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THE NEWSLETTER FOR MEDICAL STAFF LEADERS

medical staff briefing

—INSIDE—

Physician satisfaction

Find out which hospital operations satisfy physicians across the country and which leave them disappointed on p. 4.

Sample reporting form

The Greeley Company has developed a sample policy and reporting form to help your organization keep track of physicians' unprofessional conduct. Read about it on p. 7.

MSO staffing needs

The number of staff a medical staff office requires to run efficiently and effectively varies widely depending on each hospital's unique structure. Learn how to evaluate the time it requires your medical staff office to fulfill its responsibilities and functions and determine the necessary staff on p. 8.

External peer review

Todd Sagin, national medical director for The Greeley Company, answers your questions about the external peer review process on p. 10.

Enclosed with this month's issue

Inside MSB

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Physician satisfaction: Improve care and your hospital's bottom line

Hospitals were slow to warm to the idea of patient satisfaction, but now they are just as likely to focus on improving their patient satisfaction ratings as they are to focus on offering the latest technology and improving quality of care. Recent research shows that patient satisfaction is a good indicator of the quality of care that a hospital provides.

The next step for hospitals looking to improve performance and secure financial health is maintaining a greater focus on physician satisfaction. Happier physicians not only lead to happier patients, but in a highly competitive environment, they are less likely to take their patients to another hospital, says **Lowell Teska, MSPH, MBA**, director, physician satisfaction consulting for South Bend, IN-based Press Ganey Associates.

Press Ganey, best known for the patient satisfaction surveys it has conducted since 1985, began conducting physician satisfaction surveys a few years ago, which are now a fast-growing part of its business, Teska says.

"Ten years from now, the hospital that has successfully promoted physician satisfaction will be in a better position," Teska says. "Hospitals are waking up to the fact that they have to maintain physician satisfaction to keep them strategically aligned with the organization."

With the typical physician spending more time in the office and less time at the hospital, hospitals need to work harder to reach out to physicians and communicate with them, Teska says. **> p. 2**

Organization works with physicians to reduce patient complaints and risk

When faced with a patient complaint, most physicians have a few common defenses to the criticism, says **Gerald Hickson, MD**, director of the Center for Patient and Professional Advocacy (CPPA) at the Vanderbilt University Medical Center (VUMC) in Nashville, TN.

They usually respond with a variation of one of the following:

- I provide excellent care to my patients
 - This patient is difficult or impossible to satisfy
 - This patient is in poor health
 - Other physicians in my field receive more complaints
 - This patient is a drug-seeker and complaining because I didn't write the prescription
- > p. 5**

Physician satisfaction

< p. 1

“The old days of physicians hanging around the physicians’ lounge are gone,” Teska says.

Relationships between hospitals and physicians can become testy and strained when physicians compete with the hospital by offering lab services, imaging, and outpatient procedures from their own offices instead of sending patients to the hospital for the services.

Given many of the economic incentives, there is only so much loyalty hospitals can expect from physicians, but by building physician satisfaction and trust, hospitals can at least leave the door open for joint ventures, Teska says. Joint ventures with physicians are likely to be critical to hospitals’ viability in the future, she says.

Physician satisfaction surveys

The 344-bed Sacred Heart Hospital in Eau Claire, WI, has assembled a physician satisfaction team charged with supporting physicians and addressing their needs and concerns.

Three or four years ago, the hospital began performing annual surveys of its medical staff, which consists of about 180 physicians, including the physicians from two large physician groups.

Sacred Heart works with Professional Research Consultants, Inc. (PRC), in Omaha, NE, for its annual

physician satisfaction survey. PRC surveys about 45 physicians quarterly in 15-minute phone interviews. PRC keeps responses anonymous.

Kathy Axelsen, RN, clinical director of nursing services, says Sacred Heart decided to conduct phone interviews rather than a paper survey to obtain more targeted responses from physicians.

Tom Thorsness, director of regional development and physician relations for Sacred Heart, says the hospital began focusing on physician satisfaction as part of its work with the Studer Group to achieve service and operational excellence.

