitals grew, direct democracy evolved into a representative republic structure of self-governance. Under a representative republic, medical staffs elect leaders, such as department chairs and officers, and the leaders make decisions for the medical staff as a whole.

Whether structured as direct democracies or representative republics, all too many medical staffs have found that when physicians disagree, democracies have a hard time resolving conflicts. Physicians take sides. Collegiality can deteriorate into competition, distrust, and, in the worst cases, legal action. In short, democracies are messy.

Take, for example, a nasty privileging turf battle. In one hospital, a GYN oncology group recruited a new member who had completed a breast surgery fellowship. This new physician applied for breast surgery privileges. Fearing competition, the general surgeons told the CEO en masse that if she allowed the new physician to be granted breast surgery privileges, they would bring their patients to the hospital across town. On the other side, the GYN oncology group informed the CEO that if she did not grant the new physician breast surgery privileges, the group would sue the hospital for restraint of trade. In other words, it got messy.

What should the CEO do in the face of such threats? Nothing. And that is exactly what this CEO did. She knew the conflict had to be resolved through the medical staff self-governance process, not by management. As much as the CEO knew she and the hospital stood to lose if either group followed through on its threat, she stood aside and let the medical staff’s messy, democratic process work through the issue.

Each side heavily lobbied members of the credentials committee, which eventually sent a divided recommendation to the medical executive committee (MEC). At one point, the MEC vote was evenly split 6-6. It turned out the key issue was not competition for breast surgery patients. Instead, it was that a physician came into the community to skim off elective daytime billable services without taking a share of the general surgery ED call burden. When the hospital agreed to establish a task force to develop a fair, consistent approach to ED call across the medical staff, one MEC member changed his vote, producing a 7-5 vote in favor of granting the breast surgery privileges. The governing board wisely went along with the recommendation of the elected medical staff leaders.

Although the general surgeons were angry, they, too, wisely recognized that even if they disagreed with the results produced by the medical staff’s self-governing process, it would be better to accept those results than to undermine the legitimacy of medical staff self-governance.

After all, democracy is messy, but it’s better than any of the other forms of government.