Board Oversight of the Hospital Professional Community:
A Challenge More Critical Than Ever

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"A Hospital Without Doctors is Just a Hotel with Bad Food"

But which doctors provide the service makes all the difference.

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Boards Must Focus Attention on the Following:

- Recruitment and Retention of Needed Practitioners
- Maximizing Trust Between the Professional Community and Hospital Management and the Board
- Developing and Appropriately Deploying A Sufficient Group of Physician Leaders
- Promoting High Quality Care and Minimizing Institutional Risk by Assuring the Organized Medical Staff is Carrying Out Its Delegated Duties Well

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Is your hospital doing all it can to recruit and retain appropriately qualified practitioners?

- Is our hospital considered 'user-friendly' for physicians?
- Do we compensate adequately and using the best compensation formulas?

However beautiful the strategy, you should occasionally look at the results.
(Winston Churchill)

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Is your hospital doing all it can to recruit and retain appropriately qualified practitioners?

- Do we have a viable plan to address physician 'burn-out'?
- Have we created a desirable and competitive 'professional home' for our professional community? Are we exploring transformation of the work experience?

For many practitioners think of the 'Great Resignation' as the 'Great ReThink' (is my work satisfying enough? do I like the culture here? do I need to work in the same way going forward?)

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"How many times have I told you not to play doctor?"

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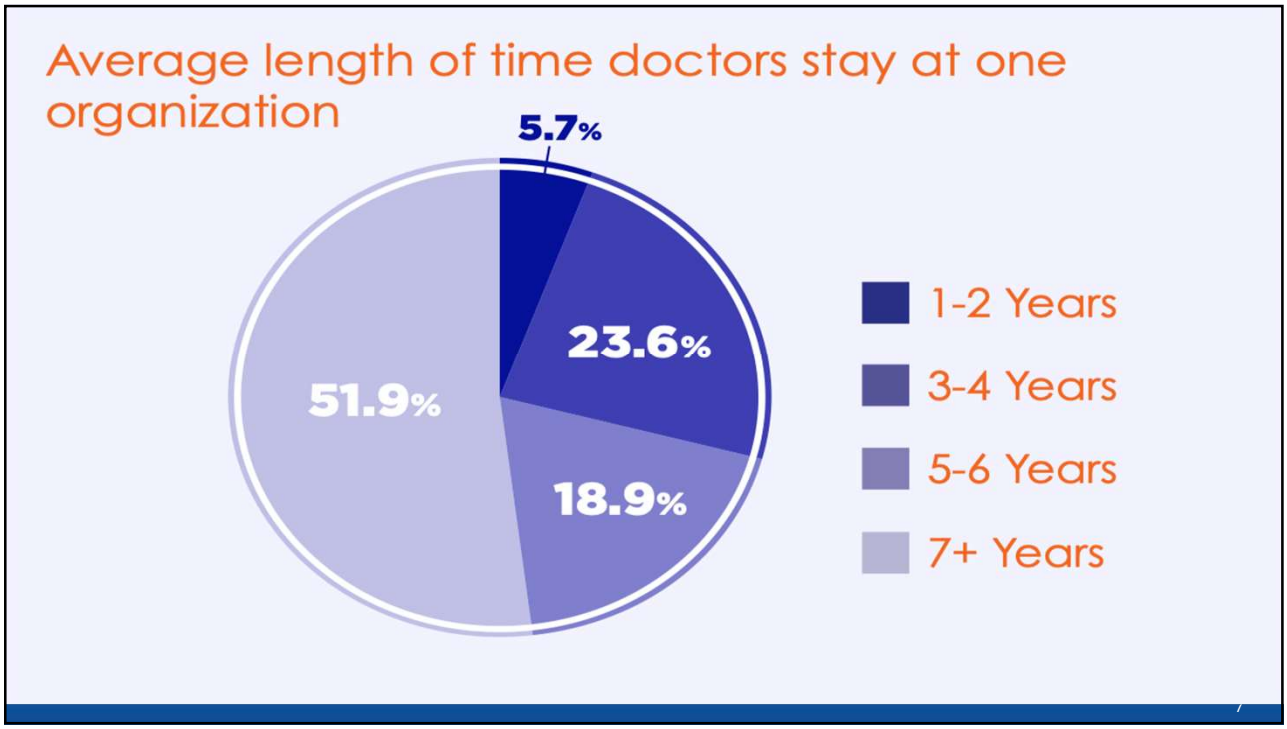

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Is your hospital doing all it can to recruit and retain appropriately qualified practitioners?

