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2-HOUR CME: MEDICAL STAFF BYLAWS: WHAT PHYSICIANS REALLY NEED TO KNOW

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Q4

Quarter 2, 2022

2-HOUR CME - MEDICAL STAFF BYLAWS: WHAT PHYSICIANS REALLY NEED TO KNOW

by Karin Zaner, JD



OBJECTIVES

Upon conclusion of this course, the physician will be able to:

1. discuss a physician's responsibilities when adhering to medical staff bylaws;
2. describe the most common concepts found in medical staff bylaws;
3. recognize the legal terminology and language used to describe medical staff bylaw concepts; and
4. describe a peer review scenario typically set forth in medical staff bylaws.

COURSE AUTHOR

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ESTIMATED TIME TO COMPLETE ACTIVITY

It should take approximately 2 hours to read this article and complete the questions and evaluation form.

RELEASE/REVIEW DATE

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Lone Star Alliance policyholders who complete this program may earn a 2.5 percent discount that will be applied to their next eligible policy period.

INTRODUCTION

If you are a practicing physician and do not have a strictly office-based practice, you likely have medical staff membership and clinical privileges at various hospitals or other health care facilities (HC facilities).

For many subspecialties (general surgery, obstetrics, gastroenterology, interventional cardiology, or pulmonology), a physician cannot practice without maintaining clinical privileges at such HC facilities, given the core procedures or surgeries these subspecialties perform at such a facility. In addition, many insurance

providers may require their physician policyholders to maintain clinical privileges of some level (i.e., active or courtesy) to grant coverage.

For each HC facility where a physician may have privileges, there exists unique, specific medical staff bylaws, credentialing, and other policies (together referred to as "MS bylaws").¹ But what are a physician's duties, obligations, and responsibilities as a medical staff member ("MS member")? And what are the duties, obligations, and responsibilities of the HC facility itself?

While it would be impossible to describe each and every variation in each and every set of MS bylaws, physicians should become aware of concepts that commonly exist in these bylaws. This article reviews the “Top 10” most important (and trickiest) ones.

Given the complexity of navigating MS bylaws and possible enforcement, obtaining experienced legal counsel as soon as possible is recommended should a physician face any of these reviewed concept scenarios.

BASIC CONCEPTS OF MS BYLAWS

Generally, a facility’s MS bylaws set forth the process to obtain and renew clinical privileges; a description of the types of MS members and their continuing duties and obligations; and the due process rights of a physician facing peer review. Depending on the HC facility’s process, the MS bylaws will contain specific policies and procedures and crucial deadlines and rights to appear and be heard.

The MS bylaws cited in this article are general examples of what may exist, with the specific language possibly varying, inconsistent, and/or non-existent in specific MS bylaws. Each physician must specifically verify the current language of any particular provision in the applicable MS bylaws they must follow and, if needed, consult with an attorney to determine application as well as most prudent legal strategy.

Enforcement

Some of the most compelling questions in this legal area involve whether the MS bylaws are contractually enforceable. Must a physician comply with them? What can a physician do if he or she believes that the medical staff or the HC facility are not in compliance with MS bylaws? Can a physician obtain a temporary restraining order or other injunctive relief to stop the violation (difficult but possible), or can they receive monetary damages (not likely)?

Typically, these questions involve peer review in which the physician may be contesting compliance with MS bylaws after being subject to an adverse action affecting clinical privileges (which can permanently affect the physician’s professional record).

One of the most important peer review cases, *Poliner vs. Texas Health Systems*, confirms that federal (and Texas) law provide very limited options for any real relief for a physician subject to peer review through outside litigation.² A physician’s alternatives may look to state statutory and common law causes of action such as defamation, antitrust violations, or an allegation of contractual violation of the MS bylaws. But federal and state peer review immunities — which presumably exist — will likely allow complete defenses to such claims for monetary relief, including breach of contract.³

In *Poliner*, the U.S. Court of Appeals for the Fifth Circuit stated that physicians may have recourse if subjected to unjustified or malicious peer review that violates the applicable MS bylaws.⁴ However, the *Poliner* case does not answer whether MS bylaws are enforceable as a contract against an HC facility in Texas. Physicians must assume that strict compliance with MS bylaws is necessary to ensure that physicians do not waive their rights to exhaust the necessary administrative rights under the MS bylaws (which include any administrative fair hearing rights). Failing to strictly comply puts physicians at great risk, with the likelihood of severe consequences to their professional status at the HC facility. Physicians practicing outside of Texas should consult with their state medical board for clarification on this point.

The enforcement of MS bylaws has numerous wrinkles and considerations that are beyond the scope of this article.

TOP 10 MS BYLAW CONCEPTS

The following “Top 10” concepts are commonly found in MS bylaws. Please note that many of these concepts are counter-intuitive, but that is what makes them crucial for physicians to understand.

1. DUTY TO DISCLOSE CERTAIN EVENTS

- *I applied for hospital credentials with information that was true at the time but is no longer accurate. What should I do?*
- *I received a state board complaint that is now an investigation. Do I need to disclose this to my hospitals?*
- *I have been notified of an automatic termination of my privileges. Do I have to self-report this?*

An important duty in MS bylaws is to disclose certain events to the HC facility’s medical staff office (MSO). Some of these events are often predictable (e.g., suspension or restriction of a medical license or Drug Enforcement Administration license; the filing of a malpractice claim; government program exclusion or disqualification) and some are not (the filing of a state medical board complaint before it becomes an investigation, or the mere resignation of privileges while not under investigation). And some MS bylaws state that if the most recent application for initial privileges or renewal of privileges has changed, then a physician must disclose such change to the HC facility.⁵

This disclosure is in addition to the application for credentials and/or renewal of credentials that is typically due every two years. This ongoing disclosure duty may have “immediate” or very expedited deadlines. If appropriate disclosure is not made, remedies may be severe (see concept number two, *Alleged falsification*).

