Med-Staff Newsletter

From the Medical Staff Practice Group

Largest Verdict in Title IX History: What Happened and What is Next for Title IX Investigations

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In December 2023, a jury in a Pennsylvania federal court entered the largest Title IX verdict in history — $15 million — against Thomas Jefferson University (the "University") in a lawsuit involving its handling of a sexual assault investigation against a former Rothman Institute surgeon, Dr. John Abraham ("Dr. Abraham").[1] At the pretrial stage, the court excluded text messages related to the sexual assault and night in question because the messages were not provided to the University as part of its investigation, and therefore, were not deemed to be relevant to the question of whether the University conducted a fair investigation.

After a four-day civil trial, jurors determined that the University's leadership violated Dr. Abraham's civil rights by discriminating against him as a male and intentionally interfered with his ability to earn money as a Rothman Institute surgeon and partner.[2] A few days later, the jury awarded Dr. Abraham $15 million in damages.

In a post-trial Memorandum, the court stated that it "appropriately" excluded the text messages before trial but erred by not allowing the University to impeach Dr. Abraham with the texts once he "opened the door" to certain issues at trial. As a result, the Court granted the University's motion for a new trial. The case ultimately settled before the new trial began. Although the underlying verdict was vacated, an important takeaway for entities conducting Title IX investigations is that evidence that is highly relevant to the underlying issues may be excluded at trial if the evidence is not included in the investigation.

1. *Abraham v. Thomas Jefferson Univ.*, No. CV 20-2967, 2023 WL 8358115, at *1 (E.D. Pa. Dec. 1, 2023).
2. Wendy Ruderman, Former Rothman orthopedic surgeon takes on Jefferson in federal court over sexual assault allegations, The Philadelphia Inquirer (Dec. 5, 2023, 12:20 PM), **https://www.inquirer.com/health/john-abraham-rothman-jefferson-sex-discrimination-case-jury-federal-20231205.html**

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Factual Background – The Alleged Sexual Assault and Related Investigation

This lawsuit stemmed from a pool party in 2018 that Dr. Abraham hosted at his Main Line home for the residents in the orthopedic program and hospital staff. Resident Jessica Philips ("Ms. Philips") was a 30 year old second year resident at the University and attended the party.[3] Throughout the evening, Ms. Philips became intoxicated and, realizing she was unable to drive, decided to sleep on Dr. Abraham's couch in the library until she was sober enough to drive home.[4] The next morning, Ms. Phillips reported waking up in Dr. Abraham's bed with him beside her, disoriented, and bruised.[5] She reported being "frozen" in bed that morning when Dr. Abraham kissed and touched her, then entered her.[6] She said the interaction that morning ended when Dr. Abraham received a phone call, and she was able to leave.[7]

Dr. Abraham had a different story. According to Dr. Abraham, Ms. Philips insisted on Dr. Abraham drinking alcohol during the party and even tipped a glass of Irish whiskey into his mouth forcing him to gulp it.[8] He reported that Ms. Philips told him she wanted to have sex and pulled him onto the floor on top of her in the library.[9] He stated he knew it was not a good idea, but his "judgment was clouded" by alcohol.[10] He claimed that Ms. Philips demanded sex, but he was unable to perform.[11] Dr. Abraham reported in deposition testimony that he was too drunk to consent to sex that night.[12]

It was reported by one of Dr. Abraham's friends who attended the party that Dr. Abraham and Ms. Philips were walking through the yard with their arms draped around one another.[13] Just before 11 p.m., one of Abraham's friends, texted him, "don't do it. "Getting c*** blocked anyway," Abraham replied. "One of my residents so I really can't anyway."[14]

Three days later, Dr. Abraham texted his then-boss (and Rothman Institute president) and said, "I have an issue." "Made a big mistake… regretting it already," he wrote in a text string. "Don't think it's illegal, just unethical … ugh."[15] Dr. Abraham and his then-boss spoke on the phone and Dr. Abraham reported that he had consensual sex with a resident.[16]

Shortly thereafter, Ms. Philips reported her recollection of the party to the physician overseeing the residency program and a Title IX investigation was initiated.[17] Within days of the party, the Rothman Institute suspended Dr. Abraham and the University asked him to take a leave of absence.[18] The University paid a private law firm nearly $100,000 to investigate the alleged sexual assault, and the resulting 58-page report drew no conclusion as to whether a rape occurred.[19]

3. Wendy Ruderman, The quiet handling of rape allegations at two Philly health institutions, The Philadelphia Inquirer (May 8, 2023), **https://www.inquirer.com/health/inq2/jefferson-rothman-rape-allegation-medical-resident-surgeon-title-ix-20230508.html**
4. *Id.*
5. *Id.*
6. *Id.*
7. *Id.*
8. *Id.*
9. Ruderman, *supra* note 3.
10. *Id.*
11. *Id.*
12. *Id.*
13. *Id.*
14. *Id.*
15. *Ruderman, supra note 3.*
16. *Id.*
17. Wendy Ruderman, Jury tells Jefferson to pay $15 million to former Rothman surgeon in sex discrimination case, The Philadelphia Inquirer (Dec. 11, 2023, 1:52 PM), **https://www.inquirer.com/health/thomas-jefferson-university-john-abraham-rothman-federal-jury-20231211.html**
18. Wendy Ruderman, Federal jury rules in favor of former Rothman orthopedic surgeon against Jefferson in sex discrimination case, The Philadelphia Inquirer (Dec. 7, 2023, 7:31 PM), **https://www.inquirer.com/health/thomas-jefferson-university-john-abraham-rothman-20231207.html**
19. Wendy Ruderman, Federal judge rules in favor of Jefferson, tossing out $15 million jury verdict for former Rothman surgeon, The Philadelphia Inquirer (Mar. 14, 2024, 6:23 PM), **https://www.inquirer.com/health/jefferson-rothman-john-abraham-title-ix-sex-discrimination-rape-20240314.html#loaded**

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The Lawsuit and Excluded Evidence

In his federal case against the University, Dr. Abraham claimed the University violated his civil rights with an unfair, gender-biased investigation.[20] He said the University did not investigate his allegation that Ms. Phillips got him drunk, so he could not consent to sex.[21] Dr. Abraham sought at least $5 million in damages from the University for financial losses and professional harm suffered and sought punitive damages.[22]

