2017

Bylaws: How to Solve and Minimize Difficult Staff Solutions

Rick D. Barton

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BYLAWS: HOW TO SOLVE AND MINIMIZE DIFFICULT STAFF SOLUTIONS

San Bernardino County Medical Society
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Creating a Culture of Safety

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The Joint Commission Sentinel Event Alert 2008

- "Behaviors that Undermine a Culture of Safety"
  - Intimidating and disruptive behaviors can foster:
    - Medical errors
    - Contribute to poor patient satisfaction and to preventable adverse outcomes
    - Increase the cost of care
    - Cause qualified clinicians, administrators and managers to seek new positions in more professional environments

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The Joint Commission Sentinel Event Alert 2008 (cont.)

- Intimidating and disruptive behaviors include:
  - Overt actions such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities
- Intimidating and disruptive behaviors are often manifested by health care professionals in positions of power. Behaviors include:
  - Reluctance or refusal to answer questions, return phone calls or pages; condescending language or voice intonation; and impatience with questions
- All intimidating and disruptive behaviors are unprofessional and should not be tolerated

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Joint Commission LD 03.01.01

- Revised in July 2012 from “disruptive, and inappropriate behaviors” to “behaviors that underline a culture of safety”
- Applicable to ambulatory care, critical access hospitals, home care, hospital, laboratory, long term care, Medicare-Medicaid certification-based long term care, and office-based surgery programs
- Standard
  - Leaders create and maintain a culture of safety and quality throughout the hospital

Joint Commission LD 03.01.01

- Element of Performance
  - 1. Leaders regularly evaluate the culture of safety and quality using valid and reliable tools.
  - 2. Leaders prioritize and implement changes identified by the evaluation.
  - 3. Leaders provide opportunities for all individuals who work in the hospital to participate in safety and quality initiatives.
  - 4. Leaders develop a code of conduct that defines acceptable behavior and ***behaviors that undermine a culture of safety***.
  - 5. Leaders create and implement a process for managing ***behaviors that undermine a culture of safety***.

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Joint Commission LD 03.01.01

- Element of Performance (cont.)
  - 6. Leaders provide education that focuses on safety and quality for all individuals.
  - 7. Leaders establish a team approach among all staff at all levels.
  - 8. All individuals who work in the hospital, including staff and licensed independent practitioners, are able to openly discuss issues of safety and quality. (See also LD.04.04.05, EP 6)
  - 9. Literature and advisories relevant to patient safety are available to all individuals who work in the hospital.
  - 10. Leaders define how members of the population(s) served can help identify and manage issues of safety and quality within the hospital.

American Medical Association Opinion No. 90452 (Dec. 2000)

- "Personal conduct, whether verbal or physical, that negatively affects or that potentially may negatively affect patient care constitutes disruptive behavior. (This includes but is not limited to conduct that interferes with one's ability to work with other members of the health care team.) However, criticism that is offered in good faith with the aim of improving patient care should not be construed as disruptive behavior."

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California Public Protection & Physician Health (CPPPH)

- "Behaviors that Undermine a Culture of Safety: Policies and Procedures for Medical Staffs and Medical Groups"
  - A pattern of failure to comply with the bylaws, policies and procedures of the medical staff and the facility can be inadvertent, or it can be willful. A pattern of willful failure to comply with rules becomes disruptive at the point that it places the medical staff or the facility in jeopardy with respect to licensing or accreditation requirements, complying with other applicable laws, or meeting other specific obligations to patients, potential patients and facility staff.

Healthcare is a Team Sport!

- Creation of a "culture of safety"
- Requires that all members of the healthcare team work together towards the common goal of patient safety
- Requires environment that facilitates safe reporting for nursing staff, healthcare workers, and others
  - AND requires that the team actually address the reports and change the behaviors

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Creating a Culture of Safety

- In a culture of safety, staff members are aware of safety issues and are free to report conditions that could lead to near misses or actual adverse events
- Open exchange of information requires management to have a non-punitive response philosophy that rewards reporting of safety issues and events and does not punish staff members involved in errors or adverse events related to system failures

Creating a Culture of Safety (cont.)

