Physician's Guide to Medical Staff Organization Bylaws

Fourth Edition

Office of General Counsel
Organized Medical Staff Services

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Preface

With increased emphasis on efficiency, economy and improved outcomes in the delivery of health care, the American Medical Association (AMA) believes it is essential to maintain the function of an organized, self-governing medical staff to ensure that the medical staff is able to discharge its patient care responsibly, effectively and efficiently. AMA policy, as outlined in its "Principles for Strengthening the Physician-Hospital Relationship," reinforces and speaks to the importance of self-governance and the nature of the medical staff's relationship to the governing body of the health care organization. The governance structure and functions of the medical staff are defined in its bylaws. These bylaws constitute a contract between the governing body and the medical staff, so it is essential that the bylaws include provisions that ensure medical staff involvement in the medical decision-making of hospitals, integrated delivery systems, or health plans. Bylaws typically include provisions related to self-governance, credentialing, due process, corrective action, and quality assessment and improvement; however, as health care continues to undergo profound changes with greater emphasis on socioeconomic issues and medical administrative functions, medical staff bylaws must broaden their focus to address these issues.

The AMA developed this fourth edition of the *Physician's Guide to Medical Staff Organization Bylaws* as a reference manual for medical staffs in drafting or amending bylaws. It also serves as a resource for those emerging issues in health care that impact the medical staff. It provides bylaws language that supports self-governance. This book also includes many bylaws issues that remain relatively constant.

The guide is not a model bylaws document. It provides links and citations to laws and regulations, accreditation body standards, case law and relevant AMA policy. It is not intended as legal advice. Rather, it presents information that can be used to develop bylaws or to update provisions that reflect the changes in health care delivery. The guide enumerates all the important elements that should be contained in any medical staff bylaws, but ultimately bylaws must be tailored to suit the needs and legal environment of particular medical staffs.

The law governing the relationship between the medical staff and the hospitals is constantly evolving. As a result, this document may not remain up to date in all respects. The reader is encouraged to consult with competent legal counsel to ensure that current law is being considered.

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Introduction

Introduction

Physicians have long regarded the role of patient advocate and the primacy of the patient-physician relationship as essential tenets of the medical profession. In recent years, these principles have been challenged by the many changes in health care delivery. Growing market competition and the consolidation of medical services have heightened efforts by health care systems and health plans to reduce costs and to tightly control the delivery of health care. One strategy to accomplish this objective is to diminish or minimize physician decision-making responsibilities, leaving the decision-making to hospital administration. This erodes the self-governing medical staff and undermines its authority. Few realize that weakening or eliminating the medical staff structure puts patients at risk for inappropriate and inadequate care.

To maintain professionalism and to safeguard patient interests, physicians must be proactive and guard against cost containment pressures that interfere with and compromise patient care. Properly drafted medical staff bylaws empower physicians. Bylaws serve as a framework for self-governance and for the regulation of processes for assuring the delivery of quality and consistent medical care. They also establish the rights, duties and responsibilities of the medical staff organization and each of its members and define the medical staff's relationship with the hospital's governing body and administration or other health care entities.

Medical Staff Reengineering

In today's health care environment, employers, managed care organizations and third-party payors are demanding two things: more efficient health care systems, and proof that their expenditures are improving patient outcomes. In addition, the public wants better information upon which to base its health care choices. To meet these needs, hospitals and other health care entities have become more competitive and are "reengineering" to improve operations. Reengineering has been defined as fundamental rethinking and radical redesign of business and operational processes to achieve improvements in quality, service and efficiency.

Physicians are also looking at ways to deliver care more efficiently. As physicians strive for efficiency and improved patient outcomes, the medical staff must examine its organizational structure and processes to ensure that they facilitate safe and efficient mechanisms to assess and deliver patient care. The goal of medical staff reengineering should be to eliminate, restructure or replace those activities and functions that do not contribute to quality improvement or patient safety. Change that improves the effectiveness of the medical staff is critical to protect patients. It is also essential that the medical staff's core principles of self-governance are maintained to preserve the physician's patient advocacy role.

Unfortunately, medical staffs often are not actively involved in reengineering. Instead, hospital administrators rely on consultants and medical staff leadership seminars to introduce the design or model with compelling arguments for restructuring the medical staff. These consultants typically propose structural changes that reduce the number of clinical departments and committees. While such reductions can significantly lessen administrative expenses and time spent in medical staff meetings, they also may eliminate or diminish medical staff responsibility for departmental and medical staff operation and function. The medical staff, therefore, must take an active role to ensure that reengineering results in a strengthening of its performance improvement processes, including credentialing, privileging, peer review, and development of critical patient care policies and guidelines.

Reengineering should strengthen the medical staff's autonomy and authority to advocate for patients and to improve the quality of and access to patient care. Well designed and written bylaws can accomplish this.

AMA Principles for Strengthening the Physician-Hospital Relationship

In November 2007, the American Medical Association (AMA) Organized Medical Staff Section (OMSS) developed, adopted and recommended to the AMA House of Delegates 12 detailed principles on strengthening the physician-hospital relationship that were adopted as AMA policy. The principles are aimed at protecting medical staff self-governance and improving health care quality and patient safety.