Interestingly, the sexual assault allegations were not at issue in the underlying case. The case centered on whether the University violated federal Title IX law, which prohibits sex-based discrimination at universities that receive federal funds.[23] In fact, U.S. District Judge Michael Baylson told jurors, "This trial is not about what took place at the party . . . The trial is about what happened after the party."[24] As a result, in pretrial procedures, the court excluded text messages sent by Dr. Abraham because these texts were not provided to the University as part of its investigation, and therefore, they were not relevant to the question of whether the University conducted a fair investigation.[25]

Dr. Abraham was allowed to testify and tell the jury his version of the story, i.e., that Ms. Philips forced him to drink alcohol and took advantage of him when he was drunk at his pool party.[26] He also told jurors that the University and the Rothman Institute's leaders warned him that he stood no chance at a Title IX hearing — no one would believe that a woman forced him to have sex.[27]

As mentioned above, the University was prohibited from informing the jury of statements that Dr. Abraham had made to the contrary of his testimony at trial.[28] For instance, the University was unable to introduce Dr. Abraham's text messages indicating that he wanted to have sex with a "young hot single female" and another text that the University argued showed that Dr. Abraham was not drunk. The University was not allowed to show the jury the text messages that indicated Dr. Abraham regretted having sex with the junior resident.[29] Further, at trial, the court ruled that the University was unable to introduce a letter written by Dr. Abraham's counsel in response to the investigation claiming Dr. Abraham was *not* intoxicated at the party.[30] Per the University, "the court excluded critical evidence that would have been used on cross-examination to impeach — if not completely dismantle — Abraham's tale."[31]

After a four-day civil trial, jurors determined that the University's leadership violated Dr. Abraham's civil rights by discriminating against him as a male and intentionally interfered with his ability to earn money as a Rothman Institute surgeon and partner.[32] A few days later, the jury awarded Dr. Abraham $15 million, $11 million to compensate him for financial losses and an additional $4 million in punitive damages for "outrageous conduct" that caused emotional distress and harm to his reputation.[33]

The University moved for mistrial and demanded a new trial. In a 120-page Memorandum, the

20. Ruderman, *supra* note 3.
21. *Id.*
22. Wendy Ruderman, Federal jury rules in favor of former Rothman orthopedic surgeon against Jefferson in sex discrimination case, The Philadelphia Inquirer (Dec. 7, 2023, 7:31 PM), **https://www.inquirer.com/health/thomas-jefferson-university-john-abraham-rothman-20231207.html**
23. Ruderman, *supra* note 2.
24. *Id.*
25. *Abraham, 2024 WL 1120987, at *1*
26. P.J. D'Annunzio, Info Kept From Jury In $15M Gender Bias Case, Pa. Court Told, Law360 (Jan. 9, 2024, 6:35 PM), **https://www.law360.com/employment-authority/discrimination/articles/1783770/info-kept-from-jury-in-15m-gender-bias-case-pa-court-told**
27. Wendy Ruderman, The $15 million jury award to a male former Rothman surgeon against Jefferson in a sex discrimination case is the largest ever, The Philadelphia Inquirer (Dec. 22, 2023, 5:00 AM), **https://www.inquirer.com/health/john-abraham-thomas-jefferson-university-verdict-20231222.htm**
28. D'Annunzio, *supra* note 26
29. *Id.*
30. *Id.*
31. *Id.*
32. Ruderman, *supra* note 2.
33. Wendy Ruderman, Jury tells Jefferson to pay $15 million to former Rothman surgeon in sex discrimination case, The Philadelphia Inquirer (Dec. 11, 2023, 1:52 PM), **https://www.inquirer.com/health/thomas-jefferson-university-john-abraham-rothman-federal-jury-20231211.html**

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District Court noted (1) it erred by not allowing the University to use the text messages to impeach Dr. Abraham after his counsel opened the door by asking witnesses to testify about what happened at the party[34] and (2) "seriously erred"[35] by not allowing the University to cross-examine Dr. Abraham on the details of the letter which might have indicated that he was not intoxicated during the evening in question. As a result, the court granted the University's Motion for a New Trial.[36]

It was reported that in May 2024, Dr. Abraham and the University settled this matter, avoiding the need for a new trial.[37]

Conclusion and Key Take Aways

Key take aways from this lawsuit and the largest Title IX verdict in history are:

- Investigate *all* claims of sexual harassment, even claims that are made by purported aggressors, and have documentation clearly outlining that the claim was investigated. This is crucial to conducting a fair investigation and not prejudging the outcome of the investigation. In a post-trial interview, Juror William Mapstone said he voted in Dr. Abraham's favor largely because the University's leadership evidenced no interest in listening to what Dr. Abraham had to say in the days after the June 2018 pool party.[38] Mr. Mapstone's vote may have been different if the University had maintained documentation showing that Dr. Abraham's claims were reviewed and vetted as part of the investigation.
- Include *all* relevant information in the investigative file. In this case, the court held that text messages that were clearly relevant to the underlying allegations of sexual harassment, but were not relevant to the lawsuit because they were not part of the underlying investigation.
- Include a list of all records requested from potential witnesses. If messages, emails, and records are requested from certain parties, document that such items were requested as part of the investigation. Even if they are not provided at the outset, it would provide a defense if the entity could show that such records were requested and sought as part of the review and investigation.

34. *Abraham*, 2024 WL 1120987, at *113 (The court had ordered pretrial that Dr. Abraham's counsel was precluded from asking questions about the events at the party. As noted in the Memorandum, Dr. Abraham's counsel asking these questions and "opening the door" was an additional reason for granting a new trial).
35. *Abraham*, 2024 WL 1120987, at *117.
36. *Id.* at *1.
37. Wendy Ruderman, Jefferson and former Rothman surgeon settle federal gender-bias lawsuit, The Philadelphia Inquirer (May 16, 2024, 3:27 PM), **https://www.inquirer.com/health/thomas-jefferson-university-john-abraham-settlement-20240516.html#:~:text=Jefferson%20and%20former%20Rothman%20surgeon%20settle%20federal%20gender%2Dbias%20lawsuit,verdict%20in%20favor%20of%20Abraham**.
38. Ruderman, *supra* note 33.

FSMB vs. SkyNet: 5 Rules for Keeping AI in Check in Medicine

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There has been a significant development that may impact healthcare providers using artificial intelligence (AI) in their practice. The Federation of State Medical Boards (FSMB) has recently released a report providing essential guidance to state regulators on the responsibilities of physicians when incorporating AI into patient care. **The full report may be accessed here**.

5 Key Take-Aways from the FSMB's New Guidance:

01
Emphasis on Education and Proficiency

Physicians must be well-informed about the AI tools they use, understanding both their capabilities and underlying technologies. This includes being aware of the data on which AI tools are trained and their operational methodologies.