- In a culture of safety, people are not merely encouraged to work toward change; they take action when it is needed.
- Inaction in the face of safety problems is taboo and eventually the pressure comes from all directions — from peers as well as leaders
- There is no room in a culture of safety for those who uselessly point fingers or say, "Safety is not my responsibility, so I'll file a report and wash my hands of it."

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Creating a Culture of Safety (cont.)

- Educating Stakeholders
  - Medical Staff Leadership
  - Hospital Leadership
  - Staff
- Communication and Transparency
  - Medical Staff Professionals with Quality Improvement
  - Medical Staff Committees with Leadership

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You Never Do Anything Anyways!

- Risks of not addressing reports by staff and others:
  - Decline in employee moral
    - Could result in higher turnover of staff
  - Decreasing number of reports
    - Staff sees reporting as futile, behavior not addressed and continues
  - Risks to hospital reputation
    - Patients feel staff doesn't communicate well, staff does not want to work at the facility, physicians don't want to be on staff with hostile nurses

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Risks of Not Addressing Staff Reports

- Nieto v. Kapoor, 238 F. 3d 1208 (10th Cir. 2001)
  - Former employees of radiation oncology department at public medical center brought state court action against department's medical director under § 1983, alleging denial of their equal protection and free expression civil rights
  - The Court of Appeals held that harassment of employees was *sufficiently severe and pervasive to create a hostile environment*
    - Court awarded $1.87 Million in compensatory damages and $1.87 Million in punitive damages

Risks of Not Addressing Staff Reports (cont.)

- Kopp v. Samaritan Health System, 13 F.3d 264 (8th Cir. 1993)
  - Hospital employee brought action against hospital and cardiologist alleging cardiologist's behavior toward her, coupled with hospital's failure to curtail his conduct, amounted to hostile-environment sexual harassment under Title VII.
    - Hospital was aware of cardiologist's behavior and because of that hospital could be liable for failing to address the disruptive behavior

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Who Is Responsible for Creating the Culture?

- All healthcare providers are responsible for creating an appropriate and safe culture
  - Hospital has a duty to ensure that nurses, volunteers, and staff members are free from a hostile work environment
    - Potential liability for failing to provide safe and harassment-free environment for staff in form of:
      - Retaliation lawsuits, FEHA, U.S.C. Section 1983 claims

Who Is Responsible for Creating the Culture? (cont.)

- All healthcare providers are responsible for creating an appropriate and safe culture (cont.)
  - Must coordinate the different reporting tools: quality, peer review, patient complaints
  - Must coordinate how to address the disruptive individual
  - Work with Medical Staff to address disruptive providers

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Who Is Responsible for Creating the Culture? (cont.)

- Medical Staff has a duty to address the problematic behaviors
  - Joint Commission LD 03.01.01
  - Eradicate behaviors that undermine culture of safety
- Medical staff is responsible for "policing its member physicians"
    - Health & Safety Code Section 1250(a); 22 CCR Section 70701(A)(1)(F);
  - "The medical staffs right of self-governance shall include, but not be limited to, all of the following: Establishing, in medical staff bylaws, rules, or regulations, clinical criteria and standards to oversee and manage quality assurance, utilization review, and other medical staff activities including, but not limited to, periodic meetings of the medical staff and its committees and departments and review and analysis of patient medical records."
    - Business and Professions Code, Section 2282.5

Miller v. Eisenhower Medical Center 27 Cal.3d 614 (1980)

- Physician applied to medical staff and provided 25 references
- Comments made by references were concerning enough that Medical Staff denied his application based on the determination that sufficient doubt existed concerning his ability to work with others
  - Based on requirement in Bylaws that members work well with others
- Physician requested a hearing, JRC upheld Medical Staff decision. Board also upheld Medical Staff decision
- Physician appealed to Court of Appeals

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Miller v. Eisenhower Medical Center (cont.)