The hospital’s recent physician satisfaction initiatives include giving nurses on certain floors a cell phone so physicians can more readily reach them when there is a question about a patient and including physicians’ detailed rounding and call preferences in the hospital’s intranet system.

When Sacred Heart performed its first survey, physicians were satisfied with the hospital’s medical records, lab services, and radiology departments. But the survey revealed dissatisfaction with surgical services—specifically with turnaround for the suites and staffing in the operating room (OR).

Jay Kaplan, MD, medical director of the Studer Group

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and physician advisor for Press Ganey Associates, says it is not enough for hospitals to listen to physicians and let them give their input. Physicians do not want to feel that they are just being placated. They want to know that action is being taken.

Kaplan, who is also director of service excellence for the California Emergency Physicians Medical Group, says it's important for hospitals to respond and give physicians regular progress reports and the reasons for the decisions they make—even if the administration decides not to make a change that is advocated by physicians.

Following are key issues in improving physician satisfaction:

- **Ease of practice.** Physicians' top priority is ensuring that their patients receive good care at the hospital. They are also concerned about ease of practice. Do they receive lab results and radiology reports on a timely basis? Is making rounds or taking calls from the hospital a hassle?

At Sacred Heart, physicians' rounding and call preferences are posted on the hospital's intranet. For example, a nurse who needs to call the physician checks on the physician's preferences on the intranet before calling after hours. The intranet also includes information about what time physicians plan to do their rounds.

In response to input the hospital received from physicians, nursing shifts in certain areas were changed to accommodate physicians doing rounds. For example, giving nurses cell phones has made it easier for physicians at Sacred Heart to reach a nurse who has called with a question or information about a patient. Nurses on med-surg units will be the next to receive cell phones, Axelsen says.

- **Staffing.** Staffing at the hospital is another key issue for physicians. Is there adequate staffing? Are staff qualified and providing good service to patients? Kaplan believes staff satisfaction should

also be an agenda item during every medical executive committee and monthly business meeting of medical staff departments.

"Medical staff meeting agendas haven't changed in 25 years," he says. "The agenda is heavily quality-laden and focused on procedures and rules."

Physicians should be regularly informed about the hospital's recruitment efforts and other staffing issues. Kaplan says he also likes to encourage physicians to be appreciative of staff and say thank you.

"When you have a better reputation with the staff you get the help you need," he says. He says that nursing ratios improve

markedly when nurses stop hiding in hallways or in the med room when physicians do their rounds.

- **Communication.** At Sacred Heart hospital, department directors are responsible for communicating with physicians who are high-admitters. When they do their rounds, a director makes a point of checking in with those physicians and finding out whether their and their patients' needs are being met and whether they have all of the tools necessary to do their jobs.

"We round with patients and . . . employees and now we are rounding with physicians," Thorsness says. "We are taking time to have one-to-one contact."

> p. 4

Physicians do not want to feel that they are just being placated. They want to know that action is being taken.

Questions? Comments? Ideas?

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Physician satisfaction

< p. 3

Top administrators at the hospital also make an effort to communicate with physicians when they are at the hospital. Kaplan says the CEO of one hospital went on rounds with the chief of medicine to see whether the patient charts were available, lab results were ready, and physicians had what they needed.

Axelsen says the hospital now works on a post-discharge electronic medical record and sends e-mails to all physicians (under the name of the chief of staff) to update the records on the system.

When physicians expressed dissatisfaction with the OR's turnaround, hospital officials realized that physicians were unaware of the efforts that the hospital had already made to improve turnaround time and collected data to better communicate the improvements that they had already made, she says. During medical staff meetings, there are four to five guests on the agenda who can inform physicians about what is happening in the hospital, Axelsen says. For example, during

a recent maternal child meeting, there was a presentation about cardiac services.

- **Leadership.** Based on surveys of 35,000 physicians nationwide, Teska says the biggest problem areas for physicians are lack of trust and confidence in hospital leadership, frustration with a perceived lack of responsiveness by the administration, and being uninformed about hospitals' plans for the future.