02
Accountability and Ethical Use

The guidance reinforces that physicians hold ultimate responsibility for AI-facilitated decisions in patient care. This involves ensuring that AI tools augment, but do not replace, professional medical judgment and maintaining a rationale for AI-recommended treatments.

03
Informed Consent and Transparency

Clear communication with patients about the use of AI in their care is mandatory. This includes discussing how AI impacts treatment decisions and ensuring patients are fully informed about their care options.

04
Data Privacy and Security

Physicians must ensure that patient data used by AI tools are handled with strict privacy measures and comply with all relevant laws and regulations

05
Regulatory Considerations

While state medical boards do not directly regulate AI as a healthcare device, they are empowered to oversee physicians using AI. The report suggests setting up standards that keep pace with the evolution of AI technologies without stifling innovation.

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Why It Matters & What's Next

As AI continues to integrate into healthcare settings, understanding the legal and ethical implications becomes increasingly vital. The American Medical Association and other stakeholders are actively discussing the balance between embracing AI advancements and protecting both patients and healthcare providers from potential pitfalls associated with AI. Potential pitfalls include bias and inaccuracy, over-reliance on technology, and privacy concerns.

States are beginning to evaluate the role of medical boards in regulating AI use within medical practice, with some states starting to enact comprehensive AI statutes that directly and indirectly regulate the use of AI in health care. For example, in May of this year Colorado enacted a comprehensive state AI law that will go into effect on February 1, 2026, and which places certain limits and obligations on developers and entities that deploy AI including for use in health care services.[1] Similarly, the Utah Department of Commerce's Office of Artificial Intelligence Policy has proposed regulations governing the use of AI chatbots and interactions by mental health care providers that is likely to be taken up by the Utah legislature later this year. Decisions and further regulatory frameworks are expected in the upcoming months, which could set precedents for how AI is integrated into healthcare nationally.

Speaking of AI . . . Use of AI in Recording Privileged and Confidential Peer Review Meetings:

While not discussed in the FSMB's report, considering the growing integration of AI tools in healthcare settings, it is important to address AI use in sensitive areas such as privileged and confidential peer review meetings. For example, if a practitioner relies on AI as opposed to exercising their professional medical judgment and this action jeopardizes patient care, peer review should be triggered. Further, using AI for recording and transcribing peer review meetings poses specific challenges and risks beyond a typical business meeting. Without carefully crafted protocols, there is a risk of breaching the confidentiality that is foundational to the peer review process, as AI generated meeting minutes or summaries may not be considered privileged material. Such breaches could undermine the legal protections typically afforded to these activities and potentially expose healthcare providers to legal liabilities. It is vital for healthcare institutions to establish and enforce strict guidelines that govern the use of AI in these sensitive settings, if AI is to be allowed at all, to maintain the integrity and confidentiality of the discussions.

1. *Concerning Consumer Protections in Interactions With Artificial Intelligence Systems*, SB 24-205, Colorado (enacted May 17, 2024).

As hospitals consider and develop AI policies and protocols we recommend they consider the following:

- Announce at the beginning of any meeting in which AI is being used to record and summarize the meeting, that AI will be used to do so, and that no other recordings of the meeting are authorized
- Require that any AI assisted documents will be marked accordingly and require review prior to being adopted as an official medical staff record
- Prohibit AI from being used to make decisions, and require that any decisions remain in the sole discretion of the medical staff based on independent verified information
- Require that all recordings are erased as a matter of routine within 30 days after the meeting
- If AI may be used to draft letters and memos, then require careful personal, (i.e., human) review of the AI generated document to ensure accuracy before being finalized. Any AI generated or assisted draft letter or draft memo must be marked accordingly.

Healing Across America: The Rise of the Interstate Medical Licensure Compact

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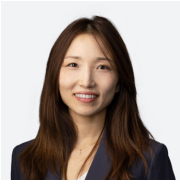

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Purpose and History of the Compact

The genesis of the Interstate Medical Licensure Compact ("Compact" or "IMLC") started in 2013, when the Federation of State Medical Boards worked with its member state boards to study the feasibility of an interstate compact to support medical license portability.[1] The final model legislative language was released in September 2014.[2] On February 27, 2015, the State of Wyoming was the first state to pass legislation, followed by South Dakota, Utah, Idaho, West Virginia, and Montana.[3] With Florida recently joining the Compact, the Compact now has 42 member jurisdictions, including 40 states, the District of Columbia and the territory of Guam.[4] IMLC legislation is pending in Massachusetts, New York, and North Carolina.[5]

The Compact is of high importance for individual medical staffs because each medical staff in a participating jurisdiction must rely on the State of Principal License to correctly and thoroughly determine a physician's eligibility. Therefore, each medical staff is prone to the risk of relying on any false or incomplete information provided through the IMLC licensing procedure.

How Does Medical Licensure Work Under the Compact?

To participate in the Compact, a state's legislature must introduce and enact a bill authorizing the state to join.[6] While the licensing process may be expedited under the Compact, the physicians are licensed by individual state's medical and osteopathic boards, and the state retains the full authority in administering its duties of oversight.[7]

To participate in the Compact, physicians must:[8]

1. Hold a full, unrestricted medical license in a Compact member-state;
2. Graduated from an accredited medical school or a school listed in the International Medical Education Directory;
3. Successfully completed ACGME- or AOA-accredited graduate medical education;
4. Passed each component of the USMLE, COMLEX-USA, or equivalent in no more than three attempts for each component;
5. Hold a current specialty certification or time-unlimited certification by an ABMS or AOABOS board;
6. Not have any history of disciplinary actions toward their medical license;
7. Not have any criminal history;
8. Not have any history of controlled substance actions toward their medical license; and
9. Not currently be under investigation.

Once a physician applies, the State of Principal License reviews the application and conducts primary-source verification including criminal background

1. Rick Masters, *Creating the Interstate Medical Licensure Compact (IMLC)*, INTERSTATE MEDICAL LICENSURE COMPACTS (Apr. 2022), **https://www.imlcc.org/wp-content/uploads/2022/04/IMLCC_Newsletter_5Anniv_April2022_Web-1.pdf**.
2. *Id.*
3. *Strategic Planning Background*, INTERSTATE MEDICAL LICENSURE COMPACT, **https://www.imlcc.org/wp-content/uploads/2020/02/Strategic-Planning-IMLCC-History.pdf** (last accessed Jun. 20, 2024).
4. *Compact State Map*, INTERSTATE MEDICAL LICENSURE COMPACTS, **https://www.imlcc.org/participating-states/** (last accessed Jun. 20, 2024).
5. *Id.*
6. *General FAQs*, INTERSTATE MEDICAL LICENSURE COMPACT, **https://www.imlcc.org/faqs/** (last accessed Jun. 20, 2024).
7. *Id.*
8. *LOQ Re-Apply*, INTERSTATE MEDICAL LICENSURE COMPACTS, **https://www.imlcc.org/loq-reapply/** (last accessed Jun. 20, 2024).