Example MS bylaw language

“A medical staff member (MS member) has a duty to provide and update the information requested on the original application and subsequent re-applications within 72 hours of the member's knowledge of any change in the information provided on the most current application form and to provide all information requested by the hospital or its medical staff, including—

- *whether he or she has been the subject of voluntary or involuntary termination of membership, suspension, reduction, or loss of clinical privileges;*
- *whether probation, involuntary leave of absence, or proctoring requirements have been imposed by any hospital or health care facility;*
- *any resignation from a hospital or health care facility pending an investigation;*
- *any pending investigation or actions taken based on professional competence or conduct that could result in an adverse action, or actions taken by any licensing agency, certification board, professional society, or government agency, including exclusion from Medicare, Medicaid, or any other governmental program;*
- *any prosecution, criminal conviction, plea of guilty, deferred adjudication, or no contest pertaining to any felony or misdemeanor (including motor vehicle violations);*
- *any pending or completed action, whether voluntary or involuntary, involving denial, revocation, cancellation, suspension, reduction, limitation, lapse, cancellation, imposition of proctoring, or probation relating to any of the following, and any non-renewal or relinquishment of, or withdrawal of, an application for any of the following to avoid investigation or possible disciplinary or adverse action:*
 - *license or certificate to practice any health-related profession in any state or country;*
 - *Drug Enforcement Administration or a state-controlled substance registration;*
 - *membership or fellowship in local, state, or national health or scientific professional organizations;*
 - *faculty appointment at any medical or other professional school;*
 - *appointment, medical staff membership, employment or membership status, or clinical privileges at any other hospital, clinic, or HC facility;*
 - *participation in a managed care agreement; or*
 - *any final judgments or settlements relating to any professional liability claims involving the MS member.”*

Practical tips

If required information is specifically listed, disclose it in writing. Although it may be practical to discuss the event with the chief of staff or other MS leader, oral disclosure is

not typically sufficient. Full, written disclosure confirms the physician's acknowledgement of the event, the complete facts of the event, and when the disclosure was made.

If disclosing an event changes the information required by the HC facility on a physician's credentialing application, a physician should disclose the change in writing in a timely manner. A physician should also be sure to update his or her credentialing application to confirm that all future applications for initial and renewed privileges are accurate and consistent. In Texas, this credentialing application would be the Texas Standardized Credentialing Application or TSCA.

Many of the disclosure questions are broad and open to interpretation. It is very important to review the entire course of your training and career, and to complete these applications truthfully. The individual physician is responsible for ensuring the applications are as accurate and forthcoming as possible before submission.

Make every effort to meet the disclosure deadline. If the deadline is missed, provide disclosure as soon as possible and be prepared to explain the reasons for the delay.

Send written disclosure to the person or entity designated in the MS bylaws (chief of MS staff, hospital president, etc.) and copy the MSO to be sure it is received.

Comply with the appropriate method to send documents. Certified Mail Return Receipt Requested is typically cited as a valid way to send, but it can be slow. Therefore, it may be prudent to “double or triple up” on such delivery methods to ensure the disclosure is received in a timely manner. You may choose to send it by facsimile (if receipt confirmed), email (if acknowledged by reply or confirmed receipt), tracked mail service (priority mail, overnight services, or other), and/or private courier. Keep proof of how the written disclosure was delivered as well as confirmation of receipt.

When possible, keep the disclosure basic (“who, what, when, where, why, and how”) and ensure that disclosure of any patient protected health information (PHI) complies with HIPAA and state privacy laws.

In addition, if an HC facility is part of a larger system or has other facilities, self-disclosure may be necessary at the other sites where you have privileges. Specific, affirmative disclosure should be made in writing, pursuant to the MS bylaws at each such HC facility in a timely manner.

Self-disclosure duties may also arise from malpractice suits or claims, state medical board actions, other HC facilities, health insurance providers, board certification entities, and other third parties.⁶

2. ALLEGED FALSIFICATION (EXPRESS OR BY OMISSION)

- *I have received a letter stating that I “falsified” my re-credentialing application. My office staff completed and submitted my application months ago, and I did not realize that a recent malpractice case was not listed. What should I do?*

Questions asked on credentialing applications and addendums requested by HC facilities are typically very broad, and mistakes or unintentional omissions can easily occur. So, physicians should take great care to fully disclose information on a re-credentialing application.

Failing to disclose or making inaccurate statements on an application can become a very serious matter. When an allegation of misrepresentation arises, MS bylaws may deal with this allegation automatically and without any real substantive due process. For example, the HC facility may not even ask the physician the following clarifying questions.

- Was the disclosure material?
- How was it materially false?
- Was it made by the physician’s office staff with the physician just signing off?
- Did the physician intend to deceive or was it just an oversight?

Instead, the HC facility may simply deem that a false statement was made and the physician failed to disclose in a timely manner. With this type of automatic provision, an HC facility may not be required to consider evidence that an updated disclosure was made but not properly received.

Example MS bylaw language

“The applicant or MS member has a duty to advise the HC facility of any change with respect to information previously submitted by him or her related to his or her credentials. The applicant or MS member shall report to the HC facility any change in information, including but not limited to any adverse action and/or professional review activity by a licensure board, federal or state health care program, or another HC facility within 10 days of actual knowledge of the action. For purposes of this section, adverse action shall mean any action based on professional competence or conduct that affects the licensure, membership or clinical privileges of an applicant or MS member.”