- Court held that bylaw provision which permitted exclusion from staff membership solely on basis of physician's "ability to work with others" must be read to demand showing, in cases of rejection on this ground, that applicant's inability to "work with others" in hospital setting was such as to present real and substantial danger that patients treated by him/her might receive other than high quality of medical care at the facility if he were admitted to membership
  - BUT in this case, the record did not show that physician's ability to work with others was limited in a manner which would pose realistic and specific threat to quality of medical care

Marmion v. Mercy Hospital, 145 Cal.App.3d 72 (1993)

- Resident was terminated by hospital from residency program because he was "unable to function within the structure of the residency training program" causing an "adverse effect on quality of medical care provided by hospital"
- Court upheld decision to terminate resident
  - Held that it is unnecessary to find that the clinician's inability to function within the structure of the residency training program had an adverse effect on quality of medical care

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Other Potential Exposure for Hospital/Medical Staff for Not Addressing Culture Problems

- California Department of Public Health
  - Can fine an institution for not appropriately dealing with abusive clinician
    - Hospital was fined $25,000.00 because it failed to appropriately address a clinician that was abusing patients and staff
- Also potential legal liability
  - 1278.5 Whistleblower retaliation actions

How Do You Deal With The Disruptive Physician?

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Before Practitioner is On Your Staff

Screening Mechanisms for Disruptive Practitioners

- Do you let a problematic practitioner on staff?
  - Do not accept applications for practitioners whose professional license is under probation
    - Also apply to DEA license, excluded provider, providers undergoing corrective action at another facility
- Misrepresentations on Practitioner's Application
  - *"Any information supplied by the applicant that contains any misrepresentations or omissions may be grounds for immediate denial, termination, revocation and/or suspension of the applicant's medical staff membership and/or clinical privileges."*

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Screening Mechanisms for Disruptive Practitioners (cont.)

- Practitioners who left staff and were not in "good standing"
  - **"Good Standing"** is used to refer to a member who is currently not under any suspension, monitoring, investigation, behavioral agreement, or serving with any limitation of voting or other prerogatives imposed by operation of the Bylaws, rules and regulations, or policy of the Medical Staff based upon an evaluation by the Medical Staff of the individual's care or conduct.
  - Any practitioner who voluntarily resigned from membership while he/she was not in Good Standing may reapply. Any such reapplication shall be processed as an initial application, and the applicant shall have the burden to submit information, including such information as may be required to demonstrate that any outstanding issues involving the practitioner before the voluntary resignation, including the reasons the practitioner was not in Good Standing, no longer exist.

Disruptive Physician on Your Staff

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Your Bylaws

- Does it address the qualifications for membership?
  - **Additional Qualifications for Membership**, "In addition to meeting the basic standards, the practitioner must:
    - b. Be determined to:
      - 1. Adhere to the lawful ethics of his or her profession;
      - 2. **Be able to work cooperatively with others in the hospital setting so as not to adversely affect patient care or hospital operations**; and
      - 3. Be willing to participate in and properly discharge Medical Staff responsibilities.
        - CHA Model Bylaws

Your Bylaws

- Could also include specific language:
  - In addition to meeting the basic standards, the practitioner must:
    - Refrain from any behavior that undermines the culture of safety

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Your Bylaws and Policies

- Do they include a "standards of conduct" provision?
  - CHA Model Bylaws- Section 2.7, Standards of Conduct
    - "Members of the Medical Staff are expected to behave in a professional manner at all times and with all people…"
    - "Interactions with all persons shall be conducted with courtesy, respect, civility, and dignity"
    - "Members of the Medical Staff shall not engage in conduct that is offensive or disruptive, whether it is written, oral, or behavioral"

Your Bylaws and Policies (cont.)