The Principles are as follows:

1. The organized medical staff and the hospital governing body are responsible for the provision of quality care, providing a safe environment for patients, staff and visitors, and working continuously to improve patient care and outcomes, with the primary responsibility for the quality of care rendered and for patient safety vested with the organized medical staff.

These activities depend on mutual accountability, interdependence, and responsibility of the organized medical staff and the hospital governing body for the proper performance of their respective obligations.

2. The organized medical staff, a self-governing organization of professionals, possessing special expertise, knowledge and training, discharges certain inherent professional responsibilities by virtue of its authority to regulate the professional practice and standards of its members, and assumes primary responsibility for many functions, including but not limited to: the determination of organized medical staff membership; performance of credentialing, privileging and other peer review; and timely oversight of clinical quality and patient safety.

3. The leaders of the organized medical staff, with input from the hospital governing body and senior hospital mangers, develop goals to address the health care needs of the community and are involved in hospital strategic planning as described in the medical staff bylaws.

4. Ongoing, timely and effective communication, by and between the hospital governing body and the organized medical staff, is critical to a constructive working relationship between the organized medical staff and the hospital governing body.

5. The organized medical staff bylaws are a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body. The organized medical staff and hospital bylaws, rules and regulations should be aligned, current with all applicable law and accreditation body requirements and not conflict with one another. The hospital bylaws, policies and other governing documents do not conflict with the organized medical staff bylaws, rules, regulations and policies, nor with the organized medical staff's autonomy and authority to self govern, as that authority is set forth in the governing documents of the organized medical staff. The organized medical staff, and the hospital governing body/administration, shall, respectively, comply with the bylaws, rules, regulations, policies and procedures of one another. Neither party is authorized to, nor shall unilaterally amend the bylaws, rules, regulations, policies or procedures of the other.

6. The organized medical staff has inherent rights of self governance, which includes but are not limited to:
   a. Initiating, developing and adopting organized medical staff bylaws, rules and regulations, and amendments thereto, subject to the approval of the hospital governing body, which approval shall not be unreasonably withheld. The organized medical staff bylaws shall be adopted or amended only by a vote of the voting membership of the organized medical staff.
   b. Identifying in the medical staff bylaws those categories of medical staff members that have voting rights.
   c. Identifying the indications for automatic or summary suspension, or termination or reduction of privileges or membership in the organized medical staff bylaws, restricting the use of summary suspension strictly for patient safety and never for purposes of punishment, retaliation or strategic advantage in a peer review matter. No summary suspension, termination or reduction of privileges can be imposed without organized medical staff action as authorized in the medical staff bylaws and under the law.
   d. Identifying a fair hearing and appeals process, including that hearing committees shall be composed of peers, and identifying the composition of an impartial appeals, contained within the organized medical staff bylaws, are adopted by the organized medical staff and approved by the hospital governing board, which approval cannot be unreasonably withheld nor unilaterally amended or altered by the hospital governing board or administration. The voting members of the organized medical staff decide any proposed changes.
   e. Establishing within the medical staff bylaws: 1) the qualifications for holding office, 2) the procedures for electing and removing its organized medical staff officers and all organized medical staff members elected to serve as voting members of the Medical Executive Committee, and 3) the qualifications for election and/or appointment to committees, department and other leadership positions.
   f. Assessing and maintaining sole control over the access and use of organized medical staff dues and assessments, and utilizing organized medical staff funds as appropriate for the purposes of the organized medical staff.
   g. Retaining and being represented by legal counsel at the option and expense of the organized medical staff.
   h. Establishing in the organized medical staff bylaws, the structure of the organized medical staff, the duties and prerogatives of organized medical staff categories, and criteria and standards for organized medical staff membership application, reapplication credentialing and criteria and processing for privileging. The standards and criteria for membership, credentialing and privileging shall be based only on quality of care criteria related to clinical qualifications and professional responsibilities, and not on economic credentialing,

conflicts of interest or other non-clinical credentialing factors.

i. Establishing in the organized medical staff bylaws, rules and regulations, clinical criteria and standards to oversee and manage quality assurance, utilization review and other organized medical staff activities, and engaging in all activities necessary and proper to implement those bylaw provisions including, but not limited to, periodic meetings of the organized medical staff and its committees and departments and review and analysis of patient medical records.

j. The right to define and delegate clearly specific authority to an elected Medical Executive Committee to act on behalf of the organized medical staff. In addition, the organized medical staff defines indications and mechanisms for delegation of authority to the Medical Executive Committee and the removal of this authority. These matters are specified in the organized medical staff bylaws.

k. Identifying within the organized medical staff bylaws a process for election and removal of elected Medical Executive Committee members.

l. Defining within the organized medical staff bylaws the election process and the qualifications, roles and responsibilities of clinical department chairs. The Medical Executive Committee must appoint any clinical chair that is not otherwise elected by the vote of the general medical staff.

m. Enforcing the organized medical staff bylaws, regulations and policies, and procedures.

n. Establishing in medical staff bylaws, medical staff involvement in contracting relationships, including exclusive contracting, medical directorships and all hospital-based physician contracts, that affect the functioning of the medical staff.

7. Organized medical staff bylaws are a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body, as well as between those two entities and the individual members of the organized medical staff.

