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FEBRUARY 2026 | VOL 14

Med-Staff Newsletter

From the Medical Staff Practice Group

Behind the Bylaws: Accreditation 360 and the Joint Commission's New Era of Hospital Oversight

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Hospital accreditation is poised to enter a period of complexity before emerging with greater clarity and simplicity, at least in theory. In the summer of 2025, The Joint Commission unveiled what it called a "transformational" overhaul of its hospital accreditation program. Branded as "Accreditation 360," the initiative promises to streamline standards, reduce regulatory burden and usher in a more transparent, outcome-oriented approach to evaluating hospitals and critical access facilities. But beneath the surface of this modernization effort lies a complex recalibration of oversight; one that invites both optimism and skepticism from legal counsel and medical staff professionals and sets up hospitals and the medical staff community for a challenging period of transition.

A Shift in Philosophy

Accreditation 360 represents not just a change in the standards themselves, but also a philosophical pivot in how The Joint Commission views its role in hospital oversight. At the heart of the Accreditation 360 initiative are two foundational shifts in The Joint Commission's approach to hospital oversight. First, the Accreditation Manual has undergone a significant revamp, marked by a substantial reduction and simplification of standards. Second, the traditional triennial survey model is being reimagined in favor of what The Joint Commission calls a "continuous engagement model," a framework that emphasizes ongoing readiness and support rather than episodic compliance checks every three years.

The Joint Commission's stated goal for this revamp is to focus on its main priorities of patient safety, quality outcomes, and continuous improvement. To that end, the Joint Commission has also introduced a new chapter in its accreditation manual: the National Performance Goals (NPGs). These replace the National Patient Safety Goals and are designed to reflect high-priority, measurable objectives for Hospitals to track and achieve. The NPGs are intended to be dynamic and capable of evolving with the health care

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landscape, emphasizing the areas of innovation, leadership, competency and staffing adequacy. Significantly, some CMS Conditions of Participation (CoPs) are now embedded within the NPGs, rather than simply cross-referenced, creating a hybrid framework that blends regulatory mandates with aspirational goals. For example, Goal 12 of the NPGs fuses the CoP mandates on credentialing and privileging with more aspirational objectives related to workforce innovation, training, competency monitoring and leadership.

Structural Overhaul: Manuals and Methodologies

The Joint Commission has highlighted how the initiative builds on previous efforts to reduce the number of standards hospitals must adhere to by removing more than 700 requirements. This follows on the earlier removal of 400 requirements in 2023. It is worth noting, however, that while the total number of standards has decreased, many standards have been merged, and other requirements survive by implication and by the practical necessities required to meet the remaining standards.

The accreditation manual itself has been reorganized to distinguish clearly between CMS CoPs and The Joint Commission requirements that go beyond federal regulations. This bifurcation is meant to help hospitals and legal teams better understand which standards are legally required and which are performance-driven enhancements. Ultimately, hospitals will need to follow both sets of standards to meet TJC accreditation requirements.

The Survey Activity Guide (SAG), long a staple of survey preparation, has been retired and replaced by the Survey Process Guide (SPG), which aligns more closely with the CMS State Operations Manual. The SPG offers a chapter-by-chapter breakdown of standards and elements of performance (EPs), integrating CMS interpretive guidelines and providing a roadmap for how surveyors will assess compliance.

The Joint Commission is also encouraging hospitals to adopt a continuous engagement model, which offers ongoing support between surveys. This model is designed to promote perpetual readiness and quality improvement, rather than episodic compliance tied to triennial surveys, but also necessitates perpetual evaluation and engagement with medical staff governance documents, policies, and procedures.

Transparency and Access

One of the most publicly visible changes is The Joint Commission's decision to make its standards searchable online. While the public version includes current effective standards, accredited organizations have access to enhanced features through the E-dition platform, including CMS crosswalks, EP filtering, and early survey policy updates. Consequently, while making the accreditation standards public is an important step towards increased transparency, organizations considering accreditation and those legal and compliance teams conducting gap analysis will still need to go through the paywall for the E-dition to make use of the enhanced features.

2026 Modification in Medical Staff Standards

In revisiting the medical staff standards through the lens of Accreditation 360, what becomes apparent is that while the 2026 rewrite represents a significant restructuring and renumbering of the standards, collapsing decades of accumulated regulatory tinkering into something more coherent and navigable, the core expectations of hospitals and medical staffs remain unchanged. As with many reforms promising clarity, the bigger picture unfolds in the tension between simplification and the enduring complexity of hospital practice.

I. Narrative Removal and Consolidation

The first and most visible transformation is the compression of previously dispersed requirements into fewer broader, more encompassing expectations.

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This consolidation can seem, at first blush, like eliminating some of the minutiae that defined medical staff accreditation: fewer cross references, fewer subparts, and fewer granular mandates. But ultimately, the consolidation is a rearrangement. Hospitals scanning the 2026 manual may find certain EPs "missing," only to discover their substance has been woven into broader, more interpretive language. For example, gone are the days of a sprawling MS.01.01.01 enumerating, in 37 separate EPs, each element that must be included in the bylaws. Rather, the same requirements can be found consolidated under the new MS.14.01.01, EPs 1, 3, 6, and 7. Simplification, in this context, introduces a new kind of interpretive pressure to discern obligations remain embedded within more generalized formulations.

II. Survey Process as a Structural Force

Perhaps one of the more consequential changes to come with the Accreditation 360 revisions of the medical staff standards is the introduction of the Survey Process Guide (SPG).

The SPG should not be mistaken as merely a replacement for the Survey Activity Guide. It is a modular based reorganization of how surveyors will approach medical staff oversight, which is more closely aligned with the Centers for Medicare and Medicaid Services (CMS) State Operations Manual (SOM). This means that Medical Staff standards are no longer freestanding, but instead are contextualized, examined, and validated through SPG defined pathways.[1]

In practical terms, this creates a new shift in focus wherein the medical staff is no longer evaluated only on what the written standards say, but also on how comprehensively its leadership, credentialing mechanisms, privileging processes, and governance structures perform when filtered through the SPG's logic.

III. Substantive Shifts Beneath the Structural Redesign

Underneath the structural overhaul of the medical staff chapter and the SPG, meaningful changes have been made to the standards themselves that carry important substantive implications.

For example, previous standards detailing specific requirements for department structure and the duties and qualifications of department chairs have been removed.[2] These have

1. The Joint Commission, Hospital Accreditation Survey Process Guide, available at: **https://www.jointcommission.org/en-us/knowledge-library/support-center/survey-or-review-preparation/survey-process-guides**
2. Formerly set out under 2025 MS.01.01.01, EP 36.