Any misrepresentation or misstatement in, or omission from the application, whether intentional or not, may constitute cause for automatic and immediate rejection of the application resulting in denial of appointment and clinical privileges. If an appointment has been granted prior to the discovery of such misrepresentation, misstatement or omission, such discovery may result in summary dismissal from the medical staff and termination of clinical privileges.”

Practical tips

In contrast with the due process procedures when a physician is denied privileges, suspended, or an adverse action is taken, an allegation of misrepresentation, misstatement, and/or omission, may swiftly lead to automatic or immediate rejection of a credentialing application or summary dismissal from the MS staff including termination of privileges. This provision is designed to circumvent the physician’s ability to contest



any factual allegations. The HC facility only needs to send a letter stating that such a misrepresentation was made, and the provision is triggered.

An allegation of falsification may also lead to a report to the National Practitioner Data Bank (NPDB), stating that rejection or denial of privileges was imposed due to the physician's behavior (i.e., an allegation of falsification, expressly or by omission). Alternatively, an HC facility may take the position that the rejection or denial of privileges is "automatic" and therefore does not require a report to the NPDB. Even if an NPDB report is not made by the HC facility, a physician would still be required to self-disclose the event.

An MS bylaw "falsification" provision may also be invoked when there has been a failure to properly update a disclosure in a credentialing application. For example, a physician may rely on office staff or credentialing staff to submit credentialing applications or renewals. While the physician may take a great deal of time and effort to complete and submit information when the initial application is sent, many physicians fail to update their applications themselves and just sign off on renewals prepared by staff (as opposed to requesting review of the entire application to ensure accuracy before signing).

An MS bylaw "falsification" provision may also be invoked if a more subtle peer review event occurs. Such provision may involve a shorter suspension of privileges (10 to 14 days), an agreed-to proctorship, or other conditions imposed on the exercise of privileges. The HC facility may take the position that a physician was required to report such an event to an MS member under the MS bylaws and failed to do so (see concept No. 1, *Duty to disclose certain events*).

Again, an allegation of falsification (as well as any privilege rejection or denial that may occur as a result) can seriously affect a physician's professional record. A physician may be required to self-disclose any number of peer review events in licensing renewals, as well as on credentialing applications and/or specific addendum.

3. FAILURE TO RESPOND AND DEEMED RESIGNATION

- *I have been notified of a peer review meeting that will happen this week, but I cannot be there due to my busy clinical schedule on that day. I think this is a fairly routine review. What should I do?*

MS bylaws that deal with a "failure to respond" or "deemed resignation" are in place to deal with a non-responsive or absent physician. Unfortunately, actions are often made without concern for how provisions may affect a physician's professional record. Be attentive and do not allow these provisions to be triggered by missing a peer

review meeting or inadvertently waiving due process rights to an administrative fair hearing under MS bylaws.

Example MS bylaw language

"An MS member who fails without good cause to appear at a meeting, provide requested health information, or undergo a requested health evaluation or examination for which the MS member received special notice in accordance with the MS bylaws shall automatically be suspended from exercising all or such portion of clinical privileges as may be specified in the meeting until the meeting occurs or the matter is resolved by subsequent action of the medical executive committee (MEC).

Failure to respond completely and to comply with a request within thirty (30) days for new, additional, or clarifying information, assistance, or an interview to support a request for clinical privileges, shall be deemed a voluntary withdrawal of the application for the clinical privileges which are the subject of the request for additional information, assistance, or the interview. An applicant whose application is deemed withdrawn shall be notified in writing of the withdrawal and that the application will not be processed. An applicant whose application is deemed withdrawn is not entitled to any of the procedural rights or processes outlined in the applicable fair hearing process.

When all reasonable attempts have been made to obtain written notification of resignation without success, the member will be assumed to have resigned and the usual resignation process will be followed."

Practical tips

Bad things can happen when physicians fail to respond or do not show up. A physician must be diligent in checking mail, email messages, text messages, and other forms of communication from the HC facility and its MSO (this includes making sure all contact information is current and accurate).

Upon notification of a peer review issue, take immediate action. Many medical liability insurance policies include peer review coverage, so check with your insurer to determine coverage.

In responding to the peer review committee (PRC), clearly communicate the requested medical facts with corroborating evidence from the medical file. Ensure the answers and materials provided allow the PRC to clearly understand the clinical care given or the facts relating to the questioned behavior. A written narrative from the physician's point of view should be submitted to the PRC and placed into the physician's peer review file, so that the physician's response to any criticisms is documented. If the PRC has an expert report at this early stage, a physician may consider obtaining his or her own expert opinion for rebuttal purposes.

When appearing in person before the PRC, be timely, respectful, and courteous. When responding in writing, a physician should be clear, concise, respectful, and legible (avoid handwritten responses). Failing to respond in the early collegial stages of peer review is a strategic mistake.

4. LEAVE OF ABSENCE

- *The chief of medical staff has strongly suggested that I take a leave of absence, given a peer review issue that has now come up in a few of my cases. Is this a good idea? Can I take a leave of absence without it affecting my professional record or my ability to remain on the medical staff in the long term?*

While the medical staff leadership or administration may tell a physician that a leave of absence is a good option under the MS bylaws, this is not always the case. Taking a leave of absence may result in a physician waiving due process rights. Reinstatement from a leave of absence is almost always subject to the sole discretion of MEC. Also, a leave of absence taken in these circumstances may have negative reporting consequences for a physician.

Example MS bylaw language

“The MS member shall submit to the department chair a written request for reinstatement at least thirty (30) days prior to the expiration of an approved period of leave of absence. The request must include a summary of activities during the leave and/or relevant health information. The department chair shall make a recommendation for review and action to the MEC. Failure by the MS member to follow the procedure for reinstatement shall result in termination of membership and privileges. In such event, the MS member shall be required to reapply and will be processed as an initial applicant.”