Teska says physicians want to know that hospitals are making strategic plans for the future and that they want to be involved in the process. At Sacred Heart, hospital officials involve physicians in planning for major service lines, particularly neurosurgery, cardiology, oncology, trauma, and maternity. The hospital also involved them in the development of its five-year strategic plan.

"The relationship between physicians and health leaders is suffering because of all the national changes that are occurring," Teska says. "Health leaders have to figure out how to effectively establish a relationship." ■

Physician satisfaction survey results

Based on the satisfaction surveys of 35,000 physicians by Press Ganey Associates, physicians are most satisfied with the quality of care hospitals provide and least satisfied with the administration of their hospitals.

Low physician satisfaction:

- Hospital administration:
 - Confidence in administration
 - Responsiveness of administration
 - Administration has positioned hospital for future
 - Information regarding strategic planning
 - Confidence in hospital board
 - Communication with hospital administration
- Patient care-related:
 - Patient care made easier

- Satisfaction with facility

High physician satisfaction:

- Quality of the medical staff
- Quality of hospital-based physicians
- Intensive care unit/critical care unit
- Patient care:
 - Staff's concern for patients
 - Services from hospital-based physicians
 - Quality of patient care
 - Specialists available for consults ■

Source: "Physician Satisfaction with Hospitals: A National Assessment" by Lowell Teska, director of physician consulting for Press Ganey Associates, presented during the November 2005 Press Ganey meeting for physician executives.

Reducing complaints

< p. 1

After being involved in about 500 interventions with physicians about patient complaints at Vanderbilt and other hospitals around the country, Hickson says he has heard all the common “pushbacks.”

Taken one at a time, it is hard to know what to make of a patient complaint, but when the complaints are aggregated and the physician is presented with data showing that he or she receives more complaints than his or her peers, Hickson says it's an entirely different discussion.

“Physicians tend to dismiss complaints when you look at them one at a time,” Hickson says. “You never have the full value of looking at complaints in the aggregate and seeing patterns.”

Link between patient complaints, malpractice suits

Since 1998, the CPPA has monitored patient complaints about physicians and identified those with high-complaint profiles, not only to improve patient care at VUMC, but also to prevent malpractice suits.

In a landmark study published in the June 14, 2002, *Journal of the American Medical Association*, Hickson and his team analyzed research that showed that the number of patient complaints a physician receives was a significant risk factor for being sued, along with high clinical volumes and the type of practice (e.g., surgical versus nonsurgical).

Hickson says physicians often take a fatalistic view of their risk of litigation and blame lawyers and their bad luck in attracting the patient who goes on to sue. Although lawyers might play a role in the malpractice crisis, Hickson says physicians and hospitals can work to prevent some of these suits by intervening with physicians who receive a disproportionate share of complaints.

Instead, be proactive, he says. Presenting information to physicians early about patient complaints gives them a heads-up to make changes. The key is to approach them in a way that will make them responsive instead of just defensive.

The CPPA, which now works with hospitals nationwide to address patient complaints, trains volunteer physicians to meet or communicate with colleagues who have high complaint profiles.

Note: Hickson says the CPPA now works with 15 other hospitals who want to use VUMC's approach in monitoring and analyzing patient complaints and intervening with physicians.

Interventions with physicians

The first goal of an intervention with a physician who has a high number of complaints is to make him or her aware of the pattern and number of complaints so he or she can initiate changes. The peer physicians, trained by the CPPA, express support and respect for their colleagues and ask them to review their complaint profile and use their judgment to decide what changes to make, Hickson says.

“It doesn't work if driven by administration,” Hickson says. “Physicians will listen to other physicians.” However, even peer physicians must be careful not to play “gotcha” and must deliver their message with humility.

> p. 6

Illustration by
Dave Harbaugh



“If you agree to chair the medical executive committee, they'll throw in a preferred parking space for \$300 per month.”