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generalized requirement that the bylaws include "the qualifications and roles and responsibilities of the department chair, when applicable."[3]

Similarly, the detailed standards regarding communication of privileging decisions, and detailed requirements regarding the medical staff leadership's role in performance improvement activities and medical staff participation in autopsy review, did not make the cut for the new 2026 medical staff standards.[4]

On the other side of the spectrum, new comprehensive standards regarding amendment of medical staff documents,[5] an express requirement for the bylaws to include the composition of the fair hearing committee,[6] and new details regarding oversight of graduate medical staff standards.[7] Further detailed breakdowns of changes to The Joint Commission accreditation standards under Accreditation 360 will be published in client alerts.

The medical staff chapter now demands more deliberate alignment between bylaws, policy, and regulatory interpretations. The integration of official crosswalks, disposition reports and designated comparison tools into the medical staff implementation process signals that interpretation itself has become a regulated act. The work of understanding and complying with the medical staff chapter now requires active engagement with the new standards, the SPGs, and The Joint Commission's new preferred continuous engagement model — turning medical staff accreditation and regulatory compliance into a more iterative, ongoing-process.

A Closer Look: Challenges and Concerns

While Accreditation 360 is framed as a burden-reduction initiative, the transition itself imposes significant operational demands. Hospitals must undertake comprehensive crosswalk analyses, revise governance documents, retrain staff, and update compliance tracking systems. For smaller facilities, these requirements may strain already limited resources.

Moreover, the reduction in the number of standards may create a false sense of relief. Many of the eliminated standards have been consolidated into broader, more abstract language, which could still encompass the same substantive expectations. This shift risks misinterpretation and may lead organizations to believe certain obligations have been removed, when they are simply embedded in more generalized language.

3. MS.14.01.01, EP 1.
4. Formerly set out under 2025 MS.06.01.09, and MS.05.01.01, respectively.
5. MS.14.02.01, EPs 2-4.
6. MS.14.01.01, EP 8.
7. MS.16.02.01, MS.16.03.01, and MS.20.01.01, respectively.

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The broader, less prescriptive standards also introduce ambiguity in surveyor interpretation. The SPG's integration of CMS guidelines may increase variability in how surveyors assess compliance, undermining predictability and fairness. Hospitals accustomed to preparing for surveys based on detailed checklists may find themselves navigating a more

The shift toward outcome-based certification raises additional concerns. Outcomes are influenced by numerous variables, many of which are outside the control of individual providers or institutions. By de-emphasizing process compliance, Accreditation 360 may inadvertently weaken the regulatory levers that ensure consistent adherence to best practices. Legal counsel should be alert to how these metrics are defined, measured and used in survey findings, particularly in peer review and privileging contexts.

Finally, the consolidation of standards and the introduction of NPGs may shift the locus of control away from medical staff governance bodies. If NPGs are interpreted as overarching mandates, they could supersede locally developed privileging criteria or peer review protocols, raising concerns about erosion of medical staff autonomy.

Looking Ahead

Accreditation 360 represents a significant recalibration of hospital oversight. Its emphasis on transparency, continuous engagement, and outcome orientation aligns with broader trends in healthcare regulation. But as with any systemic overhaul, the devil is in the details, and many of the essential details and standards remain unchanged. So, if you have been reading this with a note of apprehension, now is a good time to take a deep breath and remember that the core tenants of what we do as medical staff professionals remains unchanged. Nevertheless, legal counsel and medical staff governance professionals must approach this transition with a critical eye to ensure that clients understand not only what has changed, but what remains implicitly required.

The Joint Commission has promised a more streamlined, responsive accreditation process. Whether it delivers on that promise will depend not only on the clarity of its standards and the consistency of its surveyors, but also on the ability of hospitals to adapt without compromising the integrity of their compliance frameworks. For now, Accreditation 360 remains a work in progress that demands close attention, rigorous analysis, and strategic foresight.

Stepping Into the Role: A Practical Guide for New Medical Staff Leaders

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Every January, a new group of medical staff leaders begins their term: some bringing years of experience and others stepping into leadership for the first time. Whether you're serving as the chief of staff, a department chair, or a committee head, the transition into medical staff leadership is both an honor and a significant responsibility.

Physicians are highly trained to care for patients, but leading a self governing medical staff requires a distinct set of skills. Hospitals rely on strong medical staff leadership to safeguard quality of care, ensure patient safety, foster collaboration with administration and the governing body, and maintain compliance with regulatory requirements. These roles carry meaningful accountability for the performance and integrity of the medical staff organization. Effective orientation to the leadership role is essential to prepare new leaders with the knowledge, tools, and confidence needed to succeed.

Below are 10 key principles for medical staff leaders, drawn from the foundations of medical staff self governance, regulatory expectations, and best practices in leadership orientation.

1. You are a Leader in a Legally Recognized, Self-Governing Organization

Medical staffs are legally recognized self-governing bodies responsible for the quality of medical care within the hospital. Under the Conditions of Participation for hospitals, CMS requires that every Medicare/Medicaid certified hospital have an organized medical staff that is clearly responsible for the quality of medical care provided to patients. Specifically, 42 C.F.R. § 482.22 states that "the hospital must have an organized medical staff that operates under bylaws approved by the governing body, and which is responsible for the quality of medical care provided to patients by the hospital."

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This means you are not just a volunteer committee member, but rather part of a formally structured governance system with defined authority and obligations.

2. The Medical Staff is Accountable to the Governing Body for Quality

The organized medical staff (through its Medical Executive Committee) oversees quality of care through credentialing, privileging, ongoing evaluation of clinical performance, maintaining standards, conducting peer review and ensuring competent practice. Additionally, the medical staff advises the governing body on clinical care and services throughout the organization, including policy and procedure development and review.

The governing body of the hospital (i.e., board of directors) holds ultimate legal responsibility for patient care, safety and quality. Section 482.12(a) of the CMS regulations requires that the governing body approve the bylaws of the medical staff and ensure the medical staff is accountable to the governing body for the quality of care provided. This creates a symbiotic relationship between the governing body and the medical staff, who must work together to ensure quality in the hospital.

3. Know Your Governing Documents

The legal requirement for bylaws is fundamental. It means the medical staff must govern itself through a written framework that defines how members are appointed, evaluated and disciplined. Your medical staff bylaws, rules, regulations, policies, and related governance documents are your leadership playbook.