Practical tips

During a peer review scenario, pressure on the physician to take a leave of absence may be strong. However, this may not be a good idea for the physician’s status or professional record.

A key question when a physician goes on a leave of absence is, what is the physician’s status? Are his or her privileges restricted or not? The MS bylaws may not state this clearly. There may also be reporting ramifications of a leave of absence, as a physician will likely have to decide whether to disclose the leave of absence as a voluntary restriction with possible resulting consequences.

There is also concern as to whether a leave of absence would be reportable by the HC facility to the NPDB or state medical board. If an NPDB report is made, it must be copied to the physician’s state medical board. Some MS

bylaws may even specifically state that a leave of absence is not reportable to the NPDB, but also inconsistently characterize the leave of absence as a restriction of privileges which, if in place for over 30 days, is NPDB reportable.^{7,8}

5. ELIGIBILITY FOR MS MEMBERSHIP

- *After reviewing the MS bylaws, it appears that I am not eligible to credential at a certain HC facility. What can I do?*
- *I received a letter that I am no longer eligible to recredential at a certain hospital. What does this mean and how could this affect my professional record?*

Many MS bylaws set forth the requirements for “eligibility,” such as board-certification status; no past resignations under investigations; no past adverse actions; and more. The main argument for including these provisions is that they make the credentialing application process more efficient by weeding out those physicians who would otherwise not be approved in the credentialing process.

Many HC facilities take the position that these eligibility provisions protect physicians by removing the risk of an NPDB report, because the HC facility would not have to deny a physician’s application if he or she was not eligible. However, these provisions often prohibit physicians from joining a medical staff (or being reappointed) given their breadth and over-inclusiveness. The burden then falls on the physician to obtain a specific waiver.

Example MS bylaw language

“In the event the MS member has not met the qualifications set forth in [the eligibility section], respectively, the MS member will be deemed to have resigned at the end of his or her appointment term. In such instance, the MS member will not be eligible for reappointment or new or continued privileges for a period of one year from the effective date of the deemed resignation. Such MS member may apply as a new applicant at any time after the one-year period.”

An MS member who [does not meet a specific eligibility requirement] may apply through the Credentials Committee (CC) or the MEC for a waiver of such specific eligibility requirement. Any waiver must be approved by the MEC and governing board and may only be granted in rare circumstances. Failure to make a timely waiver application for such eligibility requirement should not be considered a hardship or extenuating circumstance. A waiver may be approved if the MS member is otherwise in good standing to include without limitation a satisfactory quality record and fulfillment of all other requirements appropriate to the MS member.”

Practical tips

Denial of an application or re-application for privileges for eligibility reasons may result in the HC facility submitting an NPDB and state medical board report. Again, the MS bylaws cannot change these definitions or requirements once a denial has occurred. This means that these eligibility requirements may lessen an unforeseen risk of an NPDB report upon denial.

That said, these eligibility provisions, depending on the MS bylaws, may be broad and over-inclusive. This creates an initial obstacle for a physician joining a medical staff. Or it may retroactively render an active MS member ineligible, without any real due process rights to contest it, given that the MS member might be deemed to have resigned at the end of his or her appointment term (see example provision).

A waiver provision, if provided in the MS bylaws, may provide some relief. If a physician can confirm that the CC or the MEC will favorably receive his or her waiver application (which, on a practical basis, may depend on whether the physician practices in a needed subspecialty or is aligned with a larger physician group), then the physician may be able to obtain initial privileges or keep an event that renders him or her ineligible from triggering a deemed resignation provision from taking effect.

A waiver provision would not likely help a solo physician, one who practices in a highly competitive subspecialty, or one who has little professional and/or personal connection to the current medical staff, HC facility, or its leadership. This type of waiver is typically at the sole discretion of the CC or the MEC with little accountability for a physician whose waiver is denied.

6. PEER REVIEW CONFIDENTIALITY AND PRIVILEGE

- *I received a peer review letter from a hospital, but the letter says that the entire matter is privileged and confidential. I know that I need legal help. Can I hire an attorney and forward these materials to him or her? Can I forward peer review materials to a colleague or an expert?*

Be aware of and strictly comply with peer review confidentiality and privilege — whether on the MEC or a PRC as a peer reviewer or as the physician being reviewed.⁹ While a physician on a PRC will likely receive guidance from the MSO or the HC facility’s legal counsel, the subject of the peer review might feel like he or she is getting mixed messages from the MS leadership or the HC facility administration.

For a physician facing peer review, the need to defend oneself and receive collegial guidance from fellow MS members and/or department leadership is both crucial and urgent. But the physician may be told that all materials are confidential and not to be disseminated. Therefore, it is important for the physician to have a clear understanding of how to proceed in obtaining legal advice.¹⁰

Example MS bylaw language

“Information submitted by the applicant is considered peer review information and shall be privileged to the fullest extent permitted by law. Such privilege shall extend to the Hospital, the Medical Staff and their authorized representatives, and to any third parties.

Information submitted, collected, or prepared by any representative of this or any other HC facility or organization or medical staff for the purpose of [broadly



defined peer review, quality assurance, credentialing, teaching, and clinical research purposes] shall, to the fullest extent permitted by law, be confidential. Said information shall not be disseminated to anyone other than a representative of the HC facility or to other health care facilities or organizations of health professionals engaged in an official, authorized activity for which the information is needed nor be used in any way except as provided herein or except as otherwise required by law.

It is expressly acknowledged by each MS member that violation of the confidentiality provided herein is grounds for immediate and permanent revocation of MS membership and clinical privileges.”

Practical tips

A physician is entitled to legal advice during a peer review. That legal counsel must also ensure that appropriate legal advice is given related to the confidentiality and privilege involved in a peer review process. Legal counsel must also ensure HIPAA compliance under federal and state law as well as patient privacy protection under state law.