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Reducing complaints

< p. 5

“We do not believe in specific prescriptions,” says Hickson of these early interventions. The attitude, he adds, is, “I don’t practice in your shoes. I know you are a thoughtful person and will do the right thing.”

Another compelling part of the message is educating physicians about the link between patient complaints and the risk for being sued. The peer physician offers assistance in helping the colleague avoid a future malpractice action.

Hospitals that want to work with physicians on patient complaints need to provide more general education about the link between those complaints and the adverse outcomes—not only the risk of malpractice, but also the loss of patients and patients who are less compliant with their medications and treatments.

At VUMC, physician peers are nominated by the department chair to serve on the patient complaint monitoring committee. They receive about six to eight hours of training. Hickson says he was initially concerned that it would be difficult to recruit physician volunteers, but he says that has not proven to be an issue. Physicians are motivated to play this role and tend to continue in the role.

Note: The committee works under peer review and quality assurance statutes to provide protection from legal discovery.

Most physicians respond to this intervention, Hickson says. However, if there is no improvement after 12 months in the complaint profile, there is a Level II intervention with the involvement of the department chair. Depending on the kind of complaints being received, Level II could involve

- referral to the Physician Wellness Program
- pairing with a role model physician who makes suggestions about clinical behavior
- a course in risk management
- a course in improving communication skills
- a redesign of the clinic/office management systems
- evaluation of staff performance/staffing levels

Analyzing patient complaints

After the office of patient affairs takes a complaint, the complaint is coded into 35 subcategories and the following six major categories:

- Accessibility
- Care and treatment
- Communication
- Concern for patient
- Money and payment
- Total complaints

“The complaint types will give you insight into the part of the practice that is generating dissatisfaction,” Hickson says.

Although billing complaints are not highly predictive of the risk of being sued for malpractice, they do have weight in the model, Hickson says, and usually it is a small number of physicians who generate most of the complaints about billing.

The single biggest predictor of a physician’s risk of being sued are complaints by the patient and the patient’s family that the physician does not seem interested or concerned about the patient, Hickson says.

“There are a whole cluster of patient complaints that say, ‘I do not feel appreciated as a human being,’ ” Hickson says. A particularly troubling complaint in terms of a physician’s risk for litigation is one in which the patient or family says the surgeon did not visit after a surgical procedure, he says.

“We find the vast majority are stunned and dismayed and want to do something about it,” says **James Pichert, PhD**, an educational psychologist who is codirector of the CPPA. After reading their patients’ complaints about interpersonal behavior, physicians might ask another physician or a member of the patient affairs office to shadow them and give them feedback.

Pichert says physicians who receive a high number of complaints are not necessarily “people > p. 12

Unprofessional conduct: Sample policy and reporting form

Editor's note: The following sample policy, developed by The Greeley Company and included in the HCPro book A Practical Guide to Preventing and Solving Disruptive Physician Behavior, is an important tool to encourage members of your medical staff, patients, and other caregivers to alert the hospital to a physicians' improper conduct. Keep in mind that legal counsel should be consulted before adopting or adapting this form for use at your institution.

Policy: Incident report for unprofessional conduct

It is the policy of [hospital name] to treat all individuals on its premises with respect, courtesy, and dignity. All employees, medical staff, and other caregivers at [hospital name] must behave in accordance with the institution's conduct policies and act professionally and cooperatively at all times. When a member of the hospital community observes a lapse in proper conduct, he or she has a responsibility to report it directly to a supervisor or use the incident report form below. All reports of improper or disruptive conduct will be investigated. It is the policy of this institution to prohibit retaliation for such reporting and those making reports will not be subject to adverse action for exercising this responsibility.

Incident report for unprofessional conduct

If you observe an occurrence of unprofessional conduct, please answer the questions below in as much detail as possible. Additional comments can be appended to this form.