- Do you include a "standards of conduct" provision?
  - CMA Model Bylaws- Section 2.7, Standards of Conduct
    - "As a condition of membership and privileges, a member shall continuously meet the requirements for professional conduct established by these bylaws"
    - "Disruptive and inappropriate medical staff member conduct affects or could affect the quality of patient care at the hospital and includes…"
    - "All complaints or reports will be discussed and decisions made in executive session"

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The Disruptive Physician

- How do you address a problematic practitioner?
  - Trend certain behaviors
  - Coordinate with other departments at hospital to keep track of staff reports regarding practitioner
    - Seek out information from patient complaints, quality, and Medical Staff
  - Document, Document, Document!
    - Document interactions, including productive interactions in writing and keep in practitioner's file

The Disruptive Physician (cont.)

- When should you investigate complaints about behavior?
  - After trend is identified
  - Depending on the severity of the complaint
  - Based on the behavior (e.g. physical threat, verbal threat)
- He Said/She Said
  - Be careful concluding that report is "unsubstantiated" or that the practitioner's conduct was "appropriate" if practitioner disputes the report
    - If receiving multiple complaints, may need to do further investigation

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Process for Dealing with Disruptive Physician

- Develop a Disruptive Physician policy
  - Can be in addition to, or as part of Code of Conduct
  - Should specifically describe behaviors that are considered "disruptive"
    - Can group behaviors according to severity
  - Can be Medical Staff specific or hospital-wide

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Disruptive Physician Policies

- Should address process for dealing with a disruptive physician
  - Steps to consider taking in policy:
    - Meeting with Chief of Staff after a specific number of complaints
    - Productive Interaction
    - Focused Professional Practice Evaluation (FPPE)
    - Referral to PACE
    - Behavioral Contract
      - Structure contract in such a way that if practitioner breaches contract, hearing only regarding the breach and not the underlying behaviors

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Process for Dealing with Disruptive Physician

- Coffee Cart conversation– DOCUMENT!
- Productive Interaction
- Escalate to formal investigation by Medical Staff
  - Resignation after investigation commences, could be reportable to National Practitioner Data Bank and California Medical Board
- Corrective Action
  - How much is enough evidence for corrective action?
    - 75 Behavioral Variance Reports against practitioner?
    - Can behavior be the only basis for corrective action?
    - Decision to summarily suspend
- Consider involving Well-Being Committee if concerns of impairment
  - Well-Being Committee may be able to address underlying behaviors causing disruption

Physician Well-Being Committee

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Purpose of Wellbeing Committees

- CMA
  - An informal, confidential access point for persons who voluntarily seek their assistance
  - To serve as a resource to the Medical Staff for evaluating and coordinating services when there is a perceived need to address individual health related issues To serve as an advisor to the Medical Staff in addressing patient safety issues that may arise from individual health related issues

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California Code of Regulations, Title 22, Section 70703

- Standing committee of the Medical Staff
- "The medical staff by-laws, and regulations shall include…provision for the performance of the following functions:…assisting the medical staff members impaired by chemical dependency and/or mental illness to obtain necessary rehabilitation services…"
  - Sec. 70703(d) requires reports of activities and recommendations relating to the functioning of the committee at least quarterly to the governing body

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Balancing Confidentiality of Activities With Responsibility to MEC

- The Wellbeing Committee
  - Maintaining a safe space for physicians in need of assistance
  - To be an effective resource to the Medical Staff to assure patient safety
- So When Must the MEC Be Told?
  - CMA- "Except in an instance where there is a *serious* risk of harm to patients, the Committee should report only to the referral source and the physician in question."
  - When harm likely, possible?
  - Any harm? "Serious" harm?

Confidentiality of Activities

- *Goodstein v. Cedars-Sinai Medical Center* (1998) 66 Cal.App.4th 1257
  - Dr. Goodstein reported by colleagues to have substance abuse problem- referred to wellbeing committee who recommends psychiatric evaluation
  - Dr. Goodstein refuses to cooperate until wellbeing divulges identity of sources
  - MEC suspends Dr. Goodstein for failure to cooperate with undergoing evaluation

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Confidentiality of Activities

- *Goodstein v. Cedars-Sinai Medical Center (cont'd)*
  - Dr. Goodstein alleges denial of fair procedure because of wellbeing refusal to identify sources of complaints
  - Court of Appeal:
    - Wellbeing Committee is a peer review committee
    - Policy of non-disclosure is appropriate and not a violation of fair procedure

Your Bylaws

- Role of Well-Being Committee and relationship with Medical Staff should be clearly defined
  - When should conduct be reported, when should referrals be made, what information will be shared between the two committees, etc.
  - Provide automatic referral to Well-Being as part of dealing with disruptive physician?

