As concern in the industry about physician impairment and liability increases, Arkansas Children's Hospital’s (ACH) policy of randomly drug testing physicians could be on the leading edge of an emerging trend. However, due to the controversial nature of random drug testing and drawbacks associated with it, ACH is still working out how to make its policy both effective and fair.

Change and improvement: Linking CME to quality

Hospitals that provide continuing medical education (CME) for their physicians should be aware of new accreditation criteria adopted by the Accreditation Council for Continuing Medical Education (ACCME) that emphasize change and improvement in the practices of both physician learners and CME programs.

Beginning in November 2008, the ACCME will transition to three levels of accreditation: provisional, accreditation, and accreditation with commendation. Due to the four-year accreditation cycle, it will take until 2012 for all CME providers to transition to the new criteria. According to the ACCME, it plans to measure “the extent to which a provider engages within its environment as a participant in quality and patient safety improvement opportunities.”

The goal is to link CME to performance improvement, not merely advancement of knowledge. The new focus is on the concept of practice-based learning and improvement, says Murray Kopelow, MD, CEO of the ACCME. “[It’s] learning as an outcome and not just a process.”

The ideal process for CME starts with an assessment of the knowledge gap—or “professional practice gap”—of physicians and designing educational activities to address those gaps. Providers should then assess the effectiveness of the learning activities in creating improvements in physicians’ competence, performance, or patient outcomes.

Hospital system institutes random drug tests for physicians

Editor’s note: In the December 2006 MSB story “Drug-impaired physicians: Should hospitals institute random drug testing?”, we reported that we could not find evidence of a hospital that randomly drug tests its physicians. In response to that article, we heard from a representative of Arkansas Children’s Hospital in Little Rock, which started a random drug-testing program for physicians in 2001.

As concern in the industry about physician impairment and liability increases, Arkansas Children’s Hospital’s (ACH) policy of randomly drug testing physicians could be on the leading edge of an emerging trend. However, due to the controversial nature of random drug testing and drawbacks associated with it, ACH is still working out how to make its policy both effective and fair.
“We want [CME providers] to measure the translation of knowledge into strategy,” Kopelow says. “The pursuit is not what facts did you learn, but how what you learned is going to change what you do.”

Although the ACCME has always required CME providers to demonstrate the effectiveness of educational activities, providers are now being asked to demonstrate change and improvement—not only by learners, but by CME providers as well.

The goal of providers should be to improve educational activities to meet the changing demands of the healthcare environment.

New criteria emphasize generating educational activities that

- match the learners’ current or potential scope of professional activities
- are appropriate in the context of desirable physician activities (e.g., ACGME/Joint Commission competencies)
- promote improvements in healthcare and not proprietary or commercial interests

The key to program success and climbing the three levels of accreditation is using data, including, but not limited to program assessments by learners, Kopelow says. Based on feedback, CME providers can assess the ability of the program to meet its stated mission for improving competence, performance, or patient outcomes. “It’s the same improvement cycle that we use everywhere in patient care,” Kopelow says.

Measuring change and improvement in the learner’s competence, performance, or patient outcomes is not as difficult as it sounds, Kopelow says. The learner’s own assessment of the ability of the educational activity to lead to improvement is sufficient—that is, if providers ask the right questions.

Rather than asking physicians what they learned, it is important to ask physicians how the educational activity will change what they do. “Ask the learner, ‘What is your strategy, what’s different than before?’,” Kopelow says. “That [demonstrates] a change in competence.”

Hospitals can also use their own formal quality measures and benchmarks to assess improvements in competence, performance, or patient outcomes.

“A lot of physicians have information about what they’re doing in their practices from these data sources,” Kopelow says. “Incorporating the information from these data sources into CME is the kind of thing that we’re trying to encourage.”

‘Trying to do better’
The ACCME will reward providers for moving up through the levels of accreditation while changing and improving their practice of CME. “Trying, and then trying to do better will be expected and rewarded by the ACCME during the accreditation process,” wrote the chair and vice chair of the ACCME in a September 2006 letter to CME providers.

Trying to do better, they write, includes seeking out needs assessment data, taking new educational approaches, entering new partnerships, and working to identify and overcome barriers to change.