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check to determine eligibility. If all requirements are met, the State of Principal License issues a formal Letter of Qualification, which is valid for 365 days to obtain licenses from multiple states through the Compact.[9]

What Are the Risks and Benefits?

Benefits

Streamlining/Reduction of Administrative Burden. The Interstate Medical Licensure Compact Commission ("IMLCC") noted that since operations, more than 25,000 physicians secured more than 100,000 licenses in IMLCC member states through April 2024.[10] Texas, Illinois and Ohio were the top three states with the most Letters of Qualification applications, and Texas, Wisconsin, and Arizona issued the most licenses.[11]

Recent annual study by the IMLCC showed that nearly 30% of all new licenses issued to physicians in 2022 were done via the IMLCC process.[12] The study also showed a steady increase in number of requests from 654 applications in April 2017 to 7,142 in April 2024, yet showed that the processing times have remained fairly consistent.[13] In April 2024, the study noted that it took on average 43 days from application to Letter of Qualification issuance, then 20 days from qualification to license issuance.[14]

Because the Compact makes it easier and quicker for physicians to obtain and renew licenses to practice in multiple states, this expedited process reduces administrative burdens, which includes those for individual medical staffs.

Information Sharing/Disciplinary Information Reporting. All state boards participating in the Compact are required to share investigative and disciplinary information with each other.[15] According to the Compact Rules, any reported disciplinary action may be a basis for discipline by other member boards.[16] In comparison, when a physician's license in a state is "revoked, surrendered, suspended or relinquished," all other state licenses of that physician shall be automatically suspended for 90 days to permit each member board to investigate the matter.[17]

Therefore, a medical staff in a participating state could find out about a state board investigative/disciplinary action against a physician in any state where the physician has a license. This free flow of information may help identify quality concerns early on that could adversely affect patient care and help promote quality care.

Access to Care. The Compact's streamlined licensing procedure may also help enhance the portability of a medical license, which may enhance access to and continuity of care. Further, the number of physicians licensed via IMLC may increase the availability of out-of-state disaster-response providers who do not need emergency waiver, which may make it easier for physicians to reach areas in urgent need of care.[18] As a result, individual medical staffs could promptly provide physicians emergency privileges to cover the patient care needs. Additionally, the Compact could facilitate the provision of telemedicine, which can help reach more patients, including those in rural areas.

Risks/Considerations

Risk of Reliance on Information. All medical staffs in participating states must rely on the State of Principal License to correctly and thoroughly review, verify, and determine a physician's eligibility. Therefore, the IMLC

9. *Id.*
10. *IMLCC Data Study Year 7,* INTERSTATE MEDICAL LICENSURE COMPACT (Jun. 15, 2024), **https://www.imlcc.org/wp-content/uploads/2024/06/IMLCC-Data-Study-April-2024-6-2024-Final-1.pdf**.
11. *Id.*
12. *Id.*
13. *Id.*
14. *Id.*
15. *General FAQs*, INTERSTATE MEDICAL LICENSURE COMPACT, **https://www.imlcc.org/faqs/** (last accessed Apr. 12, 2024); see also Issue Brief: Interstate Medical Licensure Compact, AMA, **https://www.ama-assn.org/system/files/fsmb-interstate-medical-licensure-compact-issue-brief.pdf** (last accessed Jun. 20, 2024).
16. IMLCC Rule 6.5.
17. *Id.*
18. *Interstate Medical Licensure Compact*, ABPS, **https://www.abpsus.org/medical-licensure-compact/** (last accessed Jun. 20, 2024).

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licensing procedure can create risk of reliance on false or incomplete information for individual medical staffs as they no longer conduct their own primary-source verification. Accordingly, such reliance may result in approval of membership/privileges for a physician who fall short of the medical staff's standards, which in turn may subject the organization to patient safety issues, declining reputation, as well as liabilities such negligent credentialing.

State Laws. Each physician with license through the Compact is required to abide by all requirements of each licensed state's laws and medical board. Some areas of laws and requirements to be mindful of include record retention, patient-provider relationship, abortion, informed consent, minor consent, unprofessional conduct, reporting requirements, prescribing practices, scope of practice, and telemedicine. Accordingly, individual physicians should be mindful of differing standards and requirements of each state to ensure compliance with state statues, rules, and regulations that can change.[19]

Further, insurers may have territorial restrictions and limitations on coverage based on how lawsuits are handled in each state.[20] As such, medical staffs and physicians should carefully verify professional liability coverage afforded in each state to avoid any gap in coverage.

Conclusion

Individual medical staffs should use extra caution and appropriate review processes when making a membership/privileging decision on a physician licensed via the IMLCC process. As stated, while the Compact supports an expedited licensing process, medical staffs of member states must rely on primary-source verification of the State of Principal License. Accordingly, to avoid granting membership/privileges to ineligible physicians, medical staffs should engage in complete and thorough review process with clear eligibility criteria. For example, such process may include primary-source verification of malpractice claims, current/prior affiliations, and peer references from peers in the same specialty. As we have seen a steady increase in the number of licenses issued via the IMLCC process, these types of measures by medical staffs will be valuable for ensuring patient safety and quality care.

19. MedPro Group, *Risk Considerations: Interstate Professional Licensure Compacts*, LINKEDIN (Aug. 10, 2023), **https://www.linkedin.com/pulse/risk-considerations-interstate-professional-licensure-compacts/?trk=article-ssr-frontend-pulse_more-articles_related-content-card**.
20. Chad Anguilm et al., *Interstate Licensure for Telehealth Can Fuel Medical Practice Growth*, MICHIGAN STATE MEDICAL SOCIETY (Jan. 28, 2021), **https://www.msms.org/About-MSMS/News-Media/interstate-licensure-for-telehealth-can-fuel-medical-practice-growth**.