8. The self-governing organized medical staff determines the resources and financial support it requires to effectively discharge its responsibilities. The organized medical staff works with the hospital governing board to develop a budget to satisfy those requirements and related administrative activities, which the hospital shall fund, based upon the financial resources available to the hospital.

9. The organized medical staff has elected appropriate medical staff member representation to attend hospital governing board meetings, with rights of voice and vote, to ensure appropriate organized medical staff input into hospital governance. These members should be elected only after full disclosure to the medical staff of any personal and financial interests that may have a bearing on their representation of the medical staff at such meetings. The members of the organized medical staff define the process of election and removal of these representatives.

10. Individual members of the organized medical staff, if they meet the established criteria that are applicable to hospital governing body members, are eligible for full membership on the hospital governing body. Conflict of interest policies developed for members of the organized medical staff who serve on the hospital's governing body are to apply equally to all individuals serving on the hospital governing body.

11. Well-defined disclosure and conflict of interest policies are developed by the organized medical staff which relate exclusively to their functions as officers of the organized medical staff, as members and chairs of any medical staff committee, as chairs of departments and services, and as members who participate in conducting peer review or who serve in any other positions of leadership of the medical staff.

12. Areas of dispute and concern, arising between the organized medical staff and the hospital governing body, are addressed by well-defined processes in which the organized medical staff and hospital governing body are equally represented. These processes are determined by agreement between the organized medical staff and the hospital governing body.

These principles should serve as fundamentals to guide the development of the content of medical staff bylaws.

Medical Staff Self-Governance

Medical staff self-governance forms the backbone of medical staff law. If the independence of the medical staff and its leadership is compromised, the organized medical staff's ability to fulfill its responsibility for the quality of hospital patient care is jeopardized. Selection of medical staff leaders and control over medical staff duties by the hospital or health system's board are diametrically opposed to self-governance, and that threatens patient protection and physician professionalism. To enable accountability to the governing body for the quality of patient care in the facility, the medical staff must be self-governing. Otherwise, the board is talking to itself, receiving information only from those it selects to hear.

The AMA strongly supports self-governance for medical staff organizations. The AMA identifies as minimum self-governance essentials the following rights of medical staffs: "(a) initiation, development and adoption of medical staff bylaws, rules and regulations; (b) approval or disapproval of amendments to the medical staff bylaws, rules and regulations; (c) selection and removal of medical staff officers; (d) establishment and enforcement of criteria and standards for medical staff membership; (e) establishment and maintenance of patient care standards; (f) accessibility to and use of independent legal counsel; (g) credentialing and delineation of clinical privileges; (h) medical staff control of its funds; and (i) successor-in-interest rights." AMA Policy H-235.980.[1]

Medical staff self-governance has long been and continues to be called for by the standards, and the elements of performance by which standards implementation is measured, issued by the Joint Commission in its *Comprehensive Accreditation Manual for Hospitals*.[2,3] Significant among its revisions of the medical staff standards that became effective in January 2004 is a definition of medical staff self-governance:

> Self-governance of the organized medical staff includes the following and is located in the medical staff's bylaws:
> - Initiating, developing and approving medical staff bylaws and rules and regulations;
> - Approving or disapproving amendments to the medical staff bylaws and rules and regulations;
> - Selecting and removing medical staff officers;
> - Determining the mechanism for establishing and enforcing criteria for delegating oversight responsibilities to practitioners with independent privileges;
> - Determining the mechanism for establishing and maintaining patient care standards and credentialing and delineation of clinical privileges; [and]
> - Engaging in performance improvement activities.

Medical staff self-governance, clearly supported in medical staff bylaws, is a basic requirement for Joint Commission accreditation. Joint Commission Standard MS.1.10 Element of Performance 1 states, "the organized medical staff is self-governing, as referenced in the bullets preceding MS.1.10 and related Elements of Performance."

In addition to Joint Commission Standards, some state laws and regulations mandate medical staff self-governance. Under Oregon Revised Statutes §441.055, "[t]he physicians organized into a medical staff pursuant to [Oregon law] shall propose medical staff bylaws to govern the medical staff." Under Mississippi Hospitals, Minimum Standards of Operation Regulations, Title 15, Part III, Chapter 41 §106.16, "the medical staff shall develop and adopt bylaws and rules and regulations to establish a framework for self-government and a means of accountability to the governing body, such bylaws and rules and regulations to be approved by the governing body." California law, which has codified medical staff self-governance within Business and Professions Code §2282.5 (S.B. 1325), states that:

(a) The medical staff's right of self-governance shall include, but not be limited to, all of the following:
  (1) Establishing in medical bylaws, rules, or regulations, criteria and standards, consistent with [California law] and enforce those criteria and standards.
  (2) 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.
  (3) Selecting and removing medical staff officers.
  (4) Assessing medical staff dues and utilizing the medical staff dues as appropriate for the purposes of the medical staff.
  (5) The ability to retain and be represented by independent legal counsel at the expense of the medical staff.
  (6) Initiating, developing, and adopting medical staff bylaws, rules, and regulations, and amendments thereto, subject to approval of the hospital governing board, which approval shall not be unreasonably withheld.