The base of all three levels of accreditation is a specific enhancement mission and providing specific educational interventions to meet that mission. Providers must develop a mission statement that specifies the expected results of CME, articulated in terms of improvements in competence, performance, or patient outcomes.

The ACCME does not require providers to accomplish improvements in all areas, Kopelow explains. The mission statement can be as broad or as narrow as the organization wishes. For example, the provider’s mission could be to improve patient outcomes in colonoscopies or to improve physician performance to meet specific quality benchmarks.
In assessing the impact of educational activities, CME providers can then hone and improve their structures and activities to better meet the learners’ needs.

The ACCME’s focus on changing and improving CME to meet its objectives is reflected in the new criteria, which require providers to

- identify, plan, and implement the needed or desired changes in the overall program (e.g., teachers, planners, methods, resources, facilities, etc.) that are required to improve on the ability to meet the CME mission
- demonstrate that identified program changes or improvements are underway or completed
- demonstrate that the effects of program improvements are measured

Achieving accreditation with commendation
The ACCME will create an incentive for CME providers to attain the third level of accreditation—accreditation with commendation. Providers meeting the level-three criteria will have a six-year rather than four-year accreditation cycle. This longer cycle means a 50% decrease in accreditation costs.

Beyond cost incentives, however, the ACCME expects that achieving accreditation with commendation will translate into an organization that is fully engaged in improving quality of care and patient safety.

The criteria for accreditation with commendation include requirements that the CME provider

- operates in a manner that integrates CME into the process for improving professional practice
- utilizes noneducation strategies as an adjunct to its activities (e.g., reminders, patient feedback, etc.)
- identifies factors outside of the provider’s control that have an effect on patient outcomes
- implements educational strategies to address barriers to physician change
- builds bridges with other stakeholders
- participates within an institutional or system framework for quality improvement
- be positioned to influence the scope and content of educational activities

“From an organizational perspective and a system perspective, [these criteria] describe an engaged organization, an organization that’s linking quality improvement and CME, an organization that’s in control of the content of CME [and is] not having its content dictated by anyone else, is collaborative, and is a change agent,” Kopelow explains.

The ACCME’s organizational mission is to “ensure that CME stays in touch with the health system’s needs,” he adds. To achieve this mission, Kopelow says the ACCME intends the new accreditation criteria to improve the quality of CME to make it a “strategic asset to those who are trying to promote quality and safety.”

For more information on the ACCME’s updated accreditation criteria and a list of resources, visit...
Initiated five years ago, the ACH random-testing program has yet to identify a single physician with a positive screen, but the possibility of discovery has likely had a deterrent effect, according to Timothy Martin, MD, MBA, chief of ACH’s division of pediatric anesthesia. The policy to test physicians was motivated by the hospital system’s move to require random drug testing of employees in the 1990s, says Martin. He pushed for the policy as a member of ACH’s physician health committee.

Martin, who served as a physician in the military before joining the medical staff at ACH 10 years ago, says the military’s policy of random drug testing informed his decision to establish a similar program at ACH. Although the program did not arouse resistance from physicians—the medical staff approved the policy—Martin says differences in disciplinary procedures between employees and physicians generated some resentment among employees. Employees who have a positive drug screen are terminated immediately, whereas physicians have an opportunity to enter rehabilitation.

The main difference between the two groups, of course, is that the medical staff is self-governing, whereas the human resources department controls policy for employees.

Despite some differences in the policies for testing physicians and employees, Martin says the overall impact and intent are the same—to keep patients and hospital workers safe from the effects of dangerously addictive narcotics that are readily accessible at the hospital. “In this era of accountability and transparency, I think our medical staff here was interested in standing in solidarity with our employees at the hospital,” Martin says. “There wasn’t any groundswell of opposition.”

How the program works
Not everyone at the hospital has the same level of risk for drug use. According to a 2005 Alcohol and Drug Recovery Center of the Cleveland Clinic Foundation study, anesthesiologists represent up to 13% of physicians treated for chemical dependency, despite making up less than 4% of the physician population.