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Impaired Physician Policies

- *Impaired* – Unable to practice medicine with reasonable skill and safety to patients because of a physical or mental illness, including deterioration through natural causes or loss of motor skill, or excessive use or abuse of drugs, including alcohol.

Impaired Physician Reporting

- AMA Opinion 9.0305- Physician Health and Wellness
  - To preserve the quality of their performance, physicians have a responsibility to maintain their health and wellness…When health or wellness is compromised, so may the safety and effectiveness of the medical care provided
- AMA Opinion 9.031 - Reporting Impaired, Incompetent, or Unethical Colleagues
  - Physicians have an ethical obligation to report impaired, incompetent, and/or unethical colleagues in accordance with the legal requirements in each state

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Impaired Physician Reporting

- Some state laws require physicians to report colleagues, e.g.:
  - Any person may, and a doctor of medicine, the Arizona medical association, a component county society of that association and any health care institution shall, report to the board any information that appears to show that a doctor of medicine is or may be medically incompetent, is or may be guilty of unprofessional conduct or is or may be mentally or physically unable safely to engage in the practice of medicine.

(11 states contain some variation of mandate, often referring to the state statute setting forth grounds for discipline)

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Your Impaired Physician Policies

- Every Hospital is required to have a policy for acting upon concerns that a practitioner is impaired
  - To assure patient safety by providing guidance on how to identify, report and treat impaired medical staff members
  - To provide assistance and rehabilitation to aid impaired medical staff member
  - To provide medical staff members with information and education regarding potential impairment
- Can use to help address disruptive practitioners

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The Dilemma of the Impaired Physician

- Hospitals and their medical staffs have an affirmative duty to oversee the quality of care rendered by Medical Staff members and monitor impaired physicians
- Anti-discrimination laws prohibit discrimination on the basis of age and disability

Disruptive Physician and The ADA

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Nondiscrimination

- "Medical Staff membership or particular privileges shall not be denied on the basis of age, religion, race, creed, color, national origin, or any physical or mental impairment if, after any necessary reasonable accommodation, the applicant complies with the Bylaws or Rules of the Medical Staff or the hospital."
  - Is an impairment a disability?

Anti-Discrimination Laws

- Federal Laws
  - Title VII of the Civil Rights Act of 1964
  - The Rehabilitation Act of 1973
  - Americans with Disability Act of 1990
- State laws
  - Almost every state has anti-discrimination laws prohibiting discrimination based on disability
    - E.g., California – Fair Employment and Housing Act

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Americans with Disabilities Act ("ADA")

- Title I
  - Prohibits employers from discriminatorily terminating an otherwise qualified individual due to a disability
  - Must make "reasonable accommodations" unless would cause an "undue hardship" to employer
  - Must engage in interactive process with employee to find ways to reasonably accommodate

Americans with Disabilities Act ("ADA")

- Title III:
  - Prohibits discrimination on the basis of disability with respect to public accommodations
  - No employment relationship requirement
  - Courts have held Title III of the ADA applies to non-employee Medical Staff members
    - *E.g., Menkowitz v. Pottstown Memorial Medical Center*
      - Hospital summarily suspended medical staff privileges of physician with Attention Deficit Disorder, despite psychologist's report that it would not affect his ability to treat patients
      - Court said physician had standing to sue under Title III

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ADA Limitations on Disability-Related Inquiries

- Job related and consistent with business necessity
- Generally, a medical staff can request an examination and documentation from a member regarding a disability so long as it is **reasonably related to job functions and based on reliable information that clinical performance and/or safety may be impaired**

Periodic Testing and Monitoring Under the ADA

- Direct Threat – Medical Staff may require examination if it reasonably believes physician poses a direct threat to safety of him or herself, or others
- Question of whether physician poses a direct threat must be based on individualized assessment of employee's ability to safely perform job duties

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Your Bylaws and Policies

- Does your facility have policies that address reasonable accommodation?
- Is it feasible to offer a reasonable accommodation?
- How will you ensure that a reasonable accommodation can be provided and patient safety is not compromised?