Is there a high-level of trust between the professional community and hospital management and board?

- The 1990s was a period of high distrust between doctors and hospitals
- Significant improvement has been made over the last two decades
- The global pandemic has caused erosion in practitioner- hospital relationships

It is important for the Board to step in when there is significant erosion in trust and working relationships between the medical community and management.

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A Salutary Trend: Growth in Physician Leadership to Address the Following:

- Clinical care redesign
  - ✓ Delivery of more efficient/cost effective/high value care
  - ✓ Delivery of more 'patient centered care'
  - ✓ Improved quality and patient safety
- Leadership in the development of 'population health' management
- Team leadership in an era of increasing integration and enhanced care coordination
- Creation of vision and value for new clinical structures (CINs, ACOs, employed group practices, comprehensive service lines, hybrid insurance models, patient centered medical homes, perioperative surgical homes, etc.)

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Traditional Physician Leaders:
Medical staff officers, department and committee chairs
Physician leaders in academic affairs

Expanding Roles for Physician Leaders:
Physician executives (CEOs, CMOs, VPMAs, CQO, CIO, Chief Integration Officer, Chief Transformation Officer, Chief Clinical Operating Officer, etc.)
More physicians serving on hospital governing boards
Physician leaders of ACOs and CINs
Medical directors of service lines, centers of excellence
Physician leaders of employed and contracted group practices
Physician leaders in PCMHs, perioperative surgical homes, PACE, etc.

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Poorly Coordinated Leadership Has Consequences

Department of Justice

U.S. Attorney's Office

District of Idaho

SHARE

FOR IMMEDIATE RELEASE — Friday, February 5, 2016

Seven Arrested for Multi-State Drug Trafficking and Money Laundering Ring

One of the arrested was a hospital employed physician accused of money-laundering.
After he was terminated for-cause, the doctor reached a multi-million-dollar settlement with the hospital for wrongful-discharge.

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A Hospital Board Has Two Direct Reports

- The hospital CEO
- The health system's organized medical staff:
  - The organized medical staff is accountable for the quality of care delivered by the hospital's privileged practitioners

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The 'Organized' Hospital Medical Staff

Designed long ago for a different era in medical care delivery where:

- Most physicians were in private practice
- Doctors and hospitals needed each other, and an unspoken 'contract' existed between the two
- Regulatory demands were minimal
- Quality and patient safety were assumed
- Interdisciplinary care was not the norm/integrated care was uncommon

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What Happens When Board Oversight of the Medical Staff Is Not Adequate?

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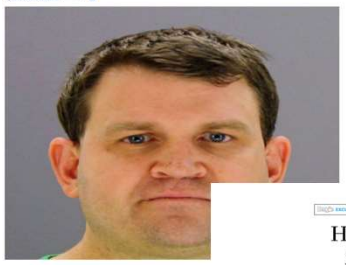
A health system's reputation is one of its most important assets!

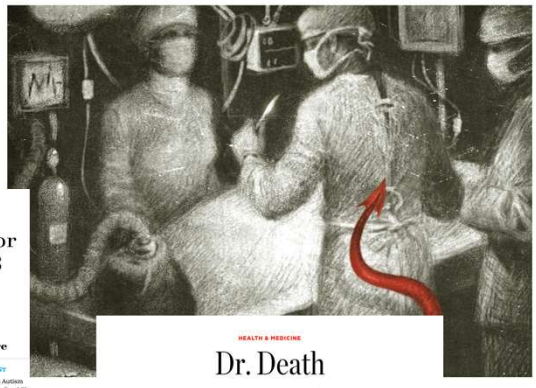
Texas neurosurgeon nicknamed 'Dr. Death' found guilty of maiming woman during surgery



PEOPLE.COM > CRIME

How 'Dr. Death' Left a Trail of Horror Across Texas Hospitals, Leaving 33 Patients Maimed or Dead

Read More



HEALTH & MEDICINE

Dr. Death

Plano surgeon Christopher Duntsch left a trail of bodies. The shocking story of a madman with a scalpel.

