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In Washington, the family of a patient who died after complications from a robotic surgery in September 2008 is suing Intuitive, claiming the injuries were a result of inadequate training from the company.

Quality and training issues come to light regarding robotic surgery

A lawsuit filed in Washington along with recent data suggests that hospitals may want to take a second look at their credentialing procedures.

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TRENDSPOTTING

1,371

The number of hospitals that have purchased the da Vinci Surgical System.

SOURCE: Intuitive Surgical, Inc.

10

At least 10 lawsuits have been filed against Intuitive in the last 15 months because of problems with the da Vinci Surgical System.

72%

At least 72% of healthcare managers indicated their facility used locum tenens physicians sometime in the previous 12 months.

SOURCE: Staff Care.
California physician assistant bill clears first hurdle

The Senate Committee on Business and Professions approved SB 352 by Sen. Fran Pavley (D-Agoura Hills), a bill designed to allow physician assistants and other providers to oversee work by medical assistants (MA). “‘Under this bill, a nurse practitioner, midwife, or physician assistant can supervise [MAs] without a physician being on the premises,’ Pavley said.

www.healthleadersmedia.com/content/PHY-290954

HHS rule merges healthcare integrity, practitioner data banks

A final rule from the Department of Health and Human Services (HHS) has merged the Healthcare Integrity and Protection Data Bank (HIPDB) and the NPDB in a move to eliminate duplication of data. The rule goes into effect May 6. All data in the HIPDB will be transferred to the NPDB, and HHS will cease operating the HIPDB when that transition is complete.

www.hcpro.com/CRD-291268-863

FROM THE FIELD

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Christine Mobley, CPMSM, CPCS

“When you have a device that has been approved, then you need training programs that have been identified, vetted, and reevaluated.”

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Evaluating new technology

Healthcare facilities that are considering any new technology need to vet it through a technology assessment committee to determine whether it will be beneficial to patient care, says Christine Mobley, CPMSM, CPCS, president of C Mobley and Associates, LLC, and partner at Edge-U-Cate, LLC, in Colorado Springs, Colo.

“It’s not just about granting privileges, it’s an overall evaluation, and there’s an awful lot involved to evaluate before you determine you’re going to bring in this piece of equipment,” she says. “It’s costly, but part of it is asking, ‘Is it going to improve the care that we are giving to our patients, and can we justify the cost and what we’re going to charge should we provide this service?’ ”

This objective review may also discuss initial considerations for credentialing physicians and what those requirements for training may be.

Hospital liability

Although the Washington lawsuit is filed against Intuitive specifically, many of the issues brought forth in the case may be of concern to hospital credentialing committees.

Hospitals are responsible for setting credentialing standards and training requirements for any procedure. Incorporating new technology adds a new dimension to these standards, and credentialing committees need to collect information from a variety of sources to implement thorough credentialing requirements. Many surgical specialties can use the da Vinci surgical system, and each procedure may have different measurements of competency. Credentialing committees, in conjunction with the hospital’s board and the medical staff, also need to be able to adjust training requirements if bad outcomes persist, says Michael Callahan, Esq., partner at Katten Muchin Rosenman, LLP, in Chicago.

“When you have a device that has been approved, then you need training programs that have been identified, vetted, and reevaluated to make sure they are still keeping up with developments all the time,” Callahan says. “There are changes in techniques and lessons learned for good outcomes and bad outcomes which need to be factored into updates in training.”

One of the issues brought to light in the case against Intuitive is that sales representatives for the...
require input from the manufacturer regarding training, ultimately the hospital is responsible for defining its credentialing standards based on its own standards of care as well as any guidelines from specialty organizations.

“I would hope a truly informed and objective institutional review board or credentials committee or whoever is evaluating this, through past experience with other devices and protocols, is making its best judgment and also factoring in whatever the manufacturer is telling them, but hardly relying on that exclusively,” Callahan says.

Ultimately, healthcare organizations will be legally held to the standard that they set for themselves, provided it falls in line with national standards of care and generally accepted methods of credentialing. That includes monitoring quality and patient outcomes of physicians who are freshly privileged to perform new procedures.

“If they didn’t follow the steps or didn’t monitor or didn’t apply their own policy, there is going to be some liability exposure there,” Callahan says.

State advisories, such as the one issued in Massachusetts, can further implicate hospitals, Callahan adds.

“I think the general standard is once you’re put on notice of an issue or a problem, you have a duty to investigate,” he says.