ACH’s employee health committee stratifies employees and physicians into low- and high-risk groups. The hospital considers those without direct access to medications (e.g., pathologists and psychiatrists) to be low risk. Pharmacists and others with access to medications are considered high risk. The hospital tests practitioners in the low-risk group at a rate of 10% per year and those in the high-risk group at a rate of 20% per year. The employee health committee meets quarterly, overseeing the testing and results.

The rate at which physicians are tested is not an arbitrary number. In fact, Martin says, finding the right rate of testing is problematic. The university hospital affiliated with ACH until recently only tested at 5% per year. That rate equated to testing physicians once every 20 years or once in his or her career, Martin says. For ACH physicians in the high-risk group, a 20% rate of testing averages out to one random drug test every five years.

The medical staff office keeps a list of physicians in both groups that it submits to the employee health committee. The committee assigns numbers to the physicians on each list and selects from the list at random for testing. With 300 physicians on ACH’s medical staff—80–100 in the high-risk group—ACH selects one or two physicians in the high-risk group and one physician in the low-risk group per month. “It truly is random,” Martin says. “We don’t allow any manipulation.”

Physicians selected for testing must present to the employee health office at the end of the day on which they are selected to provide a urine sample, which is sent to a lab for the test.

“We have taken great care to make sure that the panel we are using for the drug testing is appropriate for physicians and nurses who are actually working in a hospital,” Martin says. “A lot of programs will contract with an outside laboratory, and if you’re not careful, if you really don’t research what they’re screening for, you may see that they’re only screening for street drugs.”
The lab tests the samples for all of the major opiates, including fentanyl, an IV anesthetic that is commonly abused by physicians. According to Martin, the only major drug that the lab cannot test for is propofol, an intravenous anesthetic. “We can obtain a test for [propofol] if we suspect it,” he says. Because the drug tends to disappear from the system quickly, the timing of the screening must be done within hours of its use, he explains.

The time granted to physicians to present for the drug test is a controversial matter, Martin explains. Some medical staff members have questioned the policy of notifying physicians in the morning that they will be tested at the end of the day. “We have taken the stance that you need to give [physicians until] the end of that business day” in order to avoid disrupting patient care, Martin says. “I know there are critics of allowing that much time, but most of the screening labs can detect if the sample has been adulterated.”

**After the test**

If a physician’s test results are positive, a medical officer for the testing company contacts the physician to inquire about the result. The physician may have a legitimate explanation for a positive test result, such as a prescription.

The physician must produce evidence that explains the positive result. If the physician cannot explain the positive result in a satisfactory manner, the physician health committee intervenes. The committee meets with the physician to explain the result and its consequences.

A physician with a positive drug test is granted medical leave and his or her clinical privileges are automatically suspended. The physician is then required to undergo a psychiatric evaluation to set a course for recovery.

A physician’s recovery program depends on the drug being used and other particulars of the case, Martin explains. If the physician satisfactorily completes rehabilitation, he or she may be permitted to resume privileges in a monitored setting.

Although ACH’s random drug screening has not turned up any positive results, the hospital has uncovered drug use among physicians through for-cause testing. In these cases, it is usually a colleague or employee who alerts the physician health committee about a physician’s erratic behavior or suspicions of drug use on the job.

Martin says the committee must be careful when intervening with a drug-impaired physician to note the physician’s reaction to discovery.

Hospital representatives escort the physician home if the committee believes that his or her behavior or reaction indicates a risk that the physician may harm him- or herself or others, Martin says.

Commenting on the effectiveness of the ACH random drug-testing program in its first five years, Martin wonders whether the program has been active long enough to find evidence of a drug impairment, or whether the lack of a positive result indicates that the tests are a deterrent.

“My own belief, being an anesthesiologist, in a high-risk group, and knowing the attitudes of our staff and in our department, [is] that it is an effective deterrent,” he says.
Improving physician-hospital relations

Step 3: Create a shared vision of mutual success

by William K. Cors, MD, MMM, FACPE, senior consultant, The Greeley Company, a division of HCPro, Inc. Marblehead, MA.