Disruptive Physician and Retaliation

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Beware of the Retaliation Claim!

- Health & Safety Code § 1278.5 – provides whistleblower protections for patients, healthcare workers, and "members of the medical staff" against "discrimination or retaliation" by any "entity that owns or operates a health facility," when the person makes a *report* to relevant:
  - regulatory agencies,
  - accreditation bodies, or
  - the hospital itself about
- "issues relating to the care, services, and conditions of a facility"

Fahlen v. Sutter Central Valley Hospitals (2014)

- A physician is <u>not</u> required to exhaust administrative remedies in the peer review process before proceeding with a civil complaint for retaliation under H&S Code, § 1278.5
- Court rejected application of the long-standing exhaustion requirement established in 1976 in *Westlake Community Hospital v. Superior Court*,
  - In *Westlake*, the Supreme Court held that a physician <u>must exhaust</u> all internal hospital procedures and prevail in an administrative mandamus action in Superior Court prior to bringing a civil action seeking damages arising from a hospital decision restricting or terminating medical staff privileges

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Implications of Fahlen

- Employee or physician may submit patient safety complaints to secure "whistleblower protection" prior to investigation or adverse action by a health care facility
- Physicians can file a superior court action claiming whistleblower protection before peer review proceedings or during peer review by a health facility
  - Proceed with dual JRC and state court action?

Elements of a Retaliation Claim

- Plaintiff Engaged in Protected Activity
  - Opposed harassment, discriminatory or other offending conduct; or
  - Participated in filing complaint, investigation, testifying, etc.
- Adverse Action
  - Materially adverse
    - Demotion, termination, negative review
- Causal nexus between Protected Activity and Adverse Action
  - Substantial motivating
  - A contributing factor
  - THE contributing factor

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Health & Safety Code, §1278.5

- Public policy of the State of California to encourage health care workers to notify government entities and hospitals of suspected unsafe patient care and conditions.
- Legislature wanted to encourage this reporting in order to protect patients and to assist accreditation and government entities charged with ensuring that health care is safe.
- Legislature found and declared that whistleblower protections apply primarily to issues relating to the care, services, and conditions of a health care facility

Discriminatory Treatment—§1278.5(d)(2)

- Discriminatory treatment of a health care worker includes:
  - Discharge
  - Demotion
  - Suspension
  - Any unfavorable changes in, or breach of, the terms or conditions of a contract, employment, or privileges of the health care worker of the health care facility; or
  - The threat of any of these actions

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Health & Safety Code, §1278.5 (cont.)

- Presumption of Retaliation– 1278.5(d)(1)
  - Rebuttable presumption that an adverse action was discriminatory if it occurs within 120 days of the filing of the grievance, report or complaint

Health & Safety Code, §1278.5- Whistleblower Cases

- What type of "grievance, complaint or report" is required under 1278.5?
  - *Lin v. Dignity Health-Methodist Hosp. of Sacramento* (2014)
    - US District Court Case, California Eastern District
    - Under 1278.5, a physician's notation in a patient's Death Discharge Summary summarizing the patient's stay at the facility did not qualify as a "report"

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Medical Staff Considerations

- Medical Staff must always be aware of potential whistleblower claim when proceeding with peer review of a physician
  - Conduct separate investigation of patient safety concerns raised by medical staff member
  - Peer Review decision may not be in retaliation for physician's complaints about patient care or conditions
    - Advise Medical Executive Committee of patient safety complaints?
    - Carefully document peer review proceedings and separate quality investigation
    - Tell Medical Staff member about outcome of the patient care investigation?