They define credentialing requirements, delineate responsibilities, establish committees, outline processes for peer review and corrective action, and describe due process rights. Familiarity with these documents allows you to lead efficiently and confidently, make defensible decisions, and maintain consistency. In other words, when determining how to handle a situation, the first step of your approach should always be to check the bylaws and other governing documents.

4. Credentialing and Privileging are Core Duties

Federal and state law, as well as hospital accreditation standards (such as The Joint Commission standards), require medical staff leaders to thoroughly evaluate practitioner competence, training, judgment, and performance. The medical staff is responsible for examining credentials and recommending appointments. Privileges must be individualized, evidence-based and tied to ongoing performance evaluations (e.g., OPPE/FPPE). When leaders ensure these standards are met, they actively safeguard patients. Leaders must take their responsibility to conduct these processes seriously. The consequences of failing to adequately credential and privilege can include patient harm, litigation, loss of accreditation, and even regulatory penalties.

Signing off on an application without conducting a critical evaluation can lead to the inappropriate appointment of a member. Key to the responsibility of reviewing an application is understanding red flags that require further review and responses from the applicant, such as gaps in work history, previous disciplinary actions, unusual professional liability history, or inconsistent information.

5. Peer Review Must be Effective, Confidential, and Fair

Peer review is a protected, confidential process designed to promote quality improvement. State and federal laws provide immunity protection when peer review is conducted properly. Understanding what is and what is not protected is essential. Leaders must safeguard confidentiality, share information only through established processes, and

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ensure peer review focuses on patient safety, not personality conflicts or anti-competitive motives. Confidentiality is also critical, as breaches can potentially waive legal protection, damage reputations, and chill the candor within committee meetings that is critical to fair and open discussions.

6. Unprofessional Conduct Must be Addressed

Not all difficult behavior is "disruptive," but behavior that undermines teamwork, communication, or patient care must be addressed quickly and consistently. Leaders should apply established codes of conduct, use collegial interventions, and partner with designated committees (including physician well-being committees) to promote remediation of bad behaviors and foster an environment of collegiality.

Medical staff leaders must address unprofessional conduct of medical staff members, regardless of whether the complaint also invokes the participation of a hospital or medical group's human resources department. Work with your legal counsel to understand the options for managing disruptive behavior and when corrective action is necessary.

7. Investigations and Corrective Actions May be Necessary

When concerns arise about a medical staff member's clinical competence or professional conduct, medical staff leaders must follow the steps outlined in their bylaws and policies. These steps often include fact gathering, formal investigations, and implementation of corrective actions proportionate to the risk. Where action is taken that impacts a medical staff member's ability to practice at the hospital (such as a restriction of privileges or recommendation to terminate membership), it must be based on verifiable facts and implemented in a way that protects patients, while respecting the practitioner's rights. Some actions may trigger National Practitioner Data Bank reporting or reports to state licensing boards, which medical staff leaders must be aware of to ensure compliance.

8. Medical Staff Leaders Should Collaborate with Administration and the Governing Body

Effective medical staff leadership is grounded in partnership among the governing body, administration, and the medical staff. Each group contributes distinct expertise and capabilities to foster their mutual goal of providing quality care in a hospital that meets all legal and

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regulatory requirements. Medical staff leaders have the expertise to decipher clinical needs and standards of care that impact patient safety. Administration is responsible for operations, ensuring compliance with billing, and other regulatory requirements, as well as ensuring appropriate staffing and supplies. As the entity who is ultimately responsible for patient safety and quality, the governing body oversees all aspects of operations, financial performance, and quality of care at the hospital. Success depends on cultivating trust, mutual respect, and effective communication. Medical staff leaders who model collaboration, adhere to established processes outlined in the medical staff governing documents, and remain clear about their responsibilities, help to minimize conflict and enhance the hospital's overall performance.

9. Orientation, Education, and Access to Tools are Critical to Success as a Leader

No leader is expected to know everything on day one. New medical staff leaders should be introduced, at minimum, to medical staff governing documents, hospital services, directories, reporting structures, codes of conduct, escalation policies, peer review protections, and administrative teams who support medical staff functions. A structured internal orientation provides context and equips leaders to carry out their responsibilities with clarity and assurance.

Leaders should be given access to governing documents, committee materials, and educational resources, and they should feel comfortable seeking guidance from administrative partners. Access to training in HIPAA, harassment prevention, and diversity are essential components of the role.

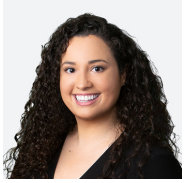
10. Leadership Requires Credibility, Commitment, and Care

Effective leaders demonstrate credibility among their peers, sound judgment, professionalism, and strong communication skills. Leadership requires time, organization and a willingness to learn. Many leaders feel stretched, but support exists. Medical staff professionals, administrative groups, and seasoned leaders can help guide you. Medical staff leadership is a service role, and by embracing education, preparation, and partnership, medical staff leaders can promote safe, high quality, and patient-centered care.

Closing Thought

Preparation for medical staff leadership is more than a single procedural step. It is an ongoing and continuous process that is the cornerstone of an effective leader. Investing in medical staff leadership training will directly benefit the organization. Through structured onboarding, health care organizations equip their leaders to uphold standards, address challenges with confidence, and lead with integrity. The responsibilities are significant, but so too is the opportunity to shape patient care and strengthen organizational culture in lasting ways.

Beyond HR: The Critical Role of Medical Staff Leadership in Physician Misconduct Cases



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When Physician Misconduct Extends Beyond HR

Hannah, an employee who works in the operating room as a surgical technologist, reports that a physician, Dr. Smith, has been making sexually suggestive comments to her during surgical cases and while preparing in the scrub area. On one occasion, while they were positioning equipment prior to a procedure, Dr. Smith stood unnecessarily close to her and placed his hand on the small of her back and "squeezed" or "kind of tickled" Hannah as he moved past her. Hannah is shaken and unsure how to respond, particularly given the high-pressure environment of the operating room and the physician's authority during procedures, but she reports the behavior to her supervisor.

The supervisor forwards the concern to HR because Hannah is a hospital employee, and the conduct clearly relates to inappropriate workplace behavior. Dr. Smith, however, is not simply another worker in the operating room. He is also a privileged member of the medical staff with ongoing access to patients and staff across the organization. Once the report surfaces, it becomes clear that the matter does not fall neatly within HR alone.