1. Date and time of incident:
2. Name of the individual engaging in improper conduct:
3. Name of other parties involved in the incident (e.g., employees, staff, patients):
4. Identify any other parties who witnessed this incident:
5. Describe the circumstances surrounding the incident and the specific unprofessional behavior observed:
6. Describe any disruption of hospital operations that resulted from this incident:
7. Describe any effect on patient care resulting from this incident:
8. Identify any interventions taken to address this incident at the time of occurrence or immediately after the event, including comments to the involved parties, reprimands, discussions with patients, other written reports or documentation, conversations with supervisors, etc.:

Submitted by: _____
(optional)

Date completed: _____

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msb credentialing

Use a time management log to analyze staffing requirements for the medical staff office

The number of staff a medical staff office (MSO) requires to run efficiently and effectively varies widely depending on each hospital's unique structure and the services it provides.

The staffing level has little relationship to the number of beds that the hospital provides; rather, it relates to the number of medical staff, number of new applicants and reapplicants each year, and complexity of the medical staff structure, including the number of committees, departments, meetings, and other responsibilities assigned to the MSO.

Using the time management log

Because MSO responsibilities and resources vary, the necessary staffing level for an MSO cannot be determined by rule of thumb or justified by a guess or vague formula (e.g., X number of practitioners requires X number of credentialing personnel). A more valid approach is to evaluate the time it requires the MSO to fulfill its assigned responsibilities and functions and thus determine the necessary staff (see the sample time management log on p. 9).

The next step is to determine exactly which tasks you and your staff carry out on a daily basis. Prepare a time management log for each employee in the MSO. Log all telephone calls and every task performed daily for a sample time period of four to six weeks. Although this is a time-consuming project and an added burden, it is the only way you are going to get a handle on exactly what you and your staff do on a daily basis. In fact, you might find that your MSO is being

asked to perform tasks that clearly are neither its primary responsibility nor included in your MSO assessment of department responsibilities.

Each function should be broken down into the number of hours required to complete the process. For example, committee support should take into consideration premeeting activities (e.g., room scheduling, ordering of food, agenda planning meetings, agenda preparation, and committee packet preparation). It also should include attendance during the actual meeting, minute preparation, and preparation of committee follow-up action items. Does the committee request research and information gathering from the MSO for its activities? If so, this task should also be included on the time management log.

Use the data gained from your staff management log to develop an average time estimate for the committee support responsibility per committee meeting. In a given year, how many committee meetings occur? Multiply your average time spent per meeting by the number of meetings to arrive at the total staff time needed per committee per year. Note that the time will vary by department and committee function. Analyze all of the various functions of the MSO in this manner. ■

Editor's note: The information above and the sample time management log on p. 9 are excerpted from Assessing Your Medical Staff Office: Tool for Productivity by Beverly Pybus, CPMSM, and Nancy Lian, CPCS, CPMSM. Call 800/650-6787 or go to www.hcmarketplace.com for more information.

Sample time management log

Name: _____

Position/title: _____

Instructions: This log is used to analyze the functions carried out in this office in an effort to determine the appropriate staffing level required to efficiently and effectively perform the responsibilities assigned to this office. Each day, you must record the date and time of every task performed that day. See below for an example:

Date	Task	Time
1/1/03, 8:15 a.m.	Telephone call from CEO regarding new applicant, Dr. John Q. Adams, general surgeon	Five minutes
1/1/03, 8:20 a.m.	Prepared request for application materials for applicant, Dr. John Q. Adams	45 minutes
1/1/03, 9:05 a.m.	Telephone call from public relations department requesting roster of medical staff, by department, specialty, and board certification status, needed by Thursday this week	10 minutes

Source: Assessing Your Medical Staff Office: Tools for Productivity, published by HCPro, Inc.

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Your questions answered: External peer review

Medical staff and MSPs involved in the peer review process are occasionally stumped by the ins and outs of the external peer review process. Below, **Todd Sagin, MD, JD**, national medical director for The Greeley Company, a division of HCPro, Inc., in Marblehead, MA, answers your questions about this often confusing process:

Q: What are the common factors that trigger an external peer review?