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Thank you!

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Questions? Please feel free to contact us any time for guidance.

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Professional Summary

Richard D. Barton has represented healthcare providers and health systems for more than 30 years. Richard's consulting and litigation practice focuses on health systems, hospitals, health associations, physician groups and individual healthcare providers. He is experienced in assisting provider organizations with their quality oversight compliance obligations and governance. He also serves as an Adjunct Professor of Law for the University of San Diego School of Law teaching Health Law and Policy.

Recognitions

- *The Best Lawyers in America*® – 2007-2017
- Martindale-Hubbell® AV Preeminent Rating
- *San Diego Super Lawyers*® – 2007-2015 (Health Care)
- *San Diego Magazine*'s Best Lawyers
- ADL Torch of Liberty Award
- "Top Lawyers," *San Diego Magazine*, 2013 - 2015
- "Southern California Super Lawyers," *Super Lawyers Magazine*, Southern California 2014

Community

- University of California President's Advisory Council on Campus Climate, Culture, and Inclusion (2010-2012)
- American Board of Trial Advocates
- Anti-Defamation League - San Diego Regional Advisory Board Chairman (1998-2002), ADL National Commissioner (2000 to present), National Executive Committee (2002 to present), Vice Chair of International Affairs (2003-2006), National Chair of Leadership (2006-2009), National Chair of Education (2009-2012), Chair Education Equity Task Force (2012 to present)
- Litigation Counsel of America – Fellow
- San Diego County Bar Association and San Diego County Medical Society – Co-Founder Joint Medical Legal Committee
- National Immigrant Women's Advocacy Project – Board Member
- International Association of Judicial Independence and World Peace International Project of Judicial Independence – Member

Education

- JD, University of Southern California Gould School of Law, 1981
- BA, University of California, Los Angeles, 1977

News Coverage

- Clark, Cheryl. "Out to Pasture: Age-Based Personnel Policies Rankle With Docs," *MedPage Today*, July 30, 2015.

Seminars

Rick has been a guest lecturer at the University of San Diego Law School, California Western School of Law, University of Vermont School of Law, Dartmouth College, San Diego State University and is a regular guest speaker on health care issues at venues around the country. He has lectured and is a regular speaker on the conflict in the Middle East, Anti-Semitism, Holocaust, Religious Freedom in the U.S. and Church-State issues.

- Co-presenter. "Telemedicine: The Doctor is In (Your Computer)," ACC-SD, San Diego, CA, June 9, 2016.
- Presenter. "Retaliation and Healthcare Providers: Navigating Health and Safety Code Section 1278.5," CAMSS 45th Annual Education Forum, Anaheim, CA, May 19-20, 2016.
- Panelist. "When Age Becomes Impairment: Issues Involving Older Physicians," Administrators in Medicine 2016 Annual Meeting, San Diego, CA, April 27, 2016.
- Co-presenter. "Impact of Recent Regulatory Changes on Medical Staff Bylaws: Proposed Amendments and Best Practices," Strafford Productions, San Diego, CA, March 3, 2016.
- Sharp Healthcare Medical Staff Leadership Retreat, January 22, 2016.
- Co-presenter - "Navigating Health and Safety Code Section 1278.5," ACC-SD, San Diego, CA, August 26, 2015.
- "Managing the Multiple Layers of Physician Oversight," CAMSS Desert Chapter, 16th Annual Educational Conference, August 14, 2015.
- "Legal Aspects of Assessing the Aging Physician", Federation of State Physician Health Programs, Inc. - Annual Education Conference & Business Meeting - April 25, 2015.
- Medical Staff Boot Camp - Sharp Memorial Hospital - New Department Chair Orientation, February 10, 2015.
- "Managing the Multiple Layers of Physician Oversight," 2015 CAMSS 44th Annual Education Forum, Universal City, CA, May 20, 2015.
- "Legal Aspects of Assessing the Aging Physician," CMA OMSS Assembly, San Diego, CA, December 4, 2014.
- "Legal Aspects of Assessing the Aging Physician," CSHA Annual Fall Seminar, Los Angeles, CA, November 7, 2014.
- "Medical Staff Bootcamp – Representing Healthcare Clients," California Western School of Law, San Diego, CA, October 20, 2014.
- Co-presenter. "SD Health Law Roundtable: To Report or Not Report - Ending Relationships with the Employed or Contract Providers," ACC-SD, San Diego, CA, September 30, 2014.
- "Legal Aspects of Assessing the Aging Physician," SCCMA Workshop, San Jose, CA, September 27, 2014.
- Co-presenter. "Dismantling the School-to-Prison Pipeline," KPBS, San Diego, CA, September 16, 2014.
- Co-presenter. "Medical Staff Bylaws: Meeting New Medicare Conditions of Participation and Joint Commission Requirements," Strafford, Webinar, September 11, 2014.
- "Medical Records Training" Southern Indian Health Council, Alpine, CA, July 29 and August 14, 2014
- "Assessing the Aging Physician – Legal Aspects," CPPPH, Los Angeles, CA, July 26, 2014.
- Co-presenter. "Meet Your Counterpart: Landmark Healthcare Legislation – Revealing the Real Impact of the ACA – 2014 Update," Association of Corporate Counsel, San Diego, CA, June 19, 2014.
- "Assessing the Aging Physician – Legal Aspects," CPPPH, Oakland, CA, June 7, 2014.