Don’t let marketing get in the way

Healthcare providers that adopt new technology commonly find that marketing impedes the credentialing process. Mobley says she has worked with healthcare facilities in the past to build credentialing and training policies around new technology such as the da Vinci system, in cases where the hospitals were too eager to market the technology to prospective patients.

Whenever any new technology is being considered, a comprehensive documented review needs to take place first, and clear credentialing guidelines should be established before initiating any marketing campaigns.

“One or two other places that I have been they have marketed it and actually had patients scheduled for the procedure and they hadn’t done anything regarding privileges yet, so those procedures needed to be postponed,” Mobley says.
Keys to properly credentialing locum tenens physicians

As hospitals rely more on locum tenens, written policies and bylaws need to support specified credentialing procedures

Locum tenens is a Latin phrase for “a person who stands in temporarily for someone else of the same profession.” In healthcare, these temporary assignments are becoming a more frequent and reliable source of care.

Years ago, locum tenens physicians were used fairly infrequently, only when there was an immediate patient need, but statistics are starting to show that healthcare providers are using more and more locum tenens to fill gaps in shifts. A survey published in March by the healthcare staffing firm Staff Care found that, for the sixth consecutive year, at least 72% of healthcare managers indicated their facility used locum tenens physicians sometime during the previous 12 months.

Some other interesting data found in the survey:

- Primary care physicians are in the greatest demand. Thirty-five percent of facilities that used locum tenens physicians were seeking primary care physicians. Thirty-one percent of facilities sought behavioral health professionals such as psychiatrists.
- Locum tenens physicians are most frequently used to fill in for physicians that have left the hospital, with 58% of those surveyed citing this reason. Staff Care attributes this to increasing physician turnover.
- Fifty-seven percent of survey respondents said they use locum tenens physicians to maintain services while they seek to fill open permanent positions, owing to a growing physician shortage.
- Technology and healthcare reform is also a factor. Five percent of respondents said they use temporary physicians when transitioning to the employed physician model, and 4% said they use temporary physicians during electronic medical record training.
- Forty-five percent of respondents said they use one to three locum tenens physicians per month, while 7% said they use four to six and 4% said they use seven or more.
- Eighty-five percent of respondents said locum tenens were worth the additional cost, up from 79% in last year’s survey.

It’s clear that more providers are using locum tenens physicians not just to fill in occasionally, but on a consistent basis, especially in high-need areas like the ED, says Kathy Matzka, CPMSM, CPCS, a consultant, speaker, and writer specializing in provider credentialing and professional staff issues in Lebanon, Ill.

The increased reliance on hospitalists has also led to a natural shift toward utilizing temporary physicians to fill that role. “I think there are just more staffing agencies out there that make it more available,” she says. “They handle all the hospital contracts with this agency and the hospital doesn’t need to worry about the HR piece of it. The agency has all of the responsibility for filling shifts and paying their salary and insurance, and it’s easier for the hospital to contract and pay one bill rather than doing the staffing themselves.”

As locum tenens become a more prominent feature in hospitals, medical staffs and credentialing committees need to review their bylaws regarding the credentialing and privileging process for temporary physicians.

Common problems

 Appropriately credentialing locum tenens physicians brings its own set of challenges, Matzka says. Those issues can be further complicated if your medical staff does not outline specific requirements in the medical staff bylaws. The following are some of the common hurdles that credentialing committees face in credentialing locum tenens physicians:

- **Communication:** When a department has a need for locum tenens, it will sometimes take the task of filling shifts into its own hands without alerting the medical staff office, says Teresa Sappington, MBA/HCM/PM, BSHA, CAPP/PM, CPHQ, CPMSM, CPCS, a consultant that specializes in medical staff affairs and healthcare regulatory compliance in Augusta, Ga. Sometimes they show up at the door at 7 a.m. ready...
to start their shift, and staff are unaware, she says.

There needs to be a defined process in which clinical departments alert the medical staff and the credentialing committee as soon as they have a need for a locum tenens physician. Although by the nature of the situation, locum tenens physicians are often credentialled with only two to three days’ notice, medical staff professionals still need time to gather basic verification requirements.

- **Long-term locum tenens:** As hospitals rely more on temporary physicians to fill shifts, some medical staff offices end up appointing locum tenens to the medical staff rather than repeatedly going through the process of assigning them temporary privileges. This can be burdensome because these physicians have the same rights and protections as other medical staff members, yet they may only be working a dozen shifts over the course of a year. Additionally, appointing locum tenens to the medical staff means they are entitled to hearing and appeal rights, requiring the medical staff to go through the entire peer review process.