(b) The medical staff bylaws shall not interfere with the independent rights of the medical staff to do any of the following, but shall set forth the procedures for:
  (1) Selecting and removing medical staff officers.
  (2) Assessing medical staff dues and utilizing the medical staff dues as appropriate for the purposes of the medical staff.

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1. Hereafter referred to as "AMA Policy" followed by section number, "H-xxx.xxx"; AMA policy is available in the AMA Policy Finder, available on the AMA Web site.
2. The Joint Commission is a private, voluntary accreditation organization, but since Joint Commission accreditation is the equivalent of compliance with the conditions of participation for Medicare and typically a requirement for third-party payor contracts, its accreditation, if not mandatory, is considered advantageous.
3. Hereafter referred to as "Joint Commission Standard" followed by the chapter designation, i.e., "MS," and standard number. Joint Commission Standards can be ordered from the Joint Commission by calling (630) 792-5431.

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(3) The ability to retain and be represented by independent legal counsel at the expense of the medical staff.

The California self-governance law codifies some of the medical staff self-governance rights that were raised and fought out in the California courts in Medical Staff of Ventura Community Memorial Hospital (San Buenaventura) v. Ventura Community Memorial Hospital. The Ventura Medical Staff sued the hospital after the hospital attempted to remove medical staff officers who were not in compliance with a unilaterally imposed economic conflict policy, evaded the medical staff credentialing and privileging process and illegally seized the medical staff fund of $250,000, among other alleged acts. The hospital argued that the medical staff did not have the right, or "standing," to sue, which argument failed in court. Following the forced resignation of the hospital administrator, the hospital and medical staff settled the case. The settlement formally acknowledged the medical staff's rights to its funds; collect and spend dues; to elect its officers; to retain its own independent legal counsel and the medical staff and hospital's obligations to comply with the medical staff bylaws. Despite the range of authority sustaining medical staff self-governance, it is all too common for medical staff bylaws to contain provisions contrary to medical staff self-governance. Inattention or complacency by the medical staff is often the cause. Bylaws provisions drafted decades ago might allow the hospital board in its own discretion to recall elected medical staff officers, or call for the slate of nominees for medical staff office to be submitted to the hospital board for review and approval. Board approval of elections results might be authorized by bylaws that have gone un-amended because the board has never failed to approve an election. Complacency should not be allowed to override the need for balance in authority, since even dormant authority can be exercised when the medical staff least suspects. Medical staff bylaws should be the medical staff's best protection, not its worst enemy, in retaining self-governance.

Self-governance is documented in medical staff bylaws. As stated in the overview to the "Medical Staff" chapter of the Joint Commission's *Comprehensive Accreditation Manual for Hospitals*, "The organized medical staff must create and maintain a set of bylaws that define its role within the context of a hospital setting and responsibilities in the oversight of care, treatment, and services. The medical staff bylaws, rules, and regulations create a framework within which medical staff members can act with a reasonable degree of freedom and confidence."

Bylaws: The Basics

Bylaws: The Basics

The Medical Staff Bylaws as a Contract

Bylaws generally are binding on the parties—the organized medical staff and the hospital or health care entity that approves and signs them, the individual medical staff members, applicants, and other practitioners who have been granted clinical privileges. A number of jurisdictions have held that medical staff bylaws always constitute a contract between the hospital and the medical staff (a contract "*per se*"). Contracts *per se* are contracts as a matter of law, without reference to additional facts such as the particular language of the bylaws. Other courts find a contract to be formed so long as key contractual elements are present. Overall, a majority of jurisdictions have held that medical staff bylaws constitute a contract between the hospital and the medical staff. Berberian v. Lancaster Osteopathic Hosp. Assoc., 149 A.2d 456 (Pa. 1959), Fahey v. Holy Family Hosp., 32 Ill. App. 3d 537 (Ill. App. Ct. 1975), Eidelson v. Archer, 645 P.2d 171 (Ala. 1982), Lewisburg Cmty. Hosp. v. Alfredson, 805 S.W.2d 756 (Tenn. 1991), Joseph v. Passaic Hosp. Assoc., 118 A.2d 696 (Sup. Ct. N.J. 1955), Terre Haute Regional Hosp., Inc. v. El-Issa, 470 N.E.2d 1371 (Ind. Ct. App. 1984), Bass v. Ambrosius, 520 N.W.2d 625 (Wis. App. 1994) (medical staff bylaws having same contractual elements as an employee handbook deemed binding on employer); *see also* Pariser v. Christian Health Care Sys., Inc., 816 F.2d 1248 (8th Cir. 1987) (interpreting Illinois law; awarded damages, albeit nominal, as the outcome was not altered by the breach); Northeast Georgia Radiological Assoc. v. Tidwell, 670 F.2d 507 (5th Cir. 1982).

