YOU ASK:
We seem unable to deal with a myriad of performance problems within our medical staff; these are problems waiting to happen. What course of action should we take?

HUGH RESPONDS:
This is a tough one because action depends upon many variables such as size of the staff, capability and motivation of staff leaders, presence or absence of a committed VPMA or medical director, history and perhaps most importantly the existing medical staff culture. Effective action often depends upon affirmative responses to these questions.

- Does the staff rank and file trust its leaders to handle these tough issues without second-guessing them at every turn?
- Has the alleged problem been documented in the past?
- Have prior staff leaders attempted to resolve the situation?

If your responses to the above questions were “yes” you are more likely to be able to resolve tough problems.

Let us consider a few examples that often “stump the staff” and unfortunately become major issues.

1. 73-year-old physician who constantly requests other physicians to assist him in his procedural interactions with patients. A few physicians reluctantly agree to work with him but often complain (to you) that this is an imposition on their time and that he should just retire or stop doing these procedures. (Note: His OPPE doesn’t show any patient care problems because he always works with another physician.)

2. A physician of any age who simply has not “gotten it” and persists in berating the nursing staff or occasionally another physician involved in the care of his patient. The physician is extremely important to the hospital’s financial position. Note: His care is not yet in question.

3. The very pleasant Internist who constantly makes small errors in judgment, diagnosis or treatment. The nursing staff is often placed in a position of having to bring these small errors to his attention (where upon he always makes needed changes.) The Nursing staff complains but will not complete an incident report or otherwise document their concerns.

4. The new physician on staff who refuses to attend his or her orientation to the EMR insisting that he knows how to chart and a course would be a waste of his time.

5. The employed surgeon who has begun to show up late for surgery but not so late that the case is canceled. He generally apologizes and offers a seemingly plausible excuse. Following surgeons often complain to the OR supervisor or to you.

You probably have your own list of seemingly intractable problem practitioners and may have figured out how to approach each one. Here are a few lessons that have been learned the hard way.

1. Always deal with a problem at its earliest stage. Waiting for some magical moment, change, or early retirement rarely works.
2. Always attempt to avoid exacerbating the situation with threats of “formal corrective action”. If formal action is warranted proceed but don’t use the possibility as a weapon. Better to suggest, “We don’t want this to proceed to the MEC for its consideration.”

3. Always consider the best and most logical route to follow when addressing a problem physician (employed or not) who is constantly late to the OR is not a clinical problem that the MEC should be asked to deal with.

4. Always remember to praise in public and chastise privately, this is especially applicable to physicians as they do not enjoy being embarrassed or chastised by large numbers of peers (i.e. the MEC).

5. Always remember that there is no one correct course of action. Effective action depends upon consideration of many factors.

6. Don’t give support to cries of, “but he hasn’t hurt anyone yet, you are picking on me because _________ (fill in the blank), he is too important to the community, we can’t afford to lose him, let’s review his charts first, or maybe he will retire soon.” Chances are that he will hurt someone. Failure to address the issue quickly will increase the likelihood that the issue will be discussed “out of school” and give rise to challenges of prejudice.

If you have a reluctant or new Chief of Staff don’t assume that he or she must be your primary actor. Often a seasoned department chair or the VPMA would be a better choice to act “for the chief”.

Let’s apply these suggestions to our case examples:

1. The 73 year old—Consider an informal meeting with a senior leader and perhaps a board member or the CEO calmly suggesting that it is time to retire or at least stop performing procedures.

2. Physician of any age -- See above but couple it with a comment from the board chair that it would be a shame if the Board was forced to act to protect the nursing staff.

3. Physician of any age -- Just because “they won’t write it down” does not mean you can’t act. Whoever hears about the behaviors should write it down. Be specific and factual.

4. The new physician -- From the VPMA “Hey buddy, attend the EMR course immediately or you will be locked out of the system, your parking card won’t work, your key card wont work, and you wont be entitled to free meals in the Doctors lounge.”

5. The employed surgeon—From the VPMA or head of the physician group, “Hey buddy, since you have so much trouble adhering to the surgical schedule we will accommodate you by scheduling your cases last each day”. Or, “shape up or ship out.” Or “Please help me understand why all the other surgeons are able to make their scheduled start times and you are not? How might we assist you?”

YOU ASK:
“Can you tell me if Hospital entities are required to have their providers credentialed through the Medical Staff process? We have several physician offices that are part of an entity owned by the Hospital and they are staffed with physicians, NP's and PA's. Do these providers need credentialed by us if they are not going to be working in the Hospital?”

HUGH Responds:
Short answer—probably, however if in doubt just ask your accreidor (TJC, HFAP, DNV, etc.)

The general rule to follow is “if it looks like a duck, quacks like a duck and walks like a duck it probably is a duck.”
- Are the providers working in a facility that operates under the hospital’s license?
- Do the providers have a name badge linking them to the hospital?
- Is the Hospital CEO responsible for the entity?
- Does the entity report to the hospital board?
- Does signage link the entity with the hospital?
- Could an informed patient reasonably assume that he or she was receiving services under the umbrella of the hospital or medical center?
- Who pays the bills and writes the checks for employees?

We must recognize that the term “in the hospital” has lost its utility. Hospitals have long stopped operating in a single building located on “the corner of 4th and Main”. They now own and operate clinics, offices, urgent care centers, surgi-centers and pharmacies in many locations.

Please keep the questions flowing.