  “You can’t fit a square peg in a round hole, and that’s what locum tenens doctors are,” Matzka says. “They don’t fit the usual bylaws template language that a regular active staff member would.”

  She recommends creating a specific locum tenens category in the medical staff bylaws that outlines exactly how they should be privileged. “A lot of times their bylaws haven’t been rewritten in the last 10 years,” Matzka says. “The way people practice medicine has changed significantly in the last 10 years, so they really need to take a look at those bylaws and see if the old ones are really fitting in with the way people practice medicine in the hospital setting.”

- **Past appointments:** One nuance to credentialing locum tenens physicians is that they have usually practiced in many hospitals. Verifying employment at every one of those hospitals is a burdensome task, so facilities need to determine exactly how many past appointments should be verified. “You need to obtain information from a sufficient number of facilities to provide the medical staff what they need to come to a decision regarding whether or not this person is competent,” Matzka says.

  Additionally, Joint Commission standards stipulate that if there is a patient care need, the hospital defines how long physician privileges last. Since locum tenens physicians are most often used to fill a patient need, the bylaws need to stipulate the length of their privileges.

### Basic requirements

The following are the basic minimum requirements in credentialing a locum tenens physician:

- Documentation of current licensure in a state where services are to be provided
- Education/training
- Current competency
- NPDB query
- Lack of Medicare/Medicaid sanctions

Since locum tenens credentialing is typically done within a short time frame, Matzka recommends using AMA Physician Masterfile or American Osteopathic Information Association profiles to quickly verify education, training, and board certification. Credentialing committees can also use information provided by the locum tenens agency to supplement their own due diligence credentialing, but this information is not considered primary source verification.

Verifying current competency can be onerous, so Matzka recommends implementing a standard interview form that can be used by the department chief to call other hospitals where the physician has worked.

“You can fax peer recommendations back and forth to ERs, but in my mind the best thing you can do to quickly document competency is for a physician to call a physician,” she says. “I feel like doctors talk to doctors better than they do to people who are nonclinicians.”

### Monitoring quality

Finally, although physicians that are not appointed to the medical staff do not have peer review rights, the hospital is still required to monitor outcomes and initiate OPPE and FPPE when necessary.

Typically locum tenens contracts will stipulate that if there are any problems with the physician—whether it’s behavior or quality—the hospital can legally terminate the contract. “But you have to watch how you appoint them because if you’re appointing them to the medical staff and giving them all the privileges to medical staff appointment, that includes hearing and appeal rights,” Matzka says.
U.S. District Court dismisses employment discrimination and due process suit

The United States District Court for the District of Columbia dismissed employment discrimination and federal due process claims against a New Hampshire hospital. The court also dismissed several tort actions and a Fifth Amendment action brought against a referring physician.

In May 2008, Edith Budik, a neuroradiologist living in Washington, D.C., applied for a locum tenens neuroradiology position at Dartmouth-Hitchcock Medical Center in Lebanon, N.H. In accordance with requirements of the New Hampshire Board of Medicine (NHBM), Dartmouth-Hitchcock submitted a letter to the NHBM regarding Budik, and Budik submitted an application to the NHBM for a locum tenens license, which was granted.

Budik later decided to apply for a permanent position at Dartmouth-Hitchcock and submitted the required employment application and New Hampshire Uniform Credentialing Application. During a three-day visit at Dartmouth-Hitchcock, Budik spoke with a credentialing specialist at the hospital regarding two previous incidents that she was unsure how to address in the credentialing application. The incidents involved two erroneous reports from 23 and 32 years prior, but had previously appeared on the Federation Credentialing Verification Service report. The credentialing specialist expressed doubts about the relevancy of these incidents, citing Dartmouth-Hitchcock’s five-year verification rule reach back for credentialing locum tenens applicants.

During the credentialing process, Col. Steven M. Princiotta, MD, the chair of the credentialing committee at Landstuhl Regional Army Medical Center, provided a negative statement to Dartmouth-Hitchcock from one of Budik’s prior performance evaluations. Princiotta indicated in his statement that Budik had problems with staff interactions, which resulted in several complaints and clinicians deciding to use other radiologists. Upon receiving Princiotta’s statement, Dartmouth-Hitchcock stopped the credentialing process for Budik and later told her that the decision was based on the incidents in the credentialing report that had taken place 23 and 32 years prior.