Hospitals and other health care entities increasingly face these types of concerns involving allegations of unprofessional conduct or sexual harassment that involve physicians or other health care providers and require a response on multiple fronts. The hospital's HR is responsible for protecting employees and enforcing the hospital's internal policies. The medical staff has an equally important obligation to uphold clinical professionalism, ensure patient safety and maintain the integrity, confidentiality, and fairness of the peer review process. Meanwhile, an affiliated medical group or foundation may have their own HR and internal procedures for handling matters that involve their employees.

The responsibilities often operate in parallel and each carry legal and regulatory implications. Understanding the role of the medical staff in addressing unprofessional behavior by privileged practitioners is essential to fulfilling the medical staff's obligations as a self-governing body to ensure patient safety. Equally important is considering the hospital's obligation to protect employees and others who come to the hospital from harm.

Professionalism as a Core Competency in Modern Healthcare

Leaders of hospitals and their medical staffs are expected to treat professionalism as a core competency, a standard reinforced by the ACGME, The Joint Commission, and the Conditions of Participation issued by CMS.[1] Professionalism encompasses integrity, respect, accountability, and compassion. Medical staffs are expected to define acceptable and unacceptable conduct within their medical staff bylaws and

1. Accreditation Council for Graduate Medical Education, ACGME Common Program Requirements (Residency) (Sept. 3, 2025), **https://www.acgme.org/globalassets/pfassets/programrequirements/2025-reformatted-requirements/cprresidency_2025_reformatted.pdf**; The Joint Commission, Sentinel Event Alert No. 40: Behaviors That Undermine a Culture of Safety (July 9, 2008; updated June 2021), **https://www.jointcommission.org/en-us/knowledge-library/newsletters/sentinel-event-alert/issue-40**.

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code of conduct so that leaders can intervene consistently when concerns arise.[2] Unprofessional behavior can take many forms, including disruptive interactions, hostile remarks, confidentiality violations, and boundary lapses.

Each of these behaviors, (whether directed at patients, members of the health care team, or others in the hospital) can contribute to a decline in teamwork, patient trust, and clinical quality.[3] Disruptive behavior can contribute to adverse events and malpractice exposure. Persistent tolerance of unprofessional behavior can also damage morale and increase turnover. It can also harm the hospital's reputation within the community. Addressing these concerns promptly is important, not only for compliance, but also for maintaining a safe, stable, and trustworthy care environment.

Unique Risks of Sexual Harassment in Clinical Environments

Sexual harassment presents unique risks in health care settings. Clinical environments require close physical proximity, overnight work, and hierarchical relationships — all of which can make it more difficult for staff to report concerns and create opportunities for individuals to misuse their authority. Generally, employers are legally responsible for protecting employees from harassment by non-employees, including privileged physicians, when the employer knows or should know about the behavior and does not take prompt action.[4] This standard is significant because it places a responsibility on the hospital to intervene, even when the physician is not on the hospital's payroll. In other words, once Hannah reports Dr. Smith's conduct, the hospital's legal obligation to protect her and other employees is activated.

Overlapping Roles

In navigating these types of complaints, consideration must be given to the status of the complainant. For example, the complainant could be an employee with health care responsibilities, such as Hannah, the surgical technologist, or another person working in the hospital, such as a hospital café worker. In some scenarios, the complainant could be a member of the medical staff, such as a physician who is also an employee or contractor of the hospital or an affiliated medical group or foundation.

Of course, consideration must also be given to the membership of the individual engaged in the alleged unprofessional behavior, who could be a member of one or more types of groups. A member of the medical staff could also be an employee of the hospital or an affiliated or independent medical group. They could also hold a professional service agreement to provide call coverage or to serve as a medical director. A report to one entity could trigger the involvement of one or more of the others, depending on the overlapping relationship among them. Each of these entities could have their own unique professional standards and process for handling complaints.

The Employer's Responsibilities Under Employment Law

In many circumstances, HR for a hospital must initiate its own workplace investigation by documenting the facts and conducting appropriate interviews. HR's responsibility is to protect the employee and to enforce internal policies, as well as state and federal laws governing workplace harassment.[5] HR may need to offer interim support to Hannah or consider workplace modifications that protect her from further contact. Depending on whether Dr. Smith is an employed physician, HR may also consider disciplinary measures, up to and including termination of employment.

2. The Joint Commission, Leadership Standard LD.03.01.01, **https://docslib.org/doc/13748282/the-joint-commission-leadership-chapter**.
3. The Joint Commission, Sentinel Event Alert No. 40: Behaviors That Undermine a Culture of Safety (July 9, 2008; updated June 2021), **https://www.jointcommission.org/en-us/knowledge-library/newsletters/sentinel-event-alert/issue-40.**
4. U.S. Equal Emp. Opportunity Comm'n, Enforcement Guidance on Harassment in the Workplace (Apr. 29, 2024) (vacated in part May 15, 2025), **https://www.eeoc.gov/laws/guidance/enforcement-guidance-harassment-workplace** U.S. Equal Emp. Opportunity Comm'n, Harassment, **https://www.eeoc.gov/harassment**; U.S. Dep't of Labor, Harassment, **https://beta.dol.gov/policy-regulations/protections-rights/nondiscrimination/harassment**.
5. U.S. Equal Emp. Opportunity Comm'n, Enforcement Guidance on Harassment in the Workplace (Apr. 29, 2024) (vacated in part May 15, 2025), **https://www.eeoc.gov/laws/guidance/enforcement-guidance-harassment-workplace**.

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Medical Staff's Independent Duties Under Bylaws and Peer Review Laws

The hospital's duty, however, does not end with HR. Unprofessional behavior by a privileged physician also implicates the medical staff's own responsibilities under the medical staff bylaws and peer review framework.[6] Even conduct that occurs outside a clinical setting can reveal lapses in judgment or respect that may affect patient care or staff safety. Medical staff leaders cannot wait for HR to complete its investigation because their role is fundamentally tied to patient safety and the integrity of clinical practice. When concerns arise, they must determine whether the behavior violates the medical staff bylaws or the code of conduct, which is required to include clear expectations for respectful and ethical behavior.

Tools for Addressing Unprofessional Conduct Within the Medical Staff Process

Medical staffs have a range of tools available for responding to professionalism concerns. Some situations call for early, informal interventions, such as a "cup of coffee conversation" that brings attention to a concerning behavior, encourages reflection, and reinforces expectations.[7] Even informal discussions should be documented in the peer review file so that patterns can be identified over time. More structured interventions may involve mentoring, leadership check-ins or formal coaching plans. These approaches acknowledge that patterns often emerge gradually and that some physicians benefit from support in identifying and modifying problematic behavior. When concerns are more serious, or when prior interventions have not been effective, medical staff leaders may refer the matter to a committee for further evaluation or investigation, issue formal letters of warning or reprimand, or require participation in remediation programs that focus on professional boundaries, cultural competency, or communication.