A: Several factors that prompt the peer review committee to seek the assistance of an external peer reviewer. Following is a list of potential triggers:

- Investigation of a sentinel event
- Necessary expertise for peer review not available
- Subject-matter experts on staff have conflict of interest
- Possibility of litigation involving the matter under review
- Anticipation of corrective action resulting from the peer review
- Internal peer review results in ambiguous or conflicting findings
- Introduction of a new technology to the institution
- Possibility exists for allegations of anticompetitive behavior by internal peer reviewers
- Need for due diligence on high-risk, high-volume procedures

Q: Who can request an external peer review?

A: The person responsible for requesting an external peer review is dictated by each organization's external peer review policy. However, an external peer review usually results from a discussion between medical staff leaders, administration (often a vice president of medical affairs), and occasionally the quality and risk management directors of members of the governing board.

External peer review is rarely the result of a unilateral decision made by one person or group. The more people involved in the decision, the more confident you

should feel about it. In some states, a recognized peer review committee should make the decision to ensure that the external peer review work produce it nondiscoverable under the state's peer review privilege laws.

The decision to seek external peer review should be documented clearly in the appropriate places in accordance with your policy.

It is not a good idea for your external peer review policy to allow a physician who disagrees with an internal peer review finding to demand an external peer review. In many cases, this physician is simply looking for vindication for a course of clinical decision that he or she undertook. However, such unfettered access to external peer review is expensive and burdensome. Although anyone should be able to request an external peer review, the decision should remain with a clearly defined group of medical staff and hospital leaders.

Q: Who should pay for the external peer review?

A: The hospital or institution in which the physician under review practices should be responsible for paying the cost of an external peer review. However, some institutions that allow a physician to challenge internal peer review findings by demanding an external peer review put the financial burden on that physician.

In other instances in which the issue of retaining outside expert consultation arises, the hospital and physician under review may agree to share the cost of the expert so no one feels that "he or she who pays the piper" influences the outcome of the review.

Q: How do we determine the sample size and select records for evaluation by the external peer reviewer?

A: Numerous issues arise when selecting medical records for review. When the concerns that prompt

the review focus on a physician's technical skills related to one type of procedure (e.g., laparoscopy or cardiac catheterization), charts chosen for review should be limited to the procedures in question.

On the other hand, when the concerns that prompt the review focus on the physician's clinical judgment, a broader set of records should be studied by the external peer review.

The external peer review organization that your facility chooses to carry out the review should have a methodology for selecting the cases for review. If the hospital, managed care organization, ambulatory facility, or physician group practice wishes to select records for review, the records chosen should document cases about which questions have been raised and should include a representative sample of additional cases handled by the same physician.

If there is no emergent crisis that precipitated the request for external review, some hospitals and ambulatory facilities choose to have a small sample of charts reviewed first. If, after that review, problems are identified, a larger, more comprehensive study is undertaken.

However, if your organization's need for an external peer reviewer is prompted by questions regarding a physician's appropriateness of care in a single instance, it may be sufficient to have only that single medical record reviewed.

To select a representative sample, the organization might need to inventory the procedures that a physician performed during a relevant period of time. The facility should then provide the external peer review consultant with records for each type of procedure. The external peer reviewer should have a methodology for identifying a sample size that is adequate to satisfy concerns about quality performance but minimizes expense to the requesting organization. Sample size should be discussed up-front in negotiating an engagement so all parties are clear about the scope of work that the external peer review will perform. ■

*Editor's note: For additional training regarding the external peer review process, check out *The Greeley Company's training handbook, Orientation to External Peer Review*, written by Todd Sagin, MD, JD, and Laura Cook Harrington, RN, CPHQ, which is available at www.hcmarketplace.com/prod-3908.html; or by calling 800/650-6787.*

Unprofessional behavior in medical school tied to future disciplinary action by medical boards

Unprofessional behavior often begins when a student learns to be a physician, and habits learned during this crucial training period may present your hospital with a tough challenge.