Budik filed complaints with the New Hampshire Human Rights Commission (HRC), alleging discrimination based on race, color, age, and gender, and the HRC ruled no probable cause. Budik appealed to the Equal Employment Opportunity Commission, which upheld the HRC’s decision and closed the file. Budik then brought claims against Dartmouth-Hitchcock for discrimination and against Princiotta for violations of certain Army regulations, the Fifth and Fourteenth Amendments to the Constitution, misrepresentation, fraud, and intentional infliction of emotional distress.

Dartmouth-Hitchcock filed a motion to dismiss the discrimination claim based on the court’s lack of personal jurisdiction. Dartmouth-Hitchcock argued that because it conducts no business in the District of Columbia and since Budik’s claim did not arise out of any contract between Dartmouth-Hitchcock and the District of Columbia, the court could not exercise personal jurisdiction over Dartmouth-Hitchcock. Budik argued that her own presence in the District of Columbia at the time she applied for employment with Dartmouth-Hitchcock was enough to connect Dartmouth-Hitchcock to the District of Columbia. The court evaluated the seven requirements of the District of Columbia’s long-arm statute and concluded that Budik failed to present evidence to satisfy any of the statutory requirements that would permit the court to exercise personal jurisdiction over Dartmouth-Hitchcock. The court dismissed Budik’s discrimination claim based on lack of personal jurisdiction.

Princiotta and the United States filed a motion to substitute the United States as the defendant in the case and dismiss the claims. Princiotta and the United States submitted a certification to the court stating that Princiotta was acting within the scope of his employment with the U.S. Air Force at the time Princiotta made the statements to Dartmouth-Hitchcock about Budik, therefore the United States was the proper defendant in this case. Budik failed to rebut the certification with specific facts, and the court granted the motion to substitute the United States as the appropriate defendant for Budik’s tort claims.

The court analyzed Budik’s claims under the Federal
Tort Claims Act and determined that the misrepresentation, fraud, and intentional infliction of emotional distress claims were statutorily barred. The court analyzed Budik’s constitutional claims under the Fifth Amendment and determined that Budik’s own allegations established that no government action had deprived her of any potential employment with Dartmouth-Hitchcock. The court dismissed each of Budik’s claims against Princiotta and the United States.


Arizona Court of Appeals upholds medical board’s decision to issue a letter of reprimand

An Arizona Court of Appeals affirmed a lower court’s decision to uphold the Arizona Medical Board’s decision to issue a letter of reprimand to a physician. The court concluded that the board’s vote to issue the letter of reprimand was valid because the board met the quorum and majority vote requirement under Arizona law.

Shakeel Aziz Kahn, MD, a family practitioner, was a member of the medical staff at Valley View Medical Center in Fort Mohave, Ariz. On June 26, 2009, Kahn was summarily suspended from the medical staff for failure to see his hospital patients on a daily basis. Valley View’s chief of staff advised the board of Kahn’s suspension and noted that Kahn’s actions may have constituted unprofessional conduct under Arizona law.

The board opened an investigation and the Board’s medical consultant, Kathleen Coffer, MD, reviewed the medical charts of three of Kahn’s patients. Coffer submitted a report to the board stating that Kahn had fallen below the standard of care in treating one of the patients, thereby causing harm to the patient.

The board filed a formal complaint against Kahn for deviating from the standard of care, and an evidentiary hearing was held before an Administrative Law Judge (ALJ). The ALJ concluded that Kahn had deviated from the standard of care and recommended that the board issue a letter of reprimand to Kahn. On August 11, 2010, the board adopted the ALJ’s recommendation.

Kahn filed a complaint for judicial review and the superior court affirmed the board’s decision. Kahn argued that the board’s decision was void because there was one vacancy on the board when it voted to issue the letter of reprimand. The court determined that under Arizona law, the statutory requirement is that seven board members must be present at a meeting to constitute a quorum and a majority vote of the quorum is necessary for the board to take any action. There were 11 board members present at the meeting on August 11, 2010, that unanimously voted to issue a letter of reprimand to Kahn. The court concluded that Kahn’s argument was without merit because the unanimous vote of the board exceeded the majority vote requirement under Arizona law and there is nothing in the law that suggests that the board loses authority to act when a board vacancy exists.

Kahn also argued that Coffer did not satisfy the expert witness qualifications set forth in the law because she practices internal medicine and he practices family medicine. Under Arizona law, expert witnesses are required to be members of the same field only during medical malpractice actions. The court stated that the board’s actions were administrative in nature and thus distinct from a malpractice case tried to a jury or a court. Under Arizona law, all relevant evidence is admissible in administrative hearings and Kahn did not contend that Coffer’s testimony was irrelevant. The court concluded that Coffer’s testimony to the Board was permissible and affirmed the superior court’s ruling.