Illinois Appellate Court Reverses Circuit Court's "Manifestly Erroneous" Discovery Ruling and Concludes Documents Are Privileged Under the Illinois Medical Studies Act "On Their Face"

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The Illinois First District Appellate Court (the "appellate court") recently reversed in part and upheld in part a previous circuit court's decision regarding the privilege and confidentiality of certain peer review documents, highlighting the importance of maintaining a clear separation between a hospital's peer review process independently from other hospital reviews. In *Veltri v. Amita Health Alexian Brothers Med. Ctr.* the appellate court reversed the circuit court's decision granting of a motion to compel the production of two documents the defendant hospital claimed as privileged under the Illinois' Medical Studies Act, 735 ILCS 5/8-2101, *et seq.* (the "MSA").[1] The appellate court, however, upheld the lower court's decision that one challenged document was not privileged under either the MSA or the Patient Safety and Quality Improvement Act of 2005 (the "PSQIA"). The decision highlights the importance of separating the reporting of the triggering event of the peer review process from reports submitted to a hospital's Patient Safety Organization ("PSO") under the PSQIA.

Documents at Issue and Claims of Privilege

In February 2021, Anne Veltri ("Plaintiff") filed a medical malpractice case against Amita Health Alexian Brothers Medical Center ("Amita") arising out of medical treatment she received in November 2019.[2] In response to Plaintiff's written discovery requests, Amita provided a privilege log claiming the "safety event review team ("SERT") notes" ("SERT Notes") containing peer comments substantively analyzing the incident and an Acesis Report containing analysis and conclusions of the Medical Staff Quality Oversight Committee ("MSQOC") were privileged under the MSA.[3] Amita also claimed that a third document, a patient safety event report ("Datix Report"), containing general information about the incident was privileged under both the MSA and PSQIA.[4] The documents were submitted to the circuit court judge for an *in camera* inspection.[5]

In support of its claim of privilege, Amita submitted an affidavit from its Director of Patient Safety and Quality explaining that when an adverse event occurs, hospital staff draft a patient safety event report in a performance software system and the report is subsequently provided to Amita's PSO, which, Amita asserted, "automatically triggers" the peer review process.[6] The patient safety event reports are then screened and, if deemed "qualifying," reviewed by Amita's SERT Committee, whose purpose is to continuously improve safety

1. *Veltri v. Amita Health Alexian Brothers Med. Ctr*, 2023 IL App (1st) 230073-U
2. *Id.* at ¶ 4.
3. *Id.* at ¶¶ 5, 37
4. *Id.* at ¶¶ 5, 37.
5. *Id.* at ¶ 15.
6. *Id.* at ¶ 7.

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and quality of patient care.[7]

Plaintiff contended that Amita failed to establish the documents were privileged under the MSA because it did not show that they "were used, requested, or generated in the course of an internal peer review process," and that PSQIA did not apply because Amita did "not assert that the documents were generated strictly for submission to an approved" PSO.[8] Plaintiff further alleged the Datix Report was used for internal quality control, was "separate and distinct from any PSO reporting," and that the privilege log did not state it was actually transmitted to a PSO.[9]

Plaintiff further argued that the Datix Report was not privileged under the MSA because it was created before the "initiation of any peer review process," and that because Amita disclosed the Datix Report to the SERT Committee and the MSQOC, it was submitted outside the PSO and not privileged under the PSQIA.[10] Amita countered that the SERT Notes and Acesis Report were clear "on their face" peer review documents.[11]

Circuit Court Rules Documents Created During Ordinary Course of Business and Not Privileged

The circuit court ruled Amita failed to demonstrate that the three documents at issue – the Datix Report, SERT notes, and Acesis Report – were privileged under either the MSA or the PSQIA because it found Amita had not shown when the committees met or ended and that, therefore, the documents were created "in the ordinary course of business."[12]

Amita filed a motion to reconsider, arguing that the circuit court failed to follow controlling case law under *Ardisana v. Northwest Cmty. Hosp., Inc., 342* Ill. App. 3d 741 (1st Dist. 2003), because Amita asserted it had established through its affidavit that the SERT Notes and Acesis Report were "an integral function of the peer review information gathering and decision-making process."[13] Amita further argued the Datix Report was privileged under the MSA because it was "reviewed, used, and relied upon" by the SERT Committee and MSQOC.[14] Plaintiff countered Amita's argument, asserting that because the documents were "connected to a standing request for all medical occurrences involving potential issues pertaining to quality of patient care rather than an investigation in a specific incident," the Datix Report was not privileged under the MSA.[15] The circuit court denied the motion to reconsider and found Amita in civil contempt for refusing to produce the three documents.[16] Amita appealed the circuit court's ruling.

Appellate Court Determines SERT Notes and Acesis Report Privileged on Their Face

The appellate court acknowledged it was Amita's burden to establish the documents were privileged but noted that when an affidavit is unrebutted by an opposing party, a court must accept the facts therein as true.[17] The appellate court further emphasized that the "crucial fact" in determining whether the MSA applies is the "timing of the peer review," because documents created before the peer review process begins, and after it ends, are not protected under the MSA.[18]

The appellate court rejected Plaintiff's argument and the circuit court's finding that the

7. *Id.* at ¶¶ 8-9.
8. *Id.* at ¶ 6.
9. *Id.*
10. *Id.* at ¶¶ 14, 16.
11. *Id.* at ¶ 17.
12. *Id.* at ¶ 18.
13. *Id.* at ¶ 20, citing *Ardisana v. Northwest Cmty. Hosp., Inc.*, 342 Ill. App. 3d 741 (1st Dist. 2003).
14. *Id.*
15. *Id.* at 21.
16. *Id.* at 22.
17. *Id.*
18. *Id.* at 32.

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MSA did not apply to the SERT Notes and Acesis Report simply because the documents did not have "firm dates" and concluded that the circuit court's finding that it was unable to determine whether the SERT notes and Acesis Report were created before or during the peer review process was "manifestly erroneous."[19] Relying on the holding in *Ardisana*, the appellate court determined that the SERT Notes and Acesis Report were on their face "squarely" in the "category of documents protected by the MSA" because they were an "integral function in the peer review information-gathering and decision-making process" since they were created "during, and pursuant to" that ongoing process.[20] The appellate court further reasoned that it was required to accept as true the description of the peer review process in Amita's affidavit regarding the creation of the SERT Notes and Acesis Report and contents of those documents because Plaintiff failed to contest those facts.[21] As such, the appellate court concluded the SERT Notes and Acesis Report were created during, and pursuant to, an ongoing peer-review investigation and, thus, privileged under the MSA.