Responding to Sexual Misconduct: When Immediate Action Is Required

For allegations involving sexual misconduct or significant boundary violations, medical staff leaders may need to move more quickly and coordinate with risk management and legal counsel. This may include a structured process that includes leadership interviews, clear communication to the practitioner that the behavior must stop, formal documentation, and a referral to the Medical Executive Committee if the concern is not resolved or if a validated complaint involves egregious conduct. Depending on the severity of the allegations and the risk to patients or staff, the medical staff may need to impose temporary restrictions or consider summary suspension while an investigation proceeds.[8] These steps help ensure the safety of patients and employees while the facts are evaluated.

Mandatory Reporting Considerations

Hospitals must also consider whether the conduct triggers mandatory reporting obligations. State medical boards often require reporting when a physician engages in conduct involving sexual misconduct, boundary violations, or actions that suggest a risk to patient safety.[9] Some situations require notification of law enforcement, state licensing agencies or professional licensing boards, particularly when minors or elderly individuals are involved. In some states, even allegations made by a patient of sexual abuse or misconduct (whether validated or not) require prompt reporting to the state practitioner licensing board of

6. 42 C.F.R. §§ 482.12, 482.22.; Tex. Occ. Code § 160.007.
7. The Joint Commission, Sentinel Event Alert No. 40: Behaviors That Undermine a Culture of Safety (July 9, 2008; updated June 2021), **https://www.jointcommission.org/en-us/knowledge-library/newsletters/sentinel-event-alert/issue-40/**.
8. Am. Med. Ass'n, Code of Medical Ethics Opinion 9.1.3: Sexual Harassment in the Practice of Medicine (2022), **https://code-medical-ethics.ama-assn.org/ethics-opinions/sexual-harassment-practice-medicine**; Fed'n of State Med. Boards, Report of the Workgroup on Physician Sexual Misconduct (May 2020),
9. Fed'n of State Med. Boards, Report of the Workgroup on Physician Sexual Misconduct (May 2020), **https://www.fsmb.org/siteassets/advocacy/policies/report-of-workgroup-on-sexual-misconduct-adopted-version.pdf**; Texas Occ. Code §160.002.

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the individual who allegedly engaged in the conduct.[10] Reporting responsibilities also arise when certain medical staff decisions limit a physician's ability to practice. For example, a summary suspension or restriction of privileges for professional competency or conduct lasting for more than 30 days are reportable to the National Practitioner Data Bank.[11] These reporting requirements often involve strict timelines, and failing to report when required can expose the hospital to regulatory scrutiny and monetary fines.

Consulting legal counsel early in the process helps ensure that the organization meets its obligations.

Impact on Credentialing, OPPE, and FPPE

Professionalism concerns also influence credentialing. The medical staff's OPPE and FPPE processes are designed to identify patterns of behavior that may affect a physician's competence or conduct.[12] Findings from professionalism investigations, especially if repeated or substantial, may lead to focused evaluations or affect reappointment decisions.[13] Incorporating outcomes into ongoing evaluations ensures that leaders recognize patterns, hold physicians accountable over time, and make defensible decisions about membership and privileges.

A Framework for Coordinated Response

Leaders benefit from a simple and consistent approach when concerns arise. The first step is to listen and ensure immediate safety. The next is to separate the processes so that HR and medical staff leaders can each carry out their responsibilities without compromising each other's work. Leaders should determine whether temporary safeguards are necessary and should document all steps in the appropriate record. When the physician holds privileges, HR and medical staff leaders may need to remain in communication about risk management considerations while preserving confidentiality. While some overlap between HR and medical staff procedures may be logistically desirable or even necessary, policies should be developed to guide any coordinated investigation process and to delineate appropriate boundaries and protections regarding confidential peer review.

10. Cal. Bus. & Prof. Code § 805.8.
11. Nat'l Practitioner Data Bank, What You Must Report to the NPDB, **https://www.npdb.hrsa.gov/hcorg/whatYouMustReportToTheDataBank.jsp**;
45 C.F.R. Part 60; Nat'l Practitioner Data Bank, NPDB Guidebook, Ch. E: Reporting Adverse Clinical Privileges Actions, **https://www.npdb.hrsa.gov/guidebook/EClinicalPrivileges.jsp**.
12. The Joint Commission, Standards FAQ: Ongoing Professional Practice Evaluation (OPPE) (Jan. 7, 2026), **https://www.jointcommission.org/en-us/knowledge-library/support-center/standards-interpretation/standards-faqs/000001500**.
13. *Id.*

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Maintaining Confidentiality and Protecting Peer Review Protections

Throughout the process, the medical staff must take care to preserve the protections afforded to peer review information and documents under the relevant state law. Peer review protections guard the medical staff's internal evaluations and deliberations. To maintain this protection, it is essential that peer review information remain within the appropriate channels.[14] HR files do not share this protection and are routinely subject to discovery in litigation. If peer review content is provided to HR or appears in HR documentation, the protections may be compromised.[15]

Prevention Through Culture, Training, and Early Intervention

Early intervention and consistent policy enforcement support a culture where employees and medical staff members feel safe and respected. Hospitals and medical staffs that emphasize professionalism communicate expectations clearly and provide meaningful training are more likely to address concerns early.[16] Reporting channels that protect those who speak up, paired with timely and consistent follow-through when concerns arise, help create an environment where unprofessional behavior is addressed promptly.

Conclusion: Why Coordinated Leadership Matters

Hannah's scenario illustrates that sexual misconduct allegations involving physicians are not just HR's responsibility. They trigger institutional duties tied to employment law, medical staff governance, patient safety, and peer review protections. Responding with clarity and coordination protects employees, supports patients, and ensures fairness to physicians. It also strengthens the culture of professionalism that is essential for high-quality care. When HR and medical staff leadership understand their roles, maintain the boundaries between their processes, and communicate thoughtfully, the hospital is better positioned to navigate these difficult situations with integrity and effectiveness.

14. Tex. Occ. Code §160.007.
15. *In re Christus Santa Rosa Healthcare Corp.*, 617 S.W.3d 586 (Tex. App.—San Antonio 2020, no pet.)
16. Am. Med. Ass'n, Code of Medical Ethics Opinion 9.1.3: Sexual Harassment in the Practice of Medicine (2022), **https://code-medical-ethics.ama-assn.org/ethics-opinions/sexual-harassment-practice-medicine**.