BY MATT GOODMAN · PUBLISHED IN D MAGAZINE NOVEMBER 2016 · ILLUSTRATION BY ANTHONY FREDA & DAN ZOLLINGER

A new Oxygen series, *License to Kill*, explores the legacy of grievously injured patients left by Dr. Christopher Duntsch

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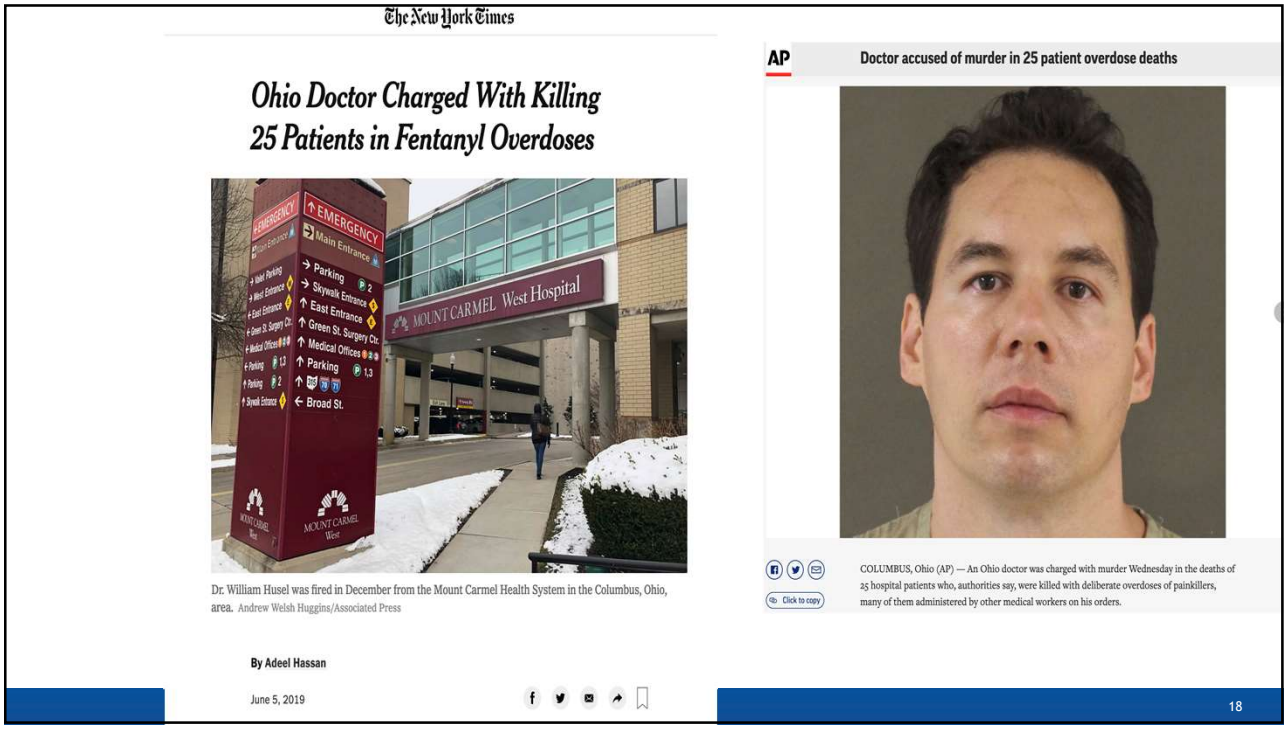
The New York Times
Ohio Doctor Charged With Killing 25 Patients in Fentanyl Overdoses
EMERGENCY
Main Entrance
Parking
Skywalk Entrance
East Entrance
Green St. Surgery Ctr.
Medical Offices
Parking
Broad St.
MOUNT CARMEL West Hospital
Dr. William Husel was fired in December from the Mount Carmel Health System in the Columbus, Ohio, area. Andrew Welsh Huggins/Associated Press
By Adeel Hassan
June 5, 2019
AP
Doctor accused of murder in 25 patient overdose deaths
Click to copy
COLUMBUS, Ohio (AP) — An Ohio doctor was charged with murder Wednesday in the deaths of 25 hospital patients who, authorities say, were killed with deliberate overdoses of painkillers, many of them administered by other medical workers on his orders.
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Mount Carmel renewed credentials of suspended physician amid patient deaths investigation

Mackenzie Bean - 22 hours ago Print | Email

SHARE

Columbus, Ohio-based Mount Carmel Health System renewed the credentials of William, Husel, DO, shortly after removing him from care duties amid a patient deaths investigation, reports *CBS* affiliate *WBNS 10 TV*.