Appellate Court Rules Datix Report Discoverable Because it was Created Before the Peer Review Process Began and Submitted Outside the PSO

As for the Datix Report, the appellate court agreed with the circuit court that it was not privileged under either the MSA or the PSQIA.[22] The appellate court reasoned that because the Datix Report was created pursuant to a general Amita protocol, and because investigations into the care at issue by the SERT Committee and the MSQOC began after their designee (the patient safety specialist) reviewed the Datix Report, it was created "before the specific investigatory processes began."[23] As a result, it was not protected from disclosure under the MSA.[24] In relying on this rationale, the appellate court rejected Amita's argument that the Datix Report revealed the deliberative process of the SERT Committee and the MSQOC, pointing out that, ironically, the "affidavit itself reveals more information" on the committees' deliberative processes than the Datix Report which contained only "basic details of the incident."[25]

In holding that the PSQIA similarly did not protect the Datix Report from disclosure, the appellate court relied on an exception to the PSQIA further espoused upon in the *Daley v. Tereul* case – which provides that if a document is "created for any purpose other than for reporting to the PSO, it is not privileged" because it is no longer patient safety work product.[26] The appellate court explained that the affidavit failed to establish that the Datix Report was created solely for reporting to Amita's PSO and instead established it was also created and analyzed for potential referral to the SERT Committee and MSQOC.[27] As a result, the appellate court affirmed the circuit court's order compelling Amita to produce the Datix Report on remand.

Lessons Learned

When a hospital wants to avail itself of the protections afforded under the MSA and PSQIA in relation to its quality and patient safety policies and committees, the privileges should be considered separately. Documents submitted to a hospital's designated PSO should not also be relied on to trigger or initiate the peer review process under the MSA. Rather, a separate reporting process

19. *Id.* at ¶ 40.
20. *Id.* at ¶¶ 39-40, citing *Ardisana*, 342 Ill. App. 3d at 748.
21. *Id.* at ¶ 40.
22. *Id.* at ¶ 39.
23. *Id.* at ¶ 42.
24. *Id.*, citing *Nielson v. Swedish Am. Hosp.*, 2017 IL App (2d) 160742, ¶¶ 69-74.
25. *Id.* at ¶ 43.
26. *Id.* at ¶ 46, citing *Daley v. Teruel*, 2018 IL App (1st) 170891, ¶ 41.
27. *Id.* at ¶ 47-48.

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for patient safety events that are potential triggers of the peer review process should be established and the reporting process should collect only “basic details of the incident” because the report at issue may not be deemed privileged under the MSA if challenged in court if it is considered created before the initiation of the peer review process. Additionally, from an operational perspective, the circuit court’s original ruling taken together with the appellate court’s opinion also highlights the importance of hospitals maintaining accurate and timely minutes and records of all peer review actions and committee meetings in order to create a clear record supporting any claims of peer review privilege.

In litigation, when faced with a decision of what documents to attempt to claim as privileged under the MSA, hospitals should consider not taking the customary blanket approach of asserting the MSA privilege over all such documents. Rather, hospitals should scrutinize their documents at issue at the beginning of written discovery and determine whether they were created before or after the initiation of the peer review privilege. For documents that were created before the triggering of the peer review process that contain only benign “basic details of the incident,” hospitals should consider not claiming those as privileged under the MSA because proving the MSA privilege over such documents is exceedingly difficult, time-consuming, and costly. Alternatively, hospitals should consider producing benign triggering documents after the circuit court has ruled they are discoverable instead of incurring the costs and delays associated with appealing such a ruling that is largely supported by the case law.

A Practical Review: Welcome to the Party — CMS and TJC Finally Allow Critical Access Hospitals to Unify Medical Staffs with Acute Care Hospitals

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Introduction

Floating under the radar of a series of regulatory changes governing the operation of Critical Access Hospitals ("CAHs") over the last eighteen months was a significant shift in the regulations governing the relationship between the medical staffs of CAHs and general acute care hospitals within the same multi-hospital health system. Effective January 23, 2023, under the Medicare Conditions of Participation ("CoPs")[1], and effective June 1, 2023, under The Joint Commission ("TJC") standards, Critical Access Hospitals will now be able to elect to create a single unified and integrated medical staff with other hospitals that are part of the same multi-hospital system, including with general acute care hospitals.[2]

Background

Prior to the changes to the CoPs and TJC standards, the Centers for Medicare & Medicaid Services ("CMS") guidelines had indicated that hospitals that are paid under a Medicare payment system other than the Hospital Inpatient Prospective Payment System ("IPPS"), which includes CAHs, may jeopardize payment status if they were to unify their medical staff with an IPPS hospital such as a general acute care hospital. In response to a previous public comment, which first appeared in a separate final rule published in 2019, CMS stated the reasoning for not allowing CAHs to create a unified medical staff with a general acute care hospital was that, "a CAH must be separately evaluated for its compliance with the CAH CoPs, which would not include the requirements included in this section of the rule [42 CFR § 482.21] since these are hospital CoPs. It would not be possible to evaluate the CAH's compliance as part of an evaluation of a hospital's compliance."[3] In short, CMS's previous perspective was that a CAH's compliance could not be effectively evaluated if its medical staff was unified with the medical staff of a general acute care hospital.

Despite the prior guidance from CMS, enough ambiguity remained in the regulations at the time that many multi-hospital systems with CAHs nonetheless established unified medical staffs that incorporated the CAH medical staff together with the medical staffs of the other general acute care hospitals within the system.

However, in 2022 CMS updated the CoPs governing CAHs to allow CAHs to establish a unified medical staff with other hospitals within the same system, including acute care hospitals thereby bringing the CAH CoPs into alignment with the CoPs governing acute care hospitals.[4]

The Joint Commission subsequently indicated its support for allowing a CAH in a multi-hospital system to participate in a unified medical staff in written comments sent to CMS on August 29, 2022, responding to the then

1. 42 CFR § 485.631(e).
2. The Joint Commission, Critical Access Hospital Accreditation Standards, MS.01.01.05.
3. Available at, **https://www.govinfo.gov/content/pkg/FR-2019-09-30/pdf/2019-20736.pdf**
4. 87 FR 72308, Nov. 23, 2022.

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proposed rules.[5] Yet it would take another year before TJC published new standards for CAHs setting out the elements of performance permitting CAHs to participate in a unified medical staff in August 2023. The new CAH standards now align with the existing TJC standards for acute care hospitals.

Legal and Accreditation Standards

Under the new Medicare CoPs and TJC standards a CAH may elect to participate in a unified and integrated medical staff with other separately certified hospitals, CAHs, or Rural Emergency Hospitals (REHs) (collectively "hospitals"), within the same system if certain established conditions are met.