NPDB Reports: Voiding Is the Exception, Not the Rule

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In July 2025, the U.S. Court of Appeals for the Fourth Circuit issued an unpublished but important decision affirming enforcement of a settlement agreement arising from a peer-review dispute. Although the appeal focused primarily on the enforceability of a settlement between the physician and the hospital, the opinion offers a useful reminder for hospitals, practitioners, medical staffs, and credentialing leaders about National Practitioner Data Bank (NPDB) reports. The opinion reinforces practical guidance on the limited pathways for NPDB report removal and the importance of precision in negotiations related to settlement agreements, communications, and medical staff processes. Unless a narrow regulatory exception applies, an NPDB report that was properly submitted must remain in the NPDB, even amid litigation pressure.

The Incident that Triggered Peer Review and the Mandatory Reporting that Followed

The underlying case began with a patient-safety incident involving Dr. Roland Chalifoux, Plaintiff-Appellant, who had long held clinical privileges specializing in interventional pain management at Wetzel County Hospital, Defendant-Appellee.[1] In June 2022, a nurse filed a complaint against Dr. Chalifoux after witnessing a patient's exclamations of pain during a procedure.[2] The hospital's Medical Executive Committee (MEC) initiated an investigation, imposed a summary suspension and, following a full hearing with counsel and witness testimony, recommended terminating Dr. Chalifoux's privileges.[3] The hospital's board of directors upheld that decision after independent review, and since the termination of privileges exceeded 30 days, the Health Care Quality Improvement Act (HCQIA) required the hospital to report the action to the NPDB.[4] Dr. Chalifoux disputed the NPDB report and submitted his subject statement to the NPDB report the hospital made after revoking his privileges.[5] The hospital also reported Dr. Chalifoux to the West Virginia Board of Osteopathic Medicine (WVBOM), which in turn initiated a licensing complaint against him.[6] However, the complaint was later dismissed, though that outcome did not affect the hospital's peer review action or its NPDB reporting obligations.[7]

The Dispute Shifts to Federal Court, then Mediation Produces a Disputed Settlement

In December 2022, Dr. Chalifoux sued the hospital, alleging that the hospital violated the Sherman Antitrust Act; breached its bylaws and denied him due process; defamed him by reporting him to the NPDB and WVBOM; and tortiously interfered with his contractual relationships with health insurance providers.[8] After months of motion practice, the parties paused litigation and attempted mediation, which opened the door to settlement discussions that would later become the focus of the appeal.[9]

During mediation, the parties reached an agreement on non-economic settlement terms and also exchanged bracketed

1. Chalifoux v. Wetzel Cty. Hosp., No. 24-1108, 2025 WL 1879597, at *1 (4th Cir. Jul. 8, 2025).
2. *Id.*
3. *Id.*
4. *Id.* at *1-2.
5. *Id.* at 2.
6. *Id.*
7. *Id*
8. *Id*
9. *Id.*.

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monetary offers.[10] Towards the end of mediation, Dr. Chalifoux's attorney proposed a bracketed offer of $200,000 to $400,000 before the parties departed for the day.[11] A month later, counsel for both parties exchanged emails, with Dr. Chalifoux's attorney confirming he had authority to settle at a $300,000 midpoint, which the hospital accepted.[12] After acceptance, however, Dr. Chalifoux refused to sign the settlement agreement, alleging there was no meeting of the minds and the bracketed offer of $200,000 to $400,000 had been withdrawn.[13] Critically for the MEC, Dr. Chalifoux also insisted that voiding the NPDB report was a required condition of the settlement agreement.[14]

The hospital moved to enforce the settlement. The district court found that a binding settlement[15] existed and that counsel had apparent authority to accept it.[16] The court also rejected the argument that the NPDB report could or should be voided.[17] The court concluded that withdrawing the NPDB report was legally impermissible because none of the regulatory criteria for voiding a report were met because the hospital's termination of privileges was reportable, had lasted more than 30 days, and had not been overturned.[18]

The NPDB Issue Takes Center Stage on Appeal

One of Dr. Chalifoux's arguments on appeal was that the settlement agreement was invalid because the hospital refused to withdraw the NPDB report.[19] He further contended that the district court erred by concluding that voiding the NPDB report was "legally impossible," alleging that the court possessed equitable power to require the hospital to do so.[20] The Fourth Circuit disagreed.

The Fourth Circuit's Framing: Not About Equity, but Federal Limits

The Fourth Circuit began by clarifying what the district court actually decided. The lower court did not hold that it lacked equitable authority in the abstract.[21] Instead, it concluded that HCQIA and its implementing regulations strictly limit when an NPDB report may be voided, and that those limits controlled the outcome.[22] This distinction mattered. The appellate court emphasized that even broad equitable powers do not permit courts — or even hospitals, for that matter — to do what HCQIA expressly prohibits.[23] The question was not whether withdrawal might be fair or desirable, but whether withdrawal was legally permissible at all.

10 *Id.* at 3.
11. *Id.*
12. *Id.*
13. *Id.*
14. *Id.*
15. *Id.*
16. *Id.*
17. *Id.*
18. *Id.*
19. *Id.* at 4.
20. *Id.*
21. *Id.* at 8.
22. *Id.*
23. *Id.*

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The Regulatory Framework: When NPDB Reports May be Voided and When They May Not

The Fourth Circuit then turned to the governing rules. The court drew on federal regulations and the NPDB Guidebook[24]
The Fourth Circuit agreed with the district court and identified only three circumstances under which a reporting entity may void a NPDB report:

1. The report was submitted in error;
2. The underlying action was not reportable; or
3. The professional review action was overturned on appeal.[25]

The court explained that although the NPDB Guidebook is neither a statute nor a regulation, it appears to "accurately represent circumstances under which a report can be altered or removed from the data bank."[26] The court also placed special emphasis on the dangers of allowing NPDB withdrawal to become a settlement tool. The court noted that permitting hospitals to rescind valid reports "for any reason, at any time" would fundamentally undermine the NPDB's national function. The court underscored that HCQIA was enacted precisely because, before the NPDB existed, physicians with competence issues could relocate without meaningful disclosure.[27]

Allowing private settlements to erase properly filed reports would recreate the very problem Congress sought to eliminate. In short, settlement pressure does not create legal authority. A hospital cannot bargain away a federal reporting obligation, and a court cannot enforce a settlement term that would require a hospital to violate HCQIA.