Typically, cases involve an aggrieved medical staff member who sues the hospital and/or medical staff leaders to obtain judicial enforcement of procedural rights promised in bylaws. Virmani v. Presbyterian Health Serv. Corp., 488 S.E.2d 284 (N.C. Ct. App. 1997) (summary suspension of privileges required under bylaws; hospital contractually bound). However, another case involved a medical staff that successfully sought to enforce the bylaws where the hospital attempted to unilaterally amend them. St. John's Hosp. Med. Staff v. St. John's Reg'l Med. Ctr., 245 N.W.2d 472 (S.D. 1976). The court held that the bylaws constituted a contract and that only amendments adopted consistent with the bylaws amendment procedure were enforceable. Building on that case, the South Dakota Supreme Court, in Mahan, et al. v. Avera St. Luke's 621 N.W.2d 150 (S.D. 2001), stated, "It is also well settled that when medical staff bylaws are approved and accepted by the governing board they become an enforceable contract between the hospital and its physicians." The issue in this case was whether the unilateral decision by the hospital to exclusively contract for spinal surgery privileges was a breach of that contract. In Austin v. Mercy Health Sys. Corp., No. 94-2905, 1995 WL 525250 (Wis. Ct. App. Sept. 7, 1995), 24 members of the medical staff sued the hospital for breach of contract. The 29 plaintiff physicians lost critical care unit and intensive care unit privileges when the hospital adopted a policy limiting intensive care privileges to intensivists and did not grant hearing rights to the physicians as required under the bylaws. The court pointed out that the hospital's unilateral action usurped the function of the medical staff committee, which, under the bylaws, had the duty of establishing credentials criteria for intensive care. Austin, 1995 WL 525250, at *5.

Some courts have held that bylaws are contracts despite explicit bylaw language recognizing the hospital board's ultimate authority. "This [ultimate authority] language in no way indicates that the hospital is not bound by the bylaws." Islami v. Covenant Med. Ctr., Inc., 822 F. Supp. 1361, 1371 (N.D. Iowa 1992); Austin, 1995 WL 525250, at *4. On the other hand, among the cases holding that bylaws are not a contract, some courts have held that because the bylaws are subject to the ultimate authority of the hospital board, the requisite mutual obligation was lacking. Munoz v. Flower Hosp., 507 N.E.2d 360 (Ohio Ct. App. 1985). Another court held that medical "staff bylaws can form a binding contract between the doctors and hospital but only where there can be found in the bylaws an intent to be bound" (Munoz, 507 N.E.2d 360) and the governing body's "ultimate authority" does not indicate any concession to be bound. Todd v. Physicians & Surgeons Comm. Hosp., 302 S.E.2d 378 (Ga. Ct. App. 1983); *see also* Weary v. Baylor Univ. Hosp., 360 S.W.2d 895, 897 (Tex. Ct. App. 1962).

Some state courts have refused to characterize medical staff bylaws as a contract because the parties were required to have bylaws and therefore, that the requisite "consideration," or the mutual bargaining that makes up a contract, was lacking. A number of states have laws requiring hospitals and medical staffs to adopt medical staff bylaws. A few state courts have held that state law requiring bylaws precludes a finding that they constitute a contract, including Missouri (Zipper v. Health Midwest, 978 S.W.2d 398 (Mo. Ct. App. 1998)), California (O'Byrne v. Santa Monica Hosp., 114 Cal. Rptr. 574 (Cal. Ct. App. 2001), and Georgia (Robles v. Humana Hosp. Cartersville, 785 F. Supp.

989 (N.D. Ga. 1992)). Subsequent to the *Zipper* case, another Missouri court found "although Medical-Dental Staff Bylaws do not constitute a contract …" a hospital has a "duty to obey its bylaws …" because they "[arose] … out of … state regulations," and due to "… a fiduciary obligation which the hospital owes to members of its medical staff," and "the public's substantial interest in the operation of hospitals, public or private." The court concluded that, "[b]y requiring hospitals to adhere to their bylaws, the risk of arbitrary decision is reduced." Goldman v. Truman Med. Ctr., No. CV97-31606, Div. 16, Jackson County Circuit Court, Missouri, April 13, 1999. Similarly, in California's *O'Byrne* case, the court acknowledged that while the bylaws did not constitute a contract, the bylaws were nonetheless binding and enforceable through injunctive relief.

Other courts have relied on various state laws to conclude that hospital medical staff bylaws, while not a contract, are nonetheless legally binding on the hospital and the medical staff. *See* Gianetti v. Norwalk Hosp., 557 A.2d 1249 (Conn. 1989) (bylaws are subject to judicial review and enforceable because they are mandated by statute and because of the relationship between doctor and hospital that is formed when the hospital extends the physician privileges); Balkissoon v. Capital Hill Hosp., 558 A.2d 304, 308 (D.C. 1989) ("the hospital's obligation to act in accordance with its bylaws is independent of any contractual right of the doctor"); Robles, 785 F. Supp. at 989 (medical staff bylaws do not meet the basic test of contracts, in that the plaintiff failed to argue contractually-required "consideration," and as such, bylaws are not enforceable. But, the hospital is still bound by the medical staff bylaws and can be enjoined from violating procedures set out in bylaws). In New York, one of the state's earliest decisions supporting enforcement of bylaws provisions found the hospital was obligated to follow the medical staff bylaws based on contract law, association law and "concepts of fundamental fairness." Murphy v. St. Agnes Hosp., 484 N.Y.2d 40, 43 (1985).

Only one state refuses to recognize bylaws as a contract or binding on other grounds. Sullivan v. Baptist Mem'l Hosp.-Golden Triangle, Inc., 722 So. 2d 675 (Miss. 1998) (holding that contract did not exist since an alternate finding would overturn established precedent).