The initial threshold requirement for unification is that the CAH and any other hospitals participating in the unified medical staff must share a single system-wide governing body carrying out the functions delegated to the governing body by CMS and TJC.[6] Assuming this initial threshold bar is cleared, the governing body may then vote to approve the adoption of a unified medical staff model, subject to acceptance by the medical staffs of each of the participating hospitals. If the governing body approves the establishment of a unified medical staff, the question of unification then turns to the individual hospital medical staffs.

The medical staffs of each separately certified hospital in the system must then vote by a majority, in accordance with the medical staff bylaws, to either accept or opt-out of the unified and integrated medical staff structure.[7] It is recommended as best practice that prior to voting on unification each hospital's medical staff bylaws address the process by which such a vote will occur. CMS has indicated that it expects all hospitals that are part of a multi-hospital system to amend their medical staff bylaws to address the potential of a vote on medical staff unification, even if unification is not being considered at present.

If the CAH and other hospitals elect to establish a single unified medical staff, then unified and integrated medical staff must establish a single set of medical staff bylaws, rules and regulations, and other governing documents that describe the medical staff's processes for self-governance, taking into account the unique characteristics and concerns of each separate hospital, and set forth the functions and responsibilities of the unified medical staff including all essentials elements required of medical staff bylaws under the CoPs and TJC standards such as qualification criteria, credentialing and privileging, peer review, and hearings and appeals.[8] The unified and integrated medical staff bylaws must also set out the process by which a member medical staffs may vote to opt out of the unified medical staff and reestablish a separate distinct medical staff.[9]

In conjunction with the governing documents, the unified medical staff must also put in place policies and procedures to ensure that the localized issues, concerns, and needs of each participating hospital medical staff given due consideration and addressed.[10]

Implementation Challenges and Considerations

Beyond the essential regulatory and accreditation requirements, establishing and maintaining a unified medical staff raises significant practical challenges and considerations for hospitals that are part of a multi-hospital system.

Addressing the Unique Needs of Each Hospital

For unified medical staffs that

5. Available at, **https://www.jointcommission.org/-/media/tjc/documents/federal-relations-and-public-policy/2022_08_29_tjc-comments_cms_rehcop-proposed-rule.pdf**
6. 42 CFR § 482.12, and TJC LD.01.02.01.
7. 42 CFR § 485.631(e)(1) and CAH MS.01.01.05, EP 1.
8. *Id.* at 485.631(e)(2) and CAH MS.01.01.05, EPs 2 & 3.
9. CAH MS.01.01.01, EP 37.
10. 42 CFR § 485.631(e)(3) and CAH MS.01.01.05, EP 4.

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include a CAH, the requirement that the unified medical staff be established in a manner that takes into account the unique circumstances of each hospital can be a particular challenge given the different requirements under the Medicare CoPs and TJC standards for CAHs as compared to general acute care hospitals. This is true for any unified medical staff that incorporates multiple hospital types in addition to those with CAHs, such as children's hospitals, rehab hospitals, small rural or community hospitals, and large academic medical centers. Taken together with the requirement that the unified medical staff have in place policies that address the considerations of each separate hospital, health systems must be careful when drafting unified medical staff bylaws and system-wide policies to account for the differences between the requirements and day-to-day functions of a CAH, or other hospital type, as compared to the other general acute care hospitals in the system.

The need to address local issues also creates a knock-on administrative challenge, as the policies must provide a clear mechanism for issues local to an individual hospital's medical staff to be brought before unified medical staff leadership and for underlying concerns, the review process, and its outcome to be properly documented. This additional administrative burden can add strain on the medical staff office and necessitates greater logistical planning at the outset to avoid complications or gaps in the implementation of the unified medical staff policies.

When the unified medical staff consists of multiple types of hospitals, a one-size-fits-all approach to policies and standards may not always be workable. For example, policies that might apply to a children's hospital may not be applicable or function in the same way at a general acute care hospital and vice-versa. Certain policies and procedures, for example call coverage, consultations, and emergency care policies, may continue to require implementation at the individual hospital level despite medical staff unification to appropriately take into account the different needs, challenges, and patient populations of each hospital. For best practices, each policy should clearly identify hospitals and facilities to which it applies.

Managing Peer Review Activities

The requirement that the medical staff bylaws, rules and regulations, and policies and procedures take into account the unique needs and circumstances of the individual hospital may also have implications for routine peer review functions such as ongoing professional practice evaluation ("OPPE") and routine focused professional practice evaluation ("FPPE") upon the grant of initial clinical privileges.

The practical logistics of medical staff unification will also require significant consideration to be tied to the process for managing peer review among and across the hospitals. The unified medical staff will need to determine whether peer review will continue to be managed locally, centralized, or if some form of hybrid approach will be used. Centralizing peer review activities can provide great benefits to the unified medical staff by improving consistency in the application of rules and requirements and ensure that clinical standards are uniformly upheld across the system hospitals. However, where hospitals choose to centralize peer review efforts, the transition to a single centralized or hybrid process poses unique challenges with regard managing the practical transition from the individual hospital's peer review efforts. Failure to properly manage the transfer of peer review activities and ongoing hearings during the transition to a unified medical staff creates a risk of important deadlines or procedural steps being missed or delayed, which in turn has the potential to result in a meaningful increase in liability exposure to the hospital and the health system. Considerable forethought must be placed into the process for handing-off any peer review files from the individual hospitals, with particular consideration given to ensuring a smooth transition of any ongoing corrective actions, investigations, or hearings and

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appeals. Policies and procedures similarly need to be put in place to address the potential transfer back to the individual hospitals in the event that any one hospital's medical staff later chooses to opt-out of the unified medical staff.

In addition to managing the transfer of ongoing peer review activities at the time of the creation or dissolution of a unified medical staff, new peer review actions taken up under a unified medical staff present unique challenges as well. The unified medical staff must strike an appropriate balance between centralizing the peer review process across the system hospitals while ensuring that local expertise is not lost, the central peer review committee is not too remote from the care provided, and a bottleneck is not created. An option to consider is the creation of an intermediate step in the peer review process whereby a local or regional peer review committee assesses a matter first before sending a report and recommendation to a centralized peer review committee. Additionally, careful coordination across the hospitals must be maintained to ensure that an action taken at one hospital is consistently applied at all of the other hospitals participating in the unified medical staff. For example, if a practitioner's clinical privileges are summarily suspended at one hospital, processes need to be in place to ensure all other hospitals within the unified medical staff are promptly notified of the suspension and able to implement it uniformly across the system. Clear communication and well-defined procedures are essential to the effective and consistent management of peer review activities throughout a unified medical staff.