Conclusion

For hospitals and medical staffs, *Chalifoux* confirms that NPDB reporting is a regulatory obligation, not a discretionary act. Accordingly, hospitals and medical staffs cannot later "fix" a report simply because a case becomes inconvenient or contentious. *Chalifoux* also reinforces the importance of resisting informal assurances that suggest NPDB outcomes are negotiable. As this case demonstrates, such assurances are legally unsustainable and may ultimately prolong litigation rather than resolve it.

Key Take-Aways from *Chalifoux*

01 NPDB reports may be voided only if submitted in error, if the action was not reportable or if the action is overturned on appeal, as dictated by HCQIA and explained in the NPDB Guidebook.

02 Settlement agreements cannot lawfully require withdrawal of a valid NPDB report.

03 Courts will not enforce settlement terms that conflict with HCQIA and its implementing regulations.

04 Medical staff leaders should treat NPDB reporting as a fixed federal duty, not a negotiable consequence of peer review.

24. The web-based version of NPDB Guidebook E-8 (2018) is available at https://www.npdb.hrsa.gov/resources/aboutGuidebooks.jsp (last visited Dec. 28, 2025).
25. *Chalifoux*, at *8.
26. *Id.*
27. *Chalifoux*, at *8, n. 2.

Welcome to the Med-Staff Newsletter's new recurring feature: **"Dear Polsinelli Med-Staff Team."** This recurring column uses fictional hypotheticals to highlight National Practitioner Data Bank (NPDB) guidance relevant to common medical staff and reporting issues. The scenarios are not legal advice, and readers are encouraged to consult legal counsel regarding specific NPDB reporting obligations.

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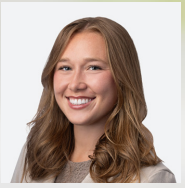

Shea A. Robinson
Associate
Phoenix

Factual Errors in NPDB Reports

Dear Polsinelli Med-Staff Team,

I am writing on behalf of my Hospital's Medical Staff Office for guidance on an NPDB report that has become unexpectedly complicated.

Recently, one of our physicians, Dr. A, resigned while the Medical Executive Committee was investigating concerns that Dr. A improperly accessed controlled substances. Our Medical Staff Office submitted an initial Adverse Action Report to the NPDB regarding Dr. A's resignation while under investigation, and we provided details in the narrative about the concerns being investigated and the status of the investigation at the time Dr. A resigned.

However, shortly after the report was filed, our team realized that a portion of the narrative was incorrect. Specifically, we stated that Dr. A failed a drug test prior to resigning. However, we were recently informed Dr. A did not undergo drug testing prior to resigning. As a result, it is not true that Dr. A failed a drug test at the hospital.

We want to fix our mistake, but we're unsure of how to do so and the proper NPDB process.

Should we submit a revision to action report? Void it entirely and submit a new initial report? Or correct it?

Sincerely,

Confused but Trying to Comply

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Dear Confused but Trying to Comply:

Fortunately, the NPDB recognizes that under certain circumstances, reports need to be updated and provides clear guidance on when a report should be revised, voided, or corrected. The NPDB has four different types of reports: Initial, Correction, Revision-to-Action, and Void. As the Initial Report is already on file here, the guidance below focuses on the latter three.

1. Should a Revision-to-Action Report Be Used?

The NPDB Guidebook notes "[a] Revision-to-Action Report is used to submit an action that relates to and/or modifies an adverse action previously reported to the NPDB… it does not negate the original action."[1]

This distinction is explained in Q&A No. 4 regarding "Submitting Reports," which provides, in part:

A Revision-to-Action Report is treated as a second and separate action by the NPDB, but it does not negate the original action that was taken. For example, if an entity subsequently changed the penalty it imposed, or if it reconsidered the grounds on which it took an action, but the original report correctly described the penalty or grounds at the time the original report was filed, then a Revision-to-Action Report, not a Correction Report, should be filed.[2]

The NPDB Help Center for Health Care Professionals FAQs also explains that a Revision-to-Action Report does not replace the preceding report(s). Rather, it becomes a part of the disclosable record.

Examples of when a Revision-to-Action Report should be submitted include:

- When the length of action is extended or reduced
- When clinical privileges are reinstated
- When the original suspension or probationary period ends.[3]

Importantly, the NPDB system will not accept a Revision-to-Action Report unless a related report has already been submitted.[4]

2. When Should a Report Be "Voided," and What Happens to the Void Report?

The NPDB Guidebook makes clear that "Voiding" a report is only appropriate in three circumstances:

- The report was submitted in error
- The action was not reportable because it did not meet NPDB reporting requirements
- The action was overturned on appeal.[5]

When the NPDB processes a Void Report, it provides the reporting entity with a Report Void Confirmation. The NPDB also sends a notification to the subject of the report and to all queriers who received the prior version of the report within the past three years. Those queriers are instructed to destroy the voided report and any copies in their possession. The reporting entity and the subject of the report should review the information to ensure that the intended report was voided, and past queriers should note that the report was voided.[6]

3. Does the NPDB Allow a Report to Be "Corrected," and What Happens to the Report that Needed to be Corrected?

Yes. The Guidebook states: "[a] Correction Report corrects an error or omission in a previously submitted report by replacing it. The reporting

1. **NPDB Guidebook, Chapter E; Page 95 in the PDF.**
2. **NPDB Guidebook, Chapter E; Page 95 in the PDF.**
3. **NPDB Help Center FAQs.**
4. **NPDB Guidebook, Chapter E; Page 86 in the PDF.**
5. **NPDB Guidebook, Chapter E; Page 88 in the PDF.**
6. **NPDB Guidebook, Chapter E; Page 93 in the PDF.** Fun fact: Per the January 2021 edition of NPDB Insights, expungement of a public record does not overturn a report held in the NPDB and an expungement is not a reason to void an NPDB report. **NPDB Insights (JAN21): Dear NPDB.**

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entity must submit a Correction Report as soon as possible after the discovery of an error or omission in a report."[7] The Guidebook also notes that "[a] Correction Report negates and replaces the current version of a report."[8]

The NPDB Help Center for Health Care Professionals FAQs further clarifies that a Correction Report can fix an error or omission in either an Initial or Revision-to-Action Report and that a reporting entity may submit additional Correction Reports as necessary.[9]

Example:

A hospital reports a clinical privileges action to the NPDB, generating an Initial Report. Later, the hospital identifies an error in the practitioner's address. The hospital submits a Correction Report with the corrected address. The Correction Report replaces the Initial Report.[10]

When the NPDB processes a Correction Report, the NPDB provides the reporting entity with a copy of the Correction Report. The NPDB also sends a notification to the subject of the report and a copy to all queriers who received the previous version of the report within the past three years. The reporting entity and the subject of the report should review the report information to ensure that it is accurate, and past queriers should note the changed report. For certain types of actions, reporters must provide a copy of the processed report to the appropriate state licensing board or state licensing or certification authority.[11]

4. Does the NPDB Provide Guidance or Examples of When a Revision-to-Action Report Should be Used Versus a Correction Report?