If seeking the medical opinion of his or her own expert, a physician should do so through counsel so that such communications clearly fall under the appropriate “attorney work product privilege” protection. (This privilege is also important for protecting consulting expert status, if needed).¹¹

Counsel may also have ways of quickly locating an unbiased and highly qualified expert in the appropriate subspecialty, which is an important asset to have early on. A physician should not try to arrange for an expert on his or her own (which could require sending patient PHI as well as peer review protected documents), as violating the peer review privilege may have severe consequences and only worsen the peer review situation.¹²

As a subject of peer review, the physician may feel pressure from the MS leadership or the HC facility administration to not hire counsel. All peer review communications he or she receives will be labeled with a statutory mandate for peer review privilege and protection. The physician may be told that he or she cannot speak with anyone else, including HC facility staff and other witnesses that may speak in the physician’s favor.

7. EXISTENCE OF AN INVESTIGATION

- *I want to resign my privileges at a hospital and/or my privileges will expire soon. How do I confirm that my status is clear, so I won’t get a NPDB report stating that I resigned while under investigation?*

MS bylaws will likely define the term “investigation,” which may require that written notice to a physician be

given in the process. While the MS bylaws are important, a physician cannot solely rely on the definition of investigation set forth by the HC facility in its MS bylaws before ascertaining whether he or she can resign or let privileges expire without triggering the HC facility’s obligation to file an NPDB report.

Example MS bylaw language

“Any MS member, any MS committee, MS leader, the HC facility president, or governing board member who reasonably believes there is sufficient basis for possible corrective action against an MS member may request an investigation be initiated for purposes of possible corrective action.

The request must be in writing, submitted to the MS president, and supported by reference to the specific activities or conduct alleged. The MS president shall promptly provide the written complaint or question to the MEC. The MS president, on behalf of the MEC shall contact the MS member and shall send written notice to him or her, no later than the end of 5th day after the decision is made to initiate an investigation. The notice shall advise the MS member of initiation of an investigation for purposes of possible corrective action and provide a general statement of the matters being investigated.

An investigation continues until issuance of a final decision by the governing board, acceptance of a resignation from the MS member by the governing board, or withdrawal of the application from processing.”

Practical tips

The NPDB outlines that an “investigation” exists from the “start of an inquiry” until final decision by the facility to close the formal investigation — and that the MS bylaws cannot change this definition.⁷ Even though a physician can point to the MS bylaws to show that an investigation as defined does not exist (see example provision above), this is not the definition the NPDB follows.

Under the *NPDB Guidebook*, a physician does not even need to be aware that an investigation exists for an NPDB report to be submitted by the HC facility after the physician resigns or his or her privileges lapse.⁷

Therefore, if there is potential for a peer review focused on a physician’s actions or behavior, the physician should assume that an investigation might exist and obtain legal help before resigning or letting privileges lapse.

The HC facility is the entity that generates the NPDB report once a physician resigns or lets his or her privileges lapse. Once an NPDB report is made, the physician has very limited remedies to dispute such report, which is essentially a permanent negative mark on the physician’s professional record.

8. AUTOMATIC SUSPENSIONS

- *I recently resigned from a physician group connected to an HC facility. I then received a notice that, because my resignation caused my malpractice insurance to be discontinued, informed me that my privileges at the HC facility have automatically been suspended. Should I be worried?*

Some suspensions are “automatic” by definition. It is important to be aware of the MS bylaws that allow automatic suspension, as well as the situations in which they occur. The reporting ramifications can be tricky (generally, anything that is automatically triggered may not be independently reportable to the NPDB), but it always depends on the specific MS provisions and the factual circumstances at issue.

Example MS bylaw language

“An MS member’s clinical privileges shall be automatically relinquished, suspended, or restricted for the following reasons [list of specific reasons]. An automatic relinquishment, suspension, or restriction under this section is not a corrective action and is not an adverse action and shall not entitle the MS member to any procedural rights of review under these MS bylaws. Automatic relinquishment, suspension, or restriction shall take effect immediately.

The occurrence of automatic action does not prevent the imposition of corrective action for the same or related grounds pursuant to the MS bylaws. The Hospital President shall provide the MS member with special notice of the imposition of automatic action. An automatic suspension lasting ninety (90) days shall become an automatic termination of MS membership and privileges.

Unless required by these MS bylaws or by law, an automatic termination or expiration of a MS member’s clinical privileges while the MS member is under investigation is not a surrender of clinical privileges while under investigation subject to mandatory NPDB reporting (i.e., having to report for a surrender of privileges while under investigation).”

Practical tips

Typically, reasons for automatic suspensions can include expiration of temporary clinical privileges; automatic termination due to medical or Drug Enforcement Administration license restriction or revocation; loss of professional liability insurance; exclusion from federal or state programs such as Medicaid or Medicare; criminal conviction; and automatic termination of a contract for professional services. However, all MS bylaws are different, and a physician must check specifically and be aware of other broader reasons.

As seen in the example above, an automatic suspension may not involve an adverse action. This means that the physician will not be entitled to due process rights for an administrative fair hearing under MS bylaws.

In some cases, the MS bylaws may allow for a limited review of the automatic suspension. This allows the physician who believes an error has been made to notify the HC facility, within a specific timeframe, and provide written evidence of the error. The HC facility may then be required to reverse any automatic action if there was an error. That decision may also be at the discretion of the HC facility.

Note that MS bylaws may be inconsistent as it relates to NPDB reporting requirements. For example, the last sentence of the example provision states that an automatic suspension is not reportable to the NPDB (even when there is an investigation pending) “unless required by these MS bylaws or law.” A physician should be aware of this qualification, as it means that NPDB law may in fact require reporting.