Summary of the State Court Decisions, where the state court has examined whether medical staff bylaws form a contract

Bylaws a Contract *Per Se*	Bylaws *May* be Binding and Enforceable on Hospitals (based on contract "K" or other grounds)	Bylaws Held Not to be Contract
Alaska	California*	California*
Illinois	Connecticut*	Connecticut*
Pennsylvania	District of Columbia*	District of Columbia*
New Jersey	Georgia*	Georgia*
South Dakota	Indiana (K)	Kansas
Tennessee	Iowa (K)	Mississippi *
	Missouri*	Missouri
	New York	
	North Carolina (K)	
	Ohio	
	Texas	
	Wisconsin (K)	

*Courts holding that, while bylaws are not contracts, they may be binding and enforceable on grounds other than contract.

AMA Policy states that "the medical staff bylaws are a contract between the organized medical staff and the hospital ..." H-235.976. Joint Commission Standard MS.1.30 of the Joint Commission *Comprehensive Accreditation Manual for Hospitals* also prohibits unilateral amendment of bylaws by the medical staff or the hospital governing body, recognizing the relationship as contractual. Despite these authorities, a clear statement in the bylaws that the hospital or health care entity and the medical staff intend the document to serve as a contract lessens potential for protracted litigation on the issue.

Sample Bylaw: Bylaws as a Contract

As of the date on which these Bylaws become effective through adoption by the Medical Staff and approval by the Board as provided in Article XVI, in consideration of the mutual promises and agreements herein contained, the sufficiency of which are hereby acknowledged, the parties intending to be legally bound agree that these Bylaws shall constitute part of the contractual relationship existing between the Hospital and the Staff Members, both individually and collectively. These Bylaws may be amended only as provided in Article XVI and may not be unilaterally amended by any action of the Board, the Administration, medical staff or any other entity.

Illinois State Medical Society Model Medical Staff Bylaws §II.D.

In spite of the direction of the case law, hospitals and health care entities may continue to argue that the bylaws are not enforceable and reject any attempt by the medical staff to clearly identify the bylaws as a contract. The debate about whether bylaws are contracts may be defused by including a statement that the bylaws are binding on the hospital, the medical staff and its members. This bylaws provision can be inserted in a "purposes" clause or in an article of general provisions at the conclusion of the bylaws.

Sample Bylaw: Binding Effect

These bylaws are intended to be binding upon the hospital, the medical staff, its members and applicants.

How to Improve the Bylaws

The AMA supports "the right to initiate development and adoption of medical staff bylaws, rules and regulations" and "approval or disapproval of amendments to the medical staff bylaws, rules and regulations" as essentials of medical staff self-governance. AMA Policy H-235.980. The medical staff should be proactive in reviewing the current bylaws to determine whether they comply with state and federal laws and regulations and other accreditation standards. Also, the medical staff must carefully review amendments offered by the administration or by individual members to ensure that they support a self-governing medical staff and are consistent with state and federal law. Bylaws must support the medical staff authority and responsibility for quality patient care.

Minimum requirements for the composition of the medical staff are mandated in the laws or regulations of some states. Typically, the requirements are a condition of licensure for the hospital or health care entity, and they are subject to review by the state department of health or other licensing authority. Amendments to bylaws, therefore, must be made to reflect any existing or new requirements. Examples of various state statutory or regulatory requirements for certain committees, duties or procedures are included in the section-by-section analysis of bylaws in this book.

Accreditation standards greatly affect the content of medical staff bylaws. The Joint Commission is the primary source of hospital accreditation in the United States. Accreditation of hospitals by the Joint Commission is voluntary. However, hospitals can meet Medicare conditions of participation and, in most states, basic licensure requirements, by obtaining accreditation from the Joint Commission, a considerable inducement to becoming accredited. Hospital accreditation under the Healthcare Facilities Accreditation Program (HFAP) of the American Osteopathic Association also has deemed status under Medicare; that is, hospitals accredited by HFAP are deemed to meet Medicare Conditions of Participation. Managed-care organizations are increasingly requiring that prospective service providers have Joint Commission accreditation. Health care entities with medical staffs have a variety of accreditation options, including the Joint Commission, the National Committee on Quality Assurance (NCQA), Accreditation Association for Ambulatory Health Care (AAAHC), American Accreditation Health Care Commission (AAHCC) and other state organizations. Medical staff bylaws should be reviewed regularly to determine compliance with the standards of these voluntary accreditation organizations.

Accreditation standards do not have the force of law, but the Joint Commission's long history of hospital accreditation and its recognition by federal and private reimbursement programs have made the standards nationally accepted minimum requirements. Joint Commission accreditation standards are published annually in its *Comprehensive Accreditation Manual for Hospitals*, which is continually revised. The 2007 Joint Commission Standards and associated Elements of Performance (which are used to score compliance) relating to hospital medical staff bylaws are set forth in Appendix A.