Aligning physicians and hospitals with a common purpose often proves difficult. These groups have different priorities and are often threatened by the other. To create a shared vision of mutual success, medical staffs, similar to their hospital counterparts, must develop a strategic plan. Joint physician-hospital strategies must include

• organized medical staff strategies
• alignment by specialty strategies
• recruitment and retention strategies
• competition and collaboration strategies

The first move toward this goal is the development of a medical staff strategic plan. Virtually every hospital with which The Greeley Company has worked has a strategic plan.

However, very few medical staffs have created such a plan. Strategic planning is a disciplined effort to produce fundamental decisions and actions that shape and guide what an organization or group is, what it does, and why it does it.

The medical executive committee should charter the development of a medical staff mission and vision statement. The mission statement should be a precise statement of purpose.

The fundamental purpose of the medical staff is to monitor and improve the quality of care that is primarily dependent on the performance of individuals who have been granted privileges.

Physicians are mutually accountable to each other for the quality of care they provide.

Use these starting points to develop a short, sharply focused, clear, and easily understood mission statement. The vision statement should answer the question: What would it look like if the medical staff fulfilled its mission? The answer should be a truly effective medical staff in form and function.

The next move is to acknowledge that the old medical staff development plan based on needs, demographics, and physician age is outdated and inadequate in today’s increasingly complex environment. Medical staffs need the following joint physician-hospital strategies:

• An organized medical staff strategy that includes a physician-hospital compact, formal leadership development, building of social capital, and increasing communication. (Many of these items will be examined in detail in future columns in this series.)
• Alignment strategies by specialty that can include options for employment, exclusive contract, medical directorship, joint venture, recruitment support, and compensation for call. Flexibility is paramount, and not all physicians or specialties get the same treatment.
• Recruitment and retention strategies based on physician-satisfaction surveys, recruitment support, a physician liaison, practice support, branding, operations councils, contracting strategies, and no- and low-volume alignment.
• Competition and collaboration strategies that include a conflict-of-interest policy, joint venture, facility leasing, economic credentialing issues, and managed care contracting.

In step one, we acknowledged the changed social contract between hospitals and physicians. In step two, we undertook the process of healing the past.

In this step, we create a shared vision of mutual success—a daunting but necessary undertaking to improve physician-hospital relations.

In the next column, I will explore the fourth step, which is formalizing the mutual expectations in a physician-hospital compact.

Until then, stay well and be the best that you can be.
Editor's note: In the December 2006 MSB, we discussed the importance of evaluating the competency of allied health practitioners (AHP). To help you navigate this challenge, we've included the following AHP evaluation form developed by Dameron Hospital Association in Stockton, CA.

SAMPLE ALLIED HEALTH PRACTITIONER PERFORMANCE/COMPETENCY EVALUATION

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### Core values

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1. **LEADERSHIP**
   - Provides consistent examples of excellence through personal commitment and integrity.

2. **INTEGRITY**
   - Maintains the confidentiality of all healthcare related information whether it identifies an individual, or could be used to identify an individual.
   - Conducts and presents self in a professional manner.
   - Treats all individuals with compassion, courtesy, and respect regardless of culture and ethnic heritage.
   - Consistently demonstrates trust, honesty, and fairness.

3. **TEAMWORK**
   - Expresses self clearly with positive verbal/nonverbal and written communication.
   - Accepts constructive criticism and offers constructive comments to others when appropriate.
   - Is open to different ideas and acceptance to alternatives to solutions.
   - Is flexible and adaptive to changes.

4. **SERVICE EXCELLENCE / FINANCIAL STABILITY**
   - Seeks opportunities for professional and personal growth.
   - Actively seeks ways to improve level of performance/service.
   - Performs all tasks to provide excellent customer service.
   - Recognizes, supports, and responds to the needs/requests of others quickly and efficiently.
   - Respects hospital equipment/properly.
   - Avoids waste and misuse of hospital resources.

5. **CODE OF CONDUCT**
   - Conducts hospital business in an ethical and lawful manner.
   - Is willing to report any knowledge of real or potential fraud or abuse according to the DHA Compliance Code of Conduct.
   - Conducts all transactions in compliance with all organization policies, procedures, standards, and practices.
   - Demonstrates knowledge of all applicable compliance and legal requirements of the job, based on the scope of practice of the position.

### Safety and prevention

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2. Uses personal protective equipment, as required.