9. SUMMARY SUSPENSIONS

- *I was involved with a difficult patient surgery last week that had a bad result. A few days later, I received a letter from the HC facility’s CMO that my clinical privileges have been summarily suspended due to a concern for patient safety. What should I do and when?*

Example MS bylaw language

“A precautionary suspension or restriction shall only be imposed as necessary to address the imminent danger and is an interim step in the peer review process and is not a complete corrective action in and of itself. It shall not imply any final finding of responsibility for the situation that caused the suspension.

Within ten (10) days of imposition of a precautionary suspension or restriction of privileges, the MEC shall review the matter resulting in a suspension or restriction. Prior to, or as part of this review, the MS member shall be given an opportunity to meet with the MEC. The MS member may propose ways other than suspension or restriction of privileges to protect patients or other persons.”

Practical tips

A physician who receives a summary suspension from an HC facility should seek legal advice. A summary suspension is a serious event that can cause damage to a physician’s reputation and ability to practice medicine.¹³

Typically, there is an initial period (10 or 14 days) that the MEC may be required to review the summary suspension and allow the physician to be heard. As with

any peer review issue, the physician should communicate the medical facts with corroborating evidence from the medical file, so that the MEC may understand the clinical care given or the facts relating to the questioned behavior. This should be done in writing for the MEC to review. The written response should be placed in the physician's peer review file, as well as submitted in-person when the physician appears before the MEC to answer all questions.

With the help of counsel, consider obtaining an expert report at an early stage, even if the PRC or MEC does not have one. A solid, unbiased report from a highly qualified expert is one of the most powerful defense tools available. The expert should be unbiased and unconnected to the physician or the HC facility.

A summary suspension or restriction of privileges that lasts longer than 30 days must be reported to the NPDB by the HC facility. This is a permanent negative mark on a physician's professional record. With the help of counsel, consider proposing ways the HC facility may lift the suspension while also agreeing to other conditions on clinical privileges, such as a focused professional practice evaluation (FPPE) or a practice improvement plan that may include CME, physician assessment, and/or proctoring requirements.

Even if not reported to the NPDB, a suspension of less than 30 days will likely be self-reportable to other HC facilities; a state medical board and other applicable state licensing entities; board certification entities; and insurance providers.

10. ADVERSE ACTION AND FAIR HEARING

- *I have received a notice from a hospital indicating that an adverse action has been taken against me and that I have the right under the MS bylaws to an administrative fair hearing process. What should I do?*

Example MS bylaw language

The MS bylaws will likely provide its own lengthy, detailed process entitled "Hearing and Appeal Procedures." The administrative fair hearing process for an HC facility will differ per facility, but the following practical tips may serve as useful to a physician.

Practical tips

As with a summary suspension, it is important for a physician to obtain legal advice. What happens at this HC facility can affect the physician's ability to practice medicine. Continuing state licensure, board certification, insurer provider status, and more are also at stake.

Be aware of the specifics of the MS bylaws (processes, deadlines, etc.) and strictly comply with them. Any failure

to do so can result in a waiver of such rights and/or an affirmation of the adverse action by default.

The administrative fair hearing process may suggest that the physician is taking part in due process, similar to a court of law. However, certain aspects of the process may adversely affect "due process" protections.

For example, the MS bylaws typically shift the burden of proof (such that the physician is presumed guilty and has the burden to show that any adverse action was arbitrary and capricious); provide that the rules of evidence do not apply (which means hearsay is allowed); and provide for no witness subpoena power (meaning no ability to compel the HC facility staff to appear as witnesses).

In this process, the MS bylaws will likely provide that the HC facility appoints the judge (hearing officer), jury (hearing panel, which likely consists of physicians on the medical staff or otherwise connected to the HC facility), and court of appeals (the MEC and then governing board). Plus, everything takes place at the HC facility's venue.

In the circumstance that the physician prevails at the hearing, a favorable decision is unlikely even if the physician presents top experts. There is often great pressure on the hearing panel to confirm the adverse action. Even if the hearing panel reverses an adverse action, the MS bylaws allow for the MEC and/or governing board to reverse that decision on appeal.

During the administrative fair hearing process, the physician's peer review file will get a lot thicker, including a transcript of the hearing itself. This peer review file can be obtained by other HC facilities and will be disclosed to the state medical board if it opens an investigation on the matter.

CONCLUSION

Physicians rightfully and justifiably expect MS bylaws to be fundamentally fair and allow them due process. However, each facility's MS bylaws may be very different in general and specific ways. MS bylaws may not in fact be fundamentally fair or allow true substantive due process to the physician, but the physician must still adhere to them or risk waiving other due process rights.

Ahead of any future peer review issue, physicians must understand and internalize these general concepts in order to identify important, potentially damaging issues when they surface. When these trickier, more complicated concepts arise, a physician should seek legal advice to determine the best strategy going forward to protect his or her professional records and avoid legal pitfalls. A physician's professional record and reputation could depend on it.