How *Not* to Improve the Bylaws: Do Not Divide Bylaws

Reengineering or otherwise streamlining the medical staff may necessitate amending the bylaws. Some health care industry advocates recommend that credentialing and hearing procedures and organizational provisions be removed from the bylaws and transferred to policy and procedure manuals, such as a "Credentialing Manual," a "Fair Hearing Plan" and an "Organizations and Functions Policy." Although the rationale offered for this is to simplify the process to amend these procedures, the result very often surrenders control of these provisions to administration. Because the Joint Commission has not previously required medical staff approval of policy and procedure manuals, hospital administration could arguably amend these critical provisions without medical staff input or approval. Another rationale frequently cited for separating critical membership and leadership functions from the bylaws is to avoid legal challenges of anticompetitive activity by the medical staff and the hospital. Following this reasoning, if the hospital has credentialing authority then the medical staff cannot be capable of anticompetitive

activity. Creation of separate policy and procedure manuals is no warranty against allegations of anticompetitive actions. Instead, relegating the bylaws provisions to a manual eliminates the medical staff's ability to govern itself or to control its rules and procedures. The threat of antitrust litigation is not a compelling argument to surrender control of the bylaws and of the medical staff to the governing body. These models invariably antagonize the medical staff, are costly to implement and difficult to maintain. The possible resulting breakdown of trust between the medical staff and governing body can create far more damage with its effect on patient care than the risk of antitrust challenges.

Joint Commission Standard MS.1.20: Improve Bylaws and Promote Self-Governance

The practice of splitting bylaws up into manuals and plans has been rendered obsolete by revisions in the Joint Commission Standard on medical staff bylaws. The Joint Commission published Standard MS.1.20 and its 32 Elements of Performance in July 2007, to delineate what medical staff bylaws must contain for Joint Commission accreditation, including many of the matters formerly sequestered in a manual or plan.

The Joint Commission originally published MS.1.20 in 2003. Because it would have resulted in returning substantive elements to medical staff bylaws that would have to be subject to vote by medical staff members, hospital lawyers and their clients lobbied to have the standard changed, or at least delayed or otherwise rendered inoperative. The Joint Commission responded by publishing additional information, corrections, revisions and clarifications over the course of the next several years. After additional field review, the Joint Commission standard was finalized, to become effective July 2009.

Standard MS.1.20 coordinates a number of long-standing and important Joint Commission objectives. Maintaining the Joint Commission's historical perspective on the basic necessity of medical staff self-governance, MS.1.20 calls for medical staff bylaws to be the product of the medical staff, rather than being restricted to the more limited control of the medical executive committee (MEC), which in some medical staffs is not elected by the members of the medical staff. As described in the release statement issued by the Joint Commission, Standard MS.1.20 "addresses situations in which a medical staff believes that its medical staff executive committee is not representing its views on issues of patient safety and quality of care. The revised standard now states that the medical staff bylaws must indicate what authority the medical staff has delegated to the medical staff executive committee, and how that authority is delegated and removed." Specifically, MS.1.20 Element of Performance 4 states that "regardless of whether the medical staff executive committee is empowered to act on behalf of the organized medical staff, the organized medical staff as a whole has the ability to adopt medical staff bylaws, rules and regulations, and policies, and amendments thereto, and propose them directly to the governing body." To comply with this Element of Performance, change will be required in medical staff bylaws if those bylaws do not allow the medical staff to vote on amendments unless they have first been approved by the medical executive committee. A mechanism for the organized medical staff to directly recommend amendment to the hospital board should be added to the bylaws amendment process.

Sample Bylaw: Direct Medical Staff Amendment Process

In addition to the processes established in this Article, amendments to the medical staff bylaws, rules and regulations and policies can be adopted by action of the medical staff, without action by the medical executive committee, at any general medical staff meeting or any special medical staff meeting called for the purpose of amending the bylaws, provided a quorum is present, by a majority vote of those active members present. Amendments adopted under this mechanism shall become effective when approved by the board, which shall not be unreasonably withheld.
Medical Association of Georgia Model Medical Staff Bylaws §X.C.

In addition to standing for the proposition that the medical staff may recommend amendments to medical staff documents without medical executive committee involvement, MS.1.20 also defines the medical executive committee's authority as being derived from the organized medical staff, which is to be stated in medical staff bylaws in at least two ways. Under MS.1.20, Element of Performance 20, the bylaws must include "The medical staff executive committee's function, size, and composition; the authority delegated to the medical staff executive committee by the organized medical staff to act on its behalf; and how such authority is delegated or removed."

Sample Bylaw: MEC Authority from the Medical Staff

The MEC is accountable to the Medical Staff—except for recommendations regarding individual membership, privileges and corrective actions, MEC decisions are subject to reversal by a majority vote of the Active Staff. Except for corrective action recommendations, the MEC shall make available to the Medical Staff a record of all actions taken, and shall limit annual expenditures to a Medical Staff-approved budget.

Note that the MEC's actions regarding a member's status or disciplinary actions are not subject to reversal by the medical staff, to prevent peer review from becoming susceptible to popularity and sympathy votes on the part of the larger voting membership. This sample also limits the MEC's spending powers to the budget as adopted by the medical staff membership.

Standard MS.1.20 Element of Performance 23 states that medical staff bylaws include "[t]hat the medical staff executive committee acts on the behalf of the organized medical staff between meetings of the organized medical staff, within the scope of its responsibilities as defined by the organized medical staff." Bylaws typically detail the medical executive committee duties and should be drafted to address the medical executive committee's authority to act on behalf of the medical staff.