Granting of Clinical Privileges

Another important practical consideration for health systems and hospitals in establishing a unified medical staff is how clinical privileges will be granted. The Joint Commission does not require privileges to be granted on a site-by-site basis, permitting a system-wide grant of clinical privileges for multi-campus organizations. Indeed, one of the core benefits of participating in a unified medical staff is the ability to have a single credentialing and privileging process with the option to grant clinical privileges to provide care across the system, which in turn allows practitioners to move seamlessly between facilities and ensure specialty care is available at all of hospitals across the system. However, unified medical staffs must continue to evaluate the appropriate range of clinical privileges granted to each practitioner on a case-by-case basis so as not to fall afoul of other TJC standards. Under MS.06.01.01, prior to granting clinical privileges, the medical staff must determine that the resources necessary to support the requested privilege are available. Not every hospital within a unified medical staff will have the same equipment, staffing, space, and other resources. Practitioners should only be granted privileges at multiple facilities to the extent those privileges can be safely and effectively exercised.

If any of the hospitals within the unified medical staff have entered into exclusive arrangement for any specific service lines this will need to be taken into consideration in a determination whether a certain non-aligned practitioner may be granted clinical privileges at such hospital. Some exclusive arrangements may need to be renegotiated after medical staff unification to effectively manage the service line across the unified medical staff and ensure consistent care throughout the system, particularly if separate hospitals within the unified medical staff have competing exclusive arrangements.

Voting and Minimum Duration Between Votes

Managing the voting process within a unified medical staff presents its own practical challenges. While the CoPs and TJC standards require that the decision to participate in, or opt-out of, a unified medical staff be approved by a majority, the unified medical staff has a fair degree of flexibility to determine the specifics of the voting process. Broadly, the requirements for voting to opt-in or opt-out of a unified medical staff must be the same as those

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for amending the medical staff bylaws. For example, the hospital may not require a supermajority to approve opting-out of the unified medical staff unless the same supermajority is required to amend the medical staff bylaws. However, within that, the medical staff has reasonable discretion to determine which members of the medical staff are eligible to vote, the process and timeline by which a vote is taken, and the minimum requirements to request a vote on unification. The bylaws, however, may not require that a petition on a vote to opt-out of the unified medical staff be signed by the same number of voting members as would be required for a successful vote to opt-out.[11] Similarly, the bylaws may not establish different criteria for the categories of members entitled to vote on unification than those used for any other type of voting on medical staff matters.[12]

The governing body of a unified medical staff may also wish to establish a minimum duration between votes to opt-out of the unified medical staff to ensure stability and consistency as much as possible; however, the interval may not be longer than two years to ensure the medical staff's self-governance does not come into question and the medical staff member's rights are not unduly restrained.[13] With regard to what constitutes a "majority" required to approve or opt-out of a unified medical staff, the voting provisions of then-current bylaws apply, but similar to approval or amendment of the bylaws, the vote to opt-out of the unified medical staff may not be delegated to the executive committee.

Other Practical Considerations

Each hospital within a unified medical staff must still demonstrate its compliance with the CoPs and adherence to TJC standards individually. As such, unified medical staff's must also be mindful of practical implications of creating a unified medical staff. There is currently no process for a system level certification or accreditation, and each separately certified hospital will continue to be surveyed by CMS and TJC individually. With this in mind, the minutes of the medical executive committee and governing body should clearly specify to which hospital(s) any discussions or actions apply. Additionally, while the medical staff may be integrated as a governing organization, this does not inherently translate to meaning the different departments of each hospital will be functionally integrated in the same way. Integration of departments across hospitals may be an option in some instances, but when such integration is not possible or impractical, close coordination between the individual hospital departments will be critical.

Medical staff unification may have implications for hospital transactions as well. If a health system acquires a new hospital and has elected to utilize a unified medical staff, then the acquired hospital must initiate the process to make the necessary changes to adopt new bylaws and other medical staff governance documents no later than six months after the date of acquisition.[14]

Other practical concerns such as friction or competition between hospitals, proportional representation of the individual medical staffs, ensuring smaller hospitals within the unified medical staff maintain a meaningful voice in decision making, and allocation of leadership positions must all also be considered when contemplating medical staff unification.

11. CMS State Operations Manual (SOM), Interpretive Guidelines A-0349, p. 197.
12. *Id.* at 201.
13. *Id.* at 198.
14. SOM, Interpretive Guidelines A-0349, p. 197.

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Conclusion

The unification of medical staffs within a multi-hospital system presents a meaningful opportunity for growth, coordination, collaboration, and improvement of patient care. Medical staff unification can provide for greater efficiency and reduced redundancy in the use of resources, improve sharing of information, boost mutual accountability, and improve standardization and consistency in credentialing, peer review, and delivery of patient care across the system. That said, unification also presents unique challenges both in terms of initial implementation and ongoing management of the unified medical staff. The recent changes to the CoPs and TJC standards to allow critical access hospitals to participate in a unified medical staff with other hospital types is a welcome reprieve for those critical access hospitals that had previously been left in the cold and unable to benefit from the advantages of participating in a unified and integrated medical staff. However, any multi-hospital system contemplating or currently operating a unified medical staff would do well to be mindful of the legal requirements and practical challenges posed. As tempting as a single set of standards and documents may be, remember that a one-size-fits-all approach will not be practicable in all instances. When in doubt, seek out guidance from competent legal counsel with solid medical staff expertise to help navigate the potential pitfalls and achieve the optimal potential benefits of creating a unified medical staff.

About Polsinelli's Medical Staff Practice

Polsinelli's Health Care attorneys guide hospitals and health systems through the medical staff governance process including credentialing, peer review, bylaws and medical staff and governing body relationships. From practitioner credentialing to hearings and appeals, and defense of litigation, our attorneys are versed in the intricacies involved in the life cycle of hospital-medical staff relationships.

Polsinelli has handled almost every type of matter involving medical staff and mid-level practitioners and has advised client on compliance with accreditation standards, hospital licensing laws, peer review laws, and federal laws governing the conduct of medical staff fair hearings. Specifically, we have extensive experience counseling hospitals on medical staff bylaws and related rules, regulations, policies and procedures, and codes of conduct. We have been active helping clients in implementing processes for effectively managing disruptive and inappropriate behaviors and in developing processes for empowering the well-being committee and managing impaired and aging providers.

Our team has experience advising through the credentialing process, advising peer review committees, representing medical executive committees in hearings and appeals, and interfacing with government entities. We also have defended hospitals and surgical centers in lawsuits filed by affected practitioners, during and after peer review.

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