SOURCES AND NOTES

1. Depending on the facility, the MS bylaws may also contain the credentialing policies or be free-standing separate policies.
2. *Poliner v. Texas Health Systems*, 537 F.3d 368 (5th Cir. 2008) (U.S. cert. denied 2009). Casetext website. Available at <https://casetext.com/case/poliner-v-texas-health-systems-2>. Accessed October 28, 2022.
3. See *Poliner v. Texas Health Systems* at 381, stating: “HCQIA [federal peer review statutory] immunity is not coextensive with compliance with an individual hospital’s bylaws. Rather, the statute imposes a uniform set of national standards. Provided that a peer review action as defined by the statute complies with those standards, a failure to comply with hospital bylaws does not defeat a peer reviewer’s right to HCQIA immunity from damages.”
4. See *Poliner v. Texas Health Systems* at 381, stating: “It bears emphasizing that this does not mean that hospitals and peer review committees that comply with the HCQIA’s requirements are free to violate the applicable bylaws and state law. The HCQIA does not gainsay the potential for abuse of the peer review process. To the contrary, Congress limited the reach of immunity to money damages. The doors to the courts remain open to doctors who are subjected to unjustified or malicious peer review, and they may seek appropriate injunctive and declaratory relief in response to such treatment.”
5. Some provisions use the term “material change” but many do not, so a physician must then decide whether to disclose even minor changes to his or her credentialing application.
6. Often, these third-party entities have their own respective duties to disclose when certain triggering events occur. A physician should review any existing bylaws, policies and procedures, websites, and/or access any member portal to determine the physician’s duties as it relates to these types of entities.
7. NPDB Guidebook. National Practitioner Data Bank. U.S. Department of Health and Human Services. Last update October 2018. Available at <https://www.npdb.hrsa.gov/guidebook>. Accessed October 26, 2022.
8. Importantly, the NPDB Guidebook makes it clear that even the MS bylaws cannot change the NPDB reporting requirements.
9. For Texas physicians, please review Section 160.007 of the Texas Occupations Code, Chapter 160, Subchapter A. Confidentiality relating to medical peer review. Available at <https://statutes.capitol.texas.gov/Docs/OC/htm/OC.160.htm#:~:text=Sec.-,160.007,.peer%20review%20committee%20is%20privileged>. Accessed October 26, 2022.
10. Although also very important, the additional confidentiality, privacy, and security protections of patient protected health information under HIPAA as well as applicable state patient privacy laws are outside the scope of this article. That said, if the counsel that the physician wants to hire does not know what HIPAA stands for and does not insist on executing and complying with a HIPAA business associates agreement (“BAA”) with the physician before receiving any patient PHI, then the physician should find another attorney.
11. Attorney work product privilege. Cornell Law School. Legal Information Institute. Available at https://www.law.cornell.edu/wex/attorney_work_product_privilege. Accessed October 26, 2022.
12. This would also be the case for violation of HIPAA as well as applicable state patient privacy laws which, again, are outside the scope of this article.
13. In other cases, a physician may receive a notice that the summary suspension is not indefinite but is for a specified period of time. If the suspension is imposed or in effect for over 30 days, then there is great risk that this will be an NPDB reportable event unless the suspension is lifted before it remains in place for that period of time. See the NPDB Guidebook (Source 7). But even if a suspension is imposed for 30 days or less (not usually NPDB reportable, see the NPDB Guidebook, “Chapter E: Reports,” “Summary Suspensions,” page 118, and “Length of Restriction,” page 120), it is still a curtailment of privileges and will likely be self-reportable to the TMB as well as to other HC facilities and third-parties (i.e., on the TSCA). In either case, a physician should retain experienced physician’s counsel to help determine whether the suspension can be reversed, shortened, or otherwise mitigated in some way.

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COMBATTING OBESITY BIAS IN HEALTH CARE SETTINGS

by Wayne Wenske, Senior Marketing Strategist



According to the Centers for Disease Control and Prevention, approximately 74 percent of U.S. adults are overweight or have obesity.¹ Patients with overweight or obesity are at greater risk for developing such conditions as hypertension, type-2 diabetes, kidney disease, dyslipidemia, stroke, cardiovascular disease, sleep apnea, and certain cancers. As the percentage of Americans with obesity has increased over the last several decades, the U.S. Department of Health and Human Services now views obesity as one of our nation’s most important and troubling health concerns.

A patient’s body mass index (BMI) has often been used to classify whether a patient is overweight or obese. But the BMI measurement has often been criticized for its lack of accuracy, oversimplification, and inability to indicate if a patient’s measurement truly reflects an individual’s overall health. However, several studies indicate that a patient’s risk of chronic illness and mortality rises with his or her BMI measurement. (Patients with overweight are those with a BMI of 25 to <30; patients with obesity are those with a BMI of 30 to <40; and patients with “severe obesity” are those with BMI of 40 or more.)^{2,3}

Unfortunately, several sources report that patients with obesity are less likely to seek health services because they feel stigmatized, disrespected, and embarrassed in health care settings. Some patients may avoid their physician’s office because they fear being weighed, judged, or insulted. These feelings can often lead to depression, anxiety, and even suicide. These patients may also avoid future care, reduce adherence to health care services, feel less trust and communicate less frequently with their providers. These factors also contribute to reduced quality of care and increased health disparities.^{4,5}

When addressing health care disparities, physicians and institutions tend to focus on race, ethnicity, gender, socioeconomic status, age, language, disability, and sexual orientation and identity. However, evidence exists that disparities are very real for patients with obesity, including negative attitudes, inadequate equipment, and overall insensitivity.

These disparities range from scales being unable to accommodate large patients; MRI machines and other scanners that are not large enough; and drug doses that have not been calibrated for obese patients. There have even been instances of obese patients encountering providers unwilling to treat them because of their weight. For example, surgeons who categorically refuse to give knee or hip replacements to obese patients or physicians who may not look past a patient’s weight as being the cause of a presenting condition. “You have shortness of breath because you need to lose weight.”⁶

OVERCOMING BIAS

Whether or not an obese patient has had a bad experience in your office, it is likely these patients have experienced negative interactions with other providers. Unfortunately, obese people routinely experience bias from others through negative attitudes that obesity somehow represents laziness, lack of self-discipline, lack of intelligence, and overindulgence. These biases are often seen in personal interactions through poor word choice, disapproving language or looks, inappropriate joking or humor, and an overall lack of empathy. This type of bias — explicit or implicit — may spill over into the health care environment and affect the quality of care given by providers to patients with obesity.