The investigation focused on the deaths of 34 intensive care patients who allegedly received excessive painkiller doses from Dr. Husel between 2015 and 2018.

The health system removed Dr. Husel from patient care in November 2018 after receiving several formal reports about his actions. However, Mount Carmel reappointed Dr. Husel to the hospital's active medical staff less than a week after his suspension. The health system fired him in December.

Mount Carmel shared the following statement on the recredentialing with *WBNS 10 TV*:

"Mount Carmel removed Dr. William Husel from all patient care on November 21, 2018. ... Although he was recredentialed during this time as part of our standard medical staff credentialing process, it is important to know that Mount Carmel did not allow Dr. Husel to care for patients after November 21, 2018."

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New York Times Special Report 5/19

All of the cardiologists at UNC Children's Hospital voiced concerns about the surgical program.

By Ellen Gabler

May 30, 2019

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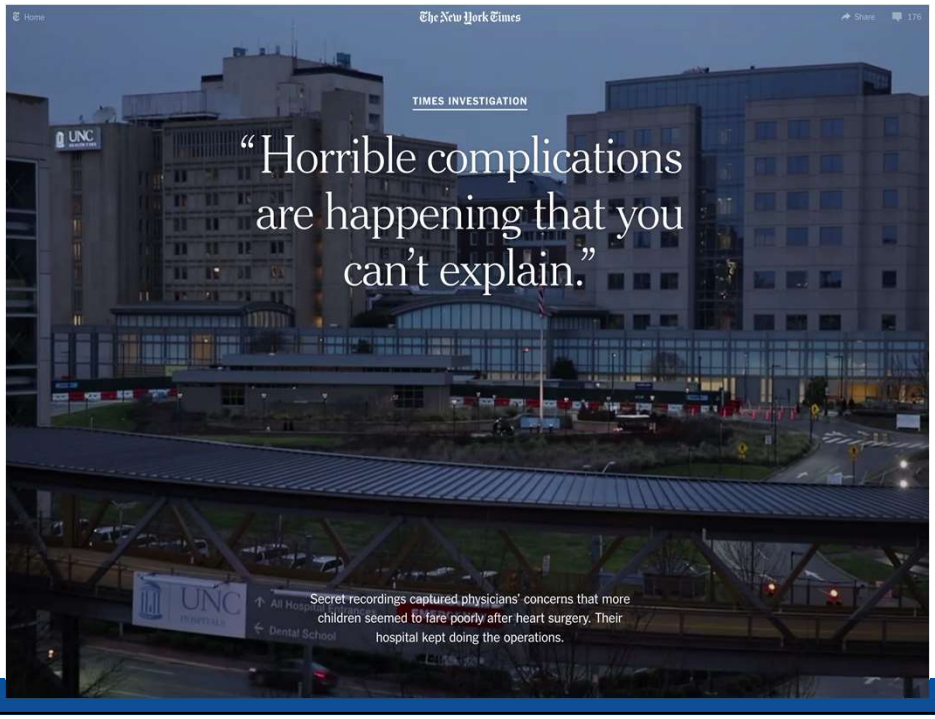

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Hospitals and Health Systems Are Facing A Rising Flood of Lawsuits:

Corporate Negligence

- Negligent Credentialing
- Negligent Oversight/Peer review

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Lawsuits from Patients with Poor Outcomes

- Negligent Credentialing
- Negligent Peer Review

Suits from the Federal Government

- False Claims Act
- Fraud and Abuse/Stark

Legal action by staff: hostile workplace/sexual harassment

Lawsuits from Physicians

- Breach of contract
- Restraint of trade
- Interference with business opportunity
- Discrimination
- Defamation
- Injunctions and restraining orders

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"I don't feel quite as fulfilled when I've saved a lawyer."

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Credentialing Is Arguably the Most Important Tool for Promoting Quality and Safety in Hospitals

How Great Is The Risk?

There are more than one million licensed physicians in the U.S.

- If 1% are incompetent = 10,000 practitioners
- 120,000 are > 70 years of age.
  Incidence of dementia is 5% = 6,000 practitioners
  Incidence of MCI is 15% = 18,000 practitioners

How Great Is The Risk?