3. Understands procedure for reporting and responding to a fire in the facility, (e.g., R.A.C.E., P.A.S.S.), and participates appropriately in fire drills.

4. Demonstrates proper medical waste management practices.
   - Takes appropriate precautions in handling hazardous material and understands procedure for reporting hazardous material spills (e.g., S.I.N.).

### Patient safety

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1. Uses active communication techniques to conduct final verification prior to starting any procedures.

2. Participates in preop verification process (checklist) to ensure that procedure is done on correct patient.

> p. 8
### Sample form

#### Patient safety

3. Uses surgical site-marking process involving the patient as appropriate.

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#### Position specific competencies


2. Reviews and revises treatment and therapy plans and presents pertinent data in a manner meaningful to the Supervising Physician.

3. Performs medical screen exams in accordance with protocol to determine whether an emergency medical condition exists (triage does not qualify as a medical screen exam).

4. Laboratory and noninterventional radiology orders are appropriate for the patient’s plan of care.

5. Ordering or transmitting an order for x-ray, other studies, therapeutic diets, physical therapy, occupational therapy, respiratory therapy, and nursing services appropriately.

6. Administers medication to a patient, or transmits orally, or in writing on a patient’s record a prescription from his/her supervising physician to a person who may lawfully furnish such medications or medical advice.

7. Recognizes and evaluates situations that call for immediate attention of a physician and institutes when necessary treatment procedures essential for the life of the patient.

8. Instructs and counsels patients regarding matters pertaining to their physical and mental health (e.g., medications, diets, social habits, family planning, normal growth and development, aging, and understanding of long-term management of patients at home).

9. Performs suturing and staple removal adhering to aseptic principles and with technical adeptness under the direction of a Supervising Physician.

10. Initiates arrangements for admissions, completes forms and charts pertinent to the patient’s medical record, and provides services to patients requiring continuing care, including patients at home.

11. Legibly documents in patient medical record as appropriate to the patient’s condition / treatment.

12. Demonstrates and complies with infection control practices as follows:
   - Practices universal/barrier precautions in patient care activities
   - Adheres to bloodborne pathogen standards
   - Appropriately handles and disposes of sharps

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Additional Comments: ______________________________________________________

Supervising Physician Evaluator Signature: ________________________________

Date: ________________________________

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Source: Dameron Hospital Association, Stockton, CA. Reprinted with permission.
Specialty hospitals and physician competitors: Require disclosure of conflicts of interest

In the May 2003 MSB, we discussed how Columbus-based OhioHealth responded when a group of 19 orthopedic physicians on its medical staff made the decision to build and invest in an orthopedic specialty facility that would compete directly with the hospital. Since the publication of that article, which detailed the revocation of several medical staff members’ privileges, a number of community hospitals have found themselves in a similar quandary.

In fact, physicians began establishing centers that competed with traditional hospital services at such a rate that the federal government got involved. Congress tucked a requirement into the complex provisions of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 that instituted an 18-month moratorium prohibiting a physician from referring patients to a specialty hospital in which he or she had an ownership interest.

In August 2006, the Centers for Medicare & Medicaid Services (CMS) released a report to Congress that identified a lack of transparency by physicians regarding their financial arrangements with specialty hospitals and stressed the need for ongoing reporting of physician investment activity. The report has left physicians and hospitals wondering how CMS will approach physician-hospital competition moving forward. In the wake of CMS’ report and in light of the confusion over its effect, it is especially important for hospitals and medical staffs to work together to develop clear policies to address physician conflicts of interest.

The obligation for disclosure
The real challenge for hospitals and physicians is figuring out a way to successfully collaborate and compete, says Rick Sheff, MD, chair and executive director of The Greeley Company, a division of HCPro, Inc., in Marblehead, MA. A solid conflict-of-interest policy that encourages full disclosure goes a long way in helping medical staffs and hospitals achieve this goal.

When developing your policy, keep in mind the following issues that typically arise when physicians and hospitals compete with one another for patients:

1. **Loss of high-profit services.** Hospitals often perceive physicians’ interest in working with or investing in a specialty hospital as a blow to their bottom line. Niche hospitals typically provide high-profit services that community hospitals rely on to fund the emergency department and other community services considered “losing or marginal.”