Medical students who display unprofessional behavior in medical school are more likely to be the subject of disciplinary actions by medical boards later in their careers, says a study published in the December 22, 2005, *New England Journal of Medicine*. The researchers compared the medical school records of 235 graduates of three medical schools who were disciplined by state medical boards between 1990 and 2003 with

the records of 469 control physicians from the same schools and graduation years.

The types of unprofessional behavior most strongly linked with disciplinary action were severe irresponsibility and severely diminished capacity for self-improvement.

Disciplinary action was also associated with low scores on the MCAT and poor grades in the first two years of medical school. The study provides evidence supporting professionalism as a measure of competence in medical school, the researchers say. ■

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Reducing complaints

< p. 6

with impaired relationship abilities. It may be that the infrastructure doesn't support the work they want to do." Physicians are trusted to be bright and capable problem-solvers who will find their own way of addressing the issue when made aware of patient complaints. In some cases, physicians gather together their team or go to the chief of service to make other changes or advocate for more resources, Pichert says.

Collecting patient complaints

An important part of the process of working effectively with physicians to address a pattern of complaints is collecting the complaint data, he says. When there is cost-cutting in a hospital, the office of patient affairs is often targeted because it is a cost center, not a revenue center, Hickson says.

To collect complaints, the hospital should place posters and other educational materials throughout the hospital that encourage patients and families to report complaints. More affluent and educated

patients are more likely to complain, Dr. Hickson says.

When recording a complaint, representatives must listen carefully and collect as much information as possible, he says.

Note: Pichert says the CPPA reviews the number of complaints and amount of information that have been collected by a facility to ensure that it is sufficient in quality and quantity before working with the organization.

Kathy Coleman, risk manager for St. John Hospital in Springfield, MO, says her hospital has worked with the CPPA for several years and seen a large decrease in complaints for high-complaint physicians. Except for the chief of the clinic and the peer physician, all information is kept strictly confidential.

Tip: Review the sample policy and reporting form on p. 7. ■

Medical Staff Briefing

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Medical Staff Briefing provides its readers with current information and advice on how to manage medical staff functions, from organizational structure to physician leadership to medical staff reengineering. In addition, it provides cutting-edge news and insights into developments in medical staff credentialing.

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Vol. 16 No. 3
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Inside

Medical Staff Briefing

How to get the most from your March *Medical Staff Briefing*

- The next step for hospitals and their medical staff looking to improve performance and secure financial health is focusing on physician satisfaction. Happier physicians not only lead to happier patients, but in a highly competitive environment, they are less likely to take their patients to another hospital. Find out more on p. 1.
- Medical staff and MSPs involved in the peer review process are occasionally stumped by the ins and outs of the external peer review process. **Todd Sagin, MD, JD**, national medical director for The Greeley Company, a division of HCPro, Inc., in Marblehead, MA, answers your questions about this often confusing process on p. 10.

For you . . .

- Because medical staff office (MSO) responsibilities and resources vary, the necessary level of staffing for an MSO cannot be determined by rule of thumb or justified by a vague formula. A more valid approach entails evaluating the time the MSO requires to fulfill its assigned responsibilities and functions and, from that, determine the necessary staff. Read more on p. 8.
- Find a sample time-management log to help determine the number of staff your MSO requires to carry out its tasks on p. 9.

For your physicians . . .

- After being involved in about 500 interventions with physicians about patient complaints at Vanderbilt University Medical Center in Nashville, TN, and other hospitals nationwide, the Center for Patient and Professional Advocacy at Vanderbilt shares the lessons it has learned about physician interventions on p. 1.

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Mandalay Bay also boasts 24 restaurants, such as Charlie Palmer's Aureole, featuring a four-story wine tower; the *restaurant rm*, an intimate environment with the freshest seafood from the world's oceans; and Red Square, which serves over 100 varieties of vodka on Las Vegas' only ice bar. In addition, the resort offers a mind-boggling array of multiple-entertainment venues: a 1,760-seat showroom featuring the Broadway hit "Mamma Mia!," the rumjungle nightclub, and a 12,000-seat special events arena.