- Surveys consistently report that 5 – 7% are repetitively disruptive/unprofessional = 50,000 practitioners
- Not all Boards and Medical Staffs Have Been Willing to Terminate These Colleagues When Their Behavior Cannot Be

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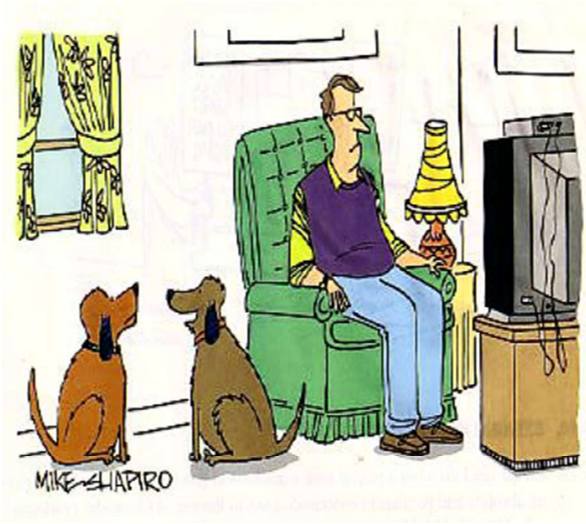

Sure, he can be annoying, but let's keep in mind that he's our only source of income."

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Important Age Demographics of the Physician Workforce

- Approximately 1/3 of practicing physicians are 55 and older
- Approximately 40% of practicing physicians are 50 and older
- 25% are > 65 and this will be more than a third by the end of the decade
- Age distribution varies by specialty – for example:
  - 40% of vascular surgeons are older than 55
  - There are only 4000 neurosurgeons in the country & 50% are > 55

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A Growing Physician Shortage

- 20% of practicing physicians are planning to leave medicine in the next 5 years
- 36% of practicing physicians are planning to leave medicine in the next 10 years
- Association of American Medical Colleges (AAMC) projects a shortage of as many as 134,000 physicians nationwide by 2034
- This projection does not factor in the increasing reports of physician burnout and the impact of the COVID-19 pandemic

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An "Elephant in the Room" Problem

Increasing challenge of physician recruitment and retention

versus

Maintenance of demanding standards for competency and quality

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Hospital Safeguards: Careful Credentialing Processes

- Compliance with accreditation credentialing standards
- Competent medical staff office/professionals
- Appropriate Policies and Procedures
- CVOs
- Medical staff credentials committee/MEC review
- ***Board review*** (done effectively, but without getting into the 'weeds')

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Some Board Best Practices Regarding Credentialing

- Authorize periodic third-party audits of credentialing activities.
- Consider requesting an annual credentials report.
  - Examples of data to include: # applicants and reappointments; # resignations; # withdrawn applications; #corrective actions; Application turnaround time; Most common red flags; # applications with material omissions; etc.
- Consider having a board member attend medical staff credentials committee meetings.
- Establish criteria for focused review and discussion by the board of selected credentials requests.

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How Should The Board Approach Credentialing in a Health System?

- Policies and Procedures should be standardized
- Criteria for Privileges should be standardized (DOPS)
- Unified Credentials Committee – a uniform recommendation should come to the board from multiple medical staffs
- All Medical Staff Appointments by System Board

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How Does the Board Provide Oversight of Peer Review?

- What reports should your board receive? From whom? How often? Reviewed by whom?
- What training have medical staff leaders received in peer review and how are they keeping up to date on best practices?
- Are the support services for peer review (e.g. quality department personnel, IT) adequate?
- Is peer review process perceived as 'disciplinary'?

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Questions Every Board Should Ask

Are our board members adequately prepared to undertake rigorous medical staff oversight?

- Is there periodic education? Do we know what we don't know?
- Are new board members adequately oriented and brought up to speed?
- Does the board have the right participation to provide significant oversight? (e.g. Legal? Physician? Med staff professional? Quality expert?)

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Final Thoughts: Board Oversight of the Medical Staff

- Does the medical staff have the right documents in place to guide its work? (e.g. bylaws, policies, job descriptions)
- Are medical staff leaders adequately prepared to undertake their responsibilities?
  - Does the hospital provide leadership development training?
  - Are new leaders provided good orientation and preparation for their new roles?
  - How is leadership succession planning approached, if at all?
- How does the board build 'social capital' with its medical staff?
- Does the board perform periodic assessments/audits of critical medical staff functions?

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A Strong, Loyal, Engaged Professional Community Must Be A Strategic Aim for Every Hospital

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