   “Physicians are really looking at drawing out the revenues that have traditionally been at the heart of the full-service community hospital,” says Robin Locke Nagele, Esq., a partner at the Philadelphia-based law firm Post & Schell.

2. **Disruption of essential medical staff functions.** Physicians who are not forthcoming about potential conflicts of interests can be barriers to achieving a truly effective medical staff. For example, credentials committee and medical executive committee meetings can be disrupted by internal battles over granting of privileges to physicians who compete with physician members of these committees.

   “The consequence of physicians not planning for the potential conflict is extensive and expensive litigation, which I think is in no one’s interest in the long term,” Nagele says.

As an example of the mayhem that can erupt when medical staff leaders fail to disclose conflicts, Nagele cites the case of a medical staff president who served on a hospital strategic planning committee. In this role, the medical staff president helped develop plans for hospital investments, while simultaneously working with a group of physicians to develop a competing ambulatory surgery center (ASC).

   “That’s an extreme case, but it’s clear that this physician placed himself in a conflict-of-interest position that he shouldn’t have been in,” Nagele says.

> p. 10
Conflicts of interest

“It’s really incumbent upon physicians to recognize that and be up-front about it.”

3. Denial of medical staff membership clinical privileges. In recent years, hospitals have developed myriad strategies for handling competition from physicians. Some have pursued joint ventures for ASCs or opted to build their own service lines to try to force competitors out of the marketplace. Hospitals that pursue these options often deny medical staff membership to physicians with competing interests. Other hospitals prohibit physicians with competing interests from serving in leadership capacities.

But, as Sheff explains, hospitals should not necessarily deny medical staff membership or leadership roles to physicians with potential conflicts. Hospitals must try to find areas in which hospital and physician interests align, and physicians must fully disclose where their interests are in conflict.

“Whether a physician competes with the hospital or not has nothing to do with the organized medical staff,” he says. “That has to do with business and how we do business.”

He explains that the role of medical staff organizations is twofold: to ensure the quality of patient care and to advocate for the interests of patients and physicians.

A physician’s self-interest should not preclude him or her from performing medical staff functions, such as peer review or serving in a leadership capacity.

Tip: The medical staff should establish a policy that states that the committee on which the physician serves decides whether the physician can participate in a particular case or discussion.

“The principle is the obligation to disclose your conflict or potential for conflict,” Sheff says.

Conflicts of interest: The case for payment reforms

Although medical staff organizations can adopt policies that aim to reduce disruptions and tension caused by conflicts of interest, it is the contention of some industry experts that national payment policy reform is imperative to reduce the stratification of hospitals and physicians into camps of “winners” and “losers” in which some services are overcompensated.

Both the diagnostic related group hospital payment system and the physician payment system are at fault for much of the competition over services such as imaging, says Robert A. Berenson, senior fellow at the Urban Institute and senior consulting researcher at the Center for Studying Health System Change, in Washington, DC.

“There is so much to be made in certain areas because of distorted payments, that it creates an incentive for physicians to engage in certain activities that are as much about income generation as about patient care,” Berenson says.

Some hospitals recruit well-known expert physicians to promote certain specialty lines, which creates resentment among other physicians who admit patients to the hospital and suddenly feel at a disadvantage, he says.

Berenson contends that medical staff can grow to resent the “privileged position” of physicians who are considered revenue generators.

For example, the higher payments for heart procedures compared with medical conditions can lead to resentment of cardiologists by internists.

Berenson hopes that recommendations made last year by the Medicare Payment Advisory Committee for reductions in payments for certain procedures can alleviate this stratification of services and increased competition.
Help us help you!
Participate in a focus group

In the interest of improving the quality of coverage in Medical Staff Briefing, we would like to invite you, our valued customers and readers, to participate in a focus group. Your participation will help us to identify emerging trends, difficult challenges, and best practices in the areas of credentialing and privileging, leadership development, medical staff planning, and the hot topics you want to know about to do your jobs better in 2007.