An “explicit” bias is one in which the person who holds the bias is aware of it and is “very clear about his or her feelings and attitudes, and related behaviors are conducted with intent.”⁷

According to a recent study, 68.5 percent of physician respondents reported that negative attitudes towards patients with obesity is common in the health care setting. These respondents cited observing such inappropriate behaviors as “mocking the patient’s appearance, looks of disgust and repulsion, lack of reaction to offensive remarks, and scaring a patient with the necessity to lose weight.”⁸

“Implicit” bias is one in which the person who holds the bias is unaware of it. It may be a bias that has seeped into a person’s belief system because of the cultural biases in which they live. They may even say or feel they do not hold the bias, but it is there unknown to them.⁷

Physicians and other health care professionals are not immune to outside influences, societal perceptions, and of making an involuntary judgment based on those influences and perceptions.

But there are ways to fight implicit bias. Probably the greatest weapon against implicit bias is self-knowledge. Increasing self-awareness is an important step in understanding and diminishing weight bias in a health care setting. Ask yourself the following questions.

- Do I make assumptions about a patient’s character, intelligence, education-level, professional success, health status, or lifestyle based on his or her weight?
- Are any weight-based assumptions I make about a patient affecting my ability to listen without bias to the patient’s concerns and consider all of the patient’s presenting problems?
- Am I comfortable working with (or treating) people of all shapes and sizes?
- Am I sensitive to the concerns and needs of patients with obesity?

- What are common stereotypes about people with obesity? Do I believe these to be true or false? Why? ^{9,10}

The Rudd Center for Food Policy and Obesity at Yale University provides the following strategies for health care providers to help reduce bias:

- Recognize that obesity is a complex etiology with multiple contributors, including genetics, biology, sociocultural influences, the environment, and individual behavior.
- Recognize that many obese patients have repeatedly tried to lose weight.
- Consider that patients may have had negative experiences with health care professionals in the past.
- Approach obese patients with sensitivity and empathy.
- Consider all causes of presenting problems, in addition to body weight.
- Emphasize the importance of behavior changes rather than just weight.
- Acknowledge the difficulty for anyone to achieve and sustain significant weight loss.
- Recognize that small weight losses can result in meaningful health gains. ¹¹

TREATING PATIENTS WITH OBESITY

The respectful, sensitive treatment of patients with obesity begins with providing a care setting that addresses their comfort, safety, and self-esteem. Make every effort to approach discussions about weight in a sensitive manner. Try to adopt more sensitive language regarding weight. Some research has shown that there are specific terms

that patients with obesity respond more favorably to when describing body weight. For example, these patients often prefer words like “body mass index,” “weight problem,” “unhealthy weight,” or “excess weight” as opposed to “heaviness,” “obesity,” “large size,” “fat” or “excess fat.” ^{12, 13}

Create a positive, open, and comfortable office space

- Provide an adequate number of sturdy, armless chairs and high, firm sofas in waiting rooms. (These will also benefit older patients who may have difficulty with mobility.)
- Provide sturdy, wide exam tables, preferably bolted to the floor to prevent tipping.
- Provide a sturdy stool or step with handles to help patients climb onto the exam table.
- Provide extra-large patient gowns.
- In the restrooms, install high, easy-rise toilets and provide adequate space surrounding the toilets. Also provide a split toilet seat, a specimen collector with a handle, and personal hygiene materials (such as moist towelettes) for easy cleaning.
- Install handrails next to toilets. ^{14, 15}

Have suitable equipment and supplies on hand to improve patient access to care.

- Use large adult blood pressure cuffs or thigh cuffs on patients with an upper-arm circumference greater than 34 cm.
- Use extra-long phlebotomy needles and tourniquets.
- Have large vaginal specula available.
- Have a weight scale with the capacity to measure patients who weigh more than 400 pounds. Position the scale in a discrete, private location.



Weighing a patient

- Weigh patients in a private area.
- Record weight without comments.
- Give patients the option of “blind weighing” or allowing the patient to face away from the scale.
- If it is not necessary for the specific patient visit, give patients the option to be weighed by asking, “Would you like to be weighed today?” Do not challenge the decision and be respectful if they elect not to be weighed.¹⁵

Encourage healthy behaviors

- If weight is related to the patient’s medical condition, ask if they wish to discuss their weight before initiating the topic. For example, “Could we talk about your weight today?” or “How are you feeling about your weight at this time?”
- Discuss realistic goals. For example, let them know that a weight loss of 5 to 7 percent of body weight may lower their chance of developing diabetes.
- Focus more on behavior changes, as opposed to an overemphasis on weight loss or the number on the scale.
- Support your patients to improve cardiovascular health through easy physical activity. Start with simple goals such as walking for 10 minutes, three times a day. Once they achieve this goal, they can build on it.
- Offer your patients information and referrals to registered dietitians, other health providers, weight management programs, and support groups, as appropriate.
- Promote self-acceptance and encourage patients to lead full and active lives.^{14, 15}

Asking appropriate questions

- When talking about healthy eating, keep the conversation positive and encouraging. Some conversation starters may include, “What are some of your family’s favorite dinners?” or “What do you most like to drink during the day?” or “Who does the grocery shopping in your home? Who cooks?” Once you have an idea of the patient’s food routines, you can make healthier suggestions or substitutions to adapt favorite meals. You can also try setting goals for cooking at home more often, drinking more water instead of soda or sweetened beverages, or adding more healthy foods, such as fruits and green, leafy vegetables to the shopping list.
- “Do you only eat when you are hungry or at mealtime, or do you also eat for other reasons, such as when you are feeling bored or stressed?” Responses may also help you make an appropriate reference to a support group or other program.¹⁶

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