Yes. Q&A No. 4 regarding "Submitting Reports" provides, in part:

A Revision-to-Action Report is separate and distinct from a Correction Report. For example, if a hospital enters the date of action incorrectly on an Initial Report, a Correction Report must be submitted to make the necessary change to the date, and the Correction Report replaces the Initial Report. However, if the hospital reports an initial action to the NPDB to suspend a physician's clinical privileges for 60 days and subsequently reinstates the physician's privileges after reducing the suspension to 45 days, the hospital must submit a Revision-to-Action Report regarding the reinstatement. A Revision-to-Action Report is treated as an addendum to the Initial Report. Together, the Initial Report and the Revision-to-Action Report provide a more complete explanation of the events.[12]

Conclusion

The NPDB provides clear mechanisms for updating reports, but each serves a distinct purpose. Understanding these distinctions ensures that entities maintain accurate NPDB records and remain compliant with reporting obligations.

In summary, a Revision-to-Action Report is appropriate when the underlying adverse action has been modified, while a Correction Report is required when the original report contains an error or omission and must be replaced. Voiding a report is permitted only when it was submitted in error, was not reportable, or was overturned on appeal. Importantly, the NPDB will not void reports outside of the Dispute Resolution process.[13] Regardless of the mechanism used, reports remain in the NPDB indefinitely unless the reporting entity corrects or voids them.[14]

So, we ask you: what should Confused but Trying to Comply do to correct the factual error in the NPDB report regarding Dr. A?

7. **NPDB Guidebook, Chapter E; Page 87 in the PDF.**
8. **NPDB Guidebook, Chapter E; Page 95 in the PDF.**
9. **NPDB Check Your Report - Correction Report.**
10. **NPDB Check Your Report - Correction Report.**
11. **NPDB Guidebook, Chapter E; Page 87 in the PDF.**
12. **NPDB Guidebook, Chapter E; Page 89 of the PDF.**
13. **NPDB Insights (SEP22): Dear NPDB.**
14. **NPDB Insights (SEP22): Dear NPDB.**

In Memoriam

John Synowicki

We honor the life and legacy of our colleague, John Synowicki. John was a shareholder in Polsinelli's Dallas office and an experienced health care litigator.

He advised hospitals and health systems nationwide regarding peer review, credentialing, and operational matters. John routinely advised on complex issues that require robust problem-solving solutions and creative approaches to facilitate client needs. He represented clients through the fair hearing process, in state and federal litigation, and in arbitration when disputes escalated.

John joined Polsinelli in 2015 and was a highly respected shareholder in the Health Care Litigation Practice in our Dallas office. He was widely recognized for his deep experience with health care law and his thoughtful, steady counsel to clients nationwide. John frequently wrote and lectured on a broad range of health law topics, including credentialing, peer review, compliance, provider mental health and well-being, risk management, and the medical staff fair hearing process. He was an active member of the National Association of Medical Staff Services (NAMSS) and served on its Ethics Committee, reflecting his deep commitment to ethics, professionalism and the health care community.

John was the kind of colleague who made those around him feel steadier and more confident, even in the most complex or high-pressure situations. Calm, thoughtful, and reassuring, he had a gift for helping others see a path forward. His warmth and humor lightened even the most stressful moments, and his down-to-earth approach made him a trusted presence for colleagues and clients alike.

Beyond his legal skill, John brought humanity to his work, particularly in matters involving guardianship and end-of-life issues, where his compassion and clarity helped guide clients and families through some of life's most difficult moments. A gifted teacher and mentor, he loved sharing his knowledge, whether presenting to medical professionals or working through challenges side by side with colleagues.

He will be remembered not only as an exceptional lawyer, but also as a mentor, colleague, and friend whose impact will be felt for years to come.

Upcoming Events

Join Polsinelli for our five-part 2026 Medical Staff virtual conference. Click here to register.

FRIDAY, FEBRUARY 20TH

- 2026 Washington Update: Congress, the Executive and Judicial Branches
- AI Tools in Health Care: Promise and Pitfalls

FRIDAY, FEBRUARY 27TH

- Hiding in Plain Sight: When Culture Endangers Care
- Government Enforcement and the Medical Staff: How to Help Your Organization Prevent Health Care Fraud

FRIDAY, MARCH 6TH

- Medical Residents and the Medical Staff: Key Touchpoints in Teaching Hospitals
- The Future of Medical Leadership: What Accreditation 360 Means for You

FRIDAY, MARCH 13TH

- **California CLE Session:** From Governance to Credentialing: Tackling Today's Top Health Care Legal Challenges for California Medical Staffs
- **Texas CLE Session:** Discussion of the new 15-day reporting requirement for physician suspensions and restrictions, navigating DNR documentation rules, distinguishing between peer review vs. medical committee privileges to protect confidentiality, and the new DOCTOR Act.

2026 Reimbursement Summit | Nashville
Email **smcguire@polsinelli.com** for more details

THURSDAY, APRIL 16TH

Healthcare Dealmakers Conference | Dallas
Register **here**

WEDNESDAY, MAY 13TH & THURSDAY, MAY 14TH

About Polsinelli's Medical Staff Practice

Polsinelli's Health Care attorneys guide hospitals and health systems through the medical staff governance process including credentialing, peer review, bylaws and medical staff and governing body relationships. From practitioner credentialing to hearings and appeals, and defense of litigation, our attorneys are versed in the intricacies involved in the life cycle of hospital-medical staff relationships.

Polsinelli has handled almost every type of matter involving medical staff and mid-level practitioners and has advised client on compliance with accreditation standards, hospital licensing laws, peer review laws, and federal laws governing the conduct of medical staff fair hearings. Specifically, we have extensive experience counseling hospitals on medical staff bylaws and related rules, regulations, policies and procedures, and codes of conduct. We have been active helping clients in implementing processes for effectively managing disruptive and inappropriate behaviors and in developing processes for empowering the well-being committee and managing impaired and aging providers.

Our team has experience advising through the credentialing process, advising peer review committees, representing medical executive committees in hearings and appeals, and interfacing with government entities. We also have defended hospitals and surgical centers in lawsuits filed by affected practitioners, during and after peer review.

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