We only ask for a few hours of your time to participate in a conference call. To thank you for your help, we will offer a free copy of our new book Proctoring and Focused Professional Practice Evaluation: Practical Approaches to Verifying Physician Competence by Robert J. Marder, MD, Mark A. Smith, MD, MBA, FACS, and Todd Sagin, MD, JD, to focus group participants. If you would like to volunteer to participate, please contact Associate Editor John Zorabedian at jzorabedian@hcpro.com.

Thank you!

John Zorabedian, Associate Editor
Medical Staff Briefing

Erin Callahan, Executive Editor
Medical Staff Briefing

News briefs

Foreign medics sentenced to death in Libya AIDS case
A Libyan court sentenced five Bulgarian nurses and a Palestinian physician to death on December 19, 2006, convicting them of deliberately infecting hundreds of children with HIV/AIDS, in a retrial ordered after a court reached the same verdict in 2004. European and American human rights and physician groups have loudly condemned both trials. The scientific evidence used against them “is so irrational it’s unbelievable,” said one of several international scientists who have visited Libya to study the case and treat the infected children, many of whom have died. Outraged families celebrated the verdict.

Scientists studying the case concluded that the outbreak of HIV in 1998 that infected 400 children at a children’s hospital was nosocomial, resulting from the reuse of contaminated medical equipment. The defendants stood accused of deliberately injecting the children with the virus. The Libyan court did not allow scientific evidence that could have proved accidental infection of the children. “Science has not been respected in this court,” said Richard Roberts, a winner of the Nobel Prize in Physiology of Medicine, who delivered a letter of protest signed by 100 Nobel laureates to the Libyan Mission in New York.


Medical staff organizations: A failed model?
Rather than providing accountability for quality, medical staff organizations (MSO) are often a hindrance to improving physician performance and patient safety, argue the authors of a perspective published December 5, 2006, in the journal Health Affairs.

Due to the limited effectiveness of MSOs in...
holding physicians accountable and improving quality, policymakers should develop innovative models rather than working to rehabilitate the failed model of the MSO, authors Ken Smithson and Stuart Baker, executives of the national hospital network VHA, Inc., state in their article “Medical Staff Organizations: A Persistent Anomaly.”

“MSOs are just not cut out for effective accountability,” Smithson and Baker write. “Their only real authority is the power to restrict or revoke privileges. As associations, they must work within an arcane political structure and follow detailed due process . . . The cards are heavily stacked in favor of physician autonomy versus their accountability.”

The authors contrast the effectiveness of associations, (e.g., MSOs) with management accountability hierarchies (MAH), such as hospital administrations.

Through MAH organizations, “authority and accountability are delegated in tiers down through layers of management.”

Source: Health Affairs 26, no. 1 (2007): w76-w79 (published online December 5, 2006).

Now it’s ‘The Joint Commission’

Effective January 8, the organization formerly known as the JCAHO changed its name to The Joint Commission, as part of a branding strategy revealed in a December 11, 2006, memo from Joint Commission President Dennis O’Leary.

“This change is simply intended to make our name more memorable than the current 18-syllable Joint Commission on Accreditation of Healthcare Organizations,” reads O’Leary’s memo.

“The shortened name signals and acknowledges the reality of progressive broadening of Joint Commission services and products in order to fulfill our mission,” the memo says.

Along with the name change come new logos for The Joint Commission and its publishing and consulting company, Joint Commission Resources, Inc.
Inside MSB
Vol. 17  No. 2
February 2007

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Shipping to AK, HI, PR is $27.00.

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Please include applicable sales tax. States that tax products and shipping and handling: CA, CO, CT, FL, GA, IL, IN, KY, LA, MA, MD, ME, MI, MN, MO, NC, NJ, NM, NY, OH, OK, PA, RI, SC, TN, TX, VA, VT, WA, WI, WV.

State that taxes products only: AZ.

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City
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ZIP
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☐ Bill me.
☐ Check enclosed (payable to HCPro, Inc.)
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☐ Bill my facility with PO #

Signature
Account number
Exp. date

(Required for authorization) (Your credit card bill will reflect a charge to HCPro, Inc.)

5 easy ways to place your order:

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Marblehead, MA 01945

FAX: 800/639-8511
E-MAIL: customerservice@hcpro.com

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ORDER ONLINE: www.hcmarketplace.com

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