- "The Dilemma of the Aging Physician: Legal and Practical Challenges," 43rd Annual CAMSS Education Forum, Sacramento, CA, May 9, 2014.
- "Assessing the Aging Physician – Legal Aspects," CPPPH, Sacramento, CA, May 3, 2014.
- "Medical Staff Boot Camp," Sharp Chula Vista Medical Center, Chula Vista, CA, February 27, 2014.
- "The Dilemma of the Aging Physician: Legal and Practical Challenges," Association of Corporate Counsel, San Diego, CA, February 20, 2014.
- "Age-Based Policies for Physician Faculty: Legal and Practical Challenges," Legal Issues Affecting Academic Medical Centers and Other Teaching Institutions Conference, Washington, DC, January, 23, 2014.
- "Legal Aspects of Assessing the Aging Physician," CPPPH, San Diego, CA, November 16, 2013.
- "Pursuing Quality Through Medical Staff and Physician Oversight: A Report from the Trenches," September 12, 2013.
- "Pursuing Quality through Medical Staff and Physician Oversight," Tri-City Board Training, San Diego, CA, July 10, 2013.
- "Promoting Quality Medical Management in Multi-Hospital Systems: A View from the Front Lines," CSHA Annual Meeting and Spring Seminar, Newport Beach, CA, April 13, 2013.
- "Pursuing Quality Through Medical Staff and Physician Oversight - A Report from the Trenches," ACC-SD/Procopio Health Law Roundtable, San Diego, CA, January 31, 2013.

Publications

Rick served as the primary author of an Amicus Curiae brief to the California Supreme Court on behalf of Jewish and Islamic medical ethics scholars in Benitez vs. North Coast Women's Group in a nationally publicized matter involving the right of a physician to refuse treatment on religious grounds on the basis of a patient's sexual orientation. In his role in the Anti-Defamation League, Rick has traveled to the Middle East and Europe for meetings with officials of the Israeli Government, the Palestinian Authority, the United Nations and European Governments. He has served as a contributor to the San Diego Union Tribune on the Israeli Palestinian conflict and Anti-Semitism.

- Contributor. "Assessing Late Career Practitioners: Policies and Procedures for Age-based Screening," California Public Protection and Physician Health, Inc., 2015.
- "Whistleblowers and the California Supreme Court's Decision in Fahlen v. Sutter Central Valley – Toward a Workable Balance for Promoting Advocacy for Patient Care," *The Legal Secretary*, February 2015.
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