Sample Bylaw: Duties of the Medical Executive Committee

The duties of the medical executive committee shall include, but not be limited to:

(a) representing and acting on behalf of the medical staff in the intervals between medical staff meetings, subject to such limitation as may be imposed by these bylaws …

California Medical Association Model Medical Staff Bylaws §11.3-2(a).

The bulk of the standard is designed, as the introduction states, to "allow for an efficient process, for the hospital and its medical staff, for creating and maintaining medical staff bylaws, rules and regulations, and policies." To do this, the standard sets forth what must be included in the medical staff bylaws. All the requirements set forth in MS.1.20 Elements of Performance 9–33 must be included in the bylaws. Procedural details—defined by the Joint Commission as describing in detail how each step in a process is to be carried out—relating to MS.1.20 Elements of Performance 9–25 have to be in medical staff bylaws. Procedural details related to MS.1.20 Element of Performance 26–33 can be either in the bylaws, or in rules and regulations or policies. The following charts show what issues and in which document they must be addressed to comply with MS.1.20, and where the issue is addressed in more detail in this guide.

Requirements and Associated Procedural Details Must Be in Bylaws	**Discussed in Guide Section**
Element of Performance 9 The structure of the organized medical staff.	Categories of Membership; Officers and Representatives of the Medical Staff; Committees; Meetings
Element of Performance 10 The process for privileging licensed independent practitioners.	Clinical Privileges
Element of Performance 11 Qualifications for appointment to the medical staff.	Membership Qualifications, Rights and Responsibilities
Element of Performance 12 Indications for automatic suspension of a practitioner's medical staff membership or clinical privileges.	Automatic Suspension
Element of Performance 13 Indications for summary suspension of a practitioner's medical staff membership or clinical privileges.	Summary Suspension
Element of Performance 14 Indications for recommending termination or suspension of medical staff membership, and/or termination, suspension, or reduction of clinical privileges.	Corrective Action Summary Suspension
Element of Performance 15 The composition of the fair hearing committee.	Hearing Body
Element of Performance 16 The roles and responsibilities of each category of practitioner on the medical staff (active, courtesy, etc.).	Categories of Membership
Element of Performance 17 Requirements for performing medical histories and physical examinations.	Histories and Physicals
Element of Performance 18 Those practitioners who are eligible to vote on the medical staff bylaws and their amendments.	Voting

Procedural Details *continued*	**Guide Section** *continued*
Element of Performance 19 A list of all the officer positions for the organized medical staff	Officer and Representatives of the Medical Staff
Element of Performance 20 The medical staff executive committee's function, size, and composition; the authority delegated to the medical staff executive committee by the organized medical staff to act on its behalf; and how such authority is delegated or removed.	Executive Committee
Element of Performance 21 The process for selecting and removing the medical staff executive committee members.	Executive Committee
Element of Performance 22 That the medical staff executive committee includes physicians and may include other practitioners as determined by the organized medical staff.	Executive Committee
Element of Performance 23 That the medical staff executive committee acts on the behalf of the organized medical staff between meetings of the organized medical staff, within the scope of its responsibilities as defined by the organized medical staff.	Executive Committee
Element of Performance 24 The process for adopting and amending the medical staff bylaws.	Amendment of Medical Staff Bylaws, Rules and Regulations, and Policies
Element of Performance 25 The process for adopting and amending medical staff rules and regulations, and policies.	Amendment of Medical Staff Bylaws, Rules and Regulations, and Policies

The processes referred to in MS.1.20 Elements of Performance 26–33 must be in the bylaws. The procedural details associated with these elements of performance may be in the bylaws or the medical staff rules and regulations, or policies, but, under Element of Performance 3, "The organized medical staff, or the medical staff executive committee as delegated by the medical staff, adopts and amends, and the governing body approves, any rules and regulations and policies that address procedural details of the requirements in MS 1.20, Elements of Performance 26–33." Note that procedural details are administrative in nature, as described in the Introduction to MS.1.20: "A *process* is a series of steps taken to accomplish a goal. A *procedural detail* describes in detail how each step in the process is to be carried out. For example, the process for credentialing licensed independent practitioners (see MS.1.20, Element of Performance 26) can be stated in several steps such as collecting information on a physician, evaluating the information, and making a decision about the information. That process will be contained in the medical staff bylaws. The procedural details associated with this process might include who collects the information, how files are kept, what organizations need to be contacted to collect all the necessary information, etc."

The processes included in MS.1.20, Elements of Performance 26–33 are critical to standard-setting, corrective action, hearing rights and other issues critical to medical staff self-governance, so that any decision to place the procedural details outside the medical staff bylaws must be carefully considered. Even if the procedural details are relegated to the rules, regulations and policies, authority to adopt and amend may remain with the medical staff as a whole and not delegated to the medical executive committee. Moreover, there is no requirement that such details must be outside the medical staff bylaws, and many reasons for including them in the medical staff bylaws, not the least of which is to assure that the medical staff organization retains control over key processes that affect its members. These issues and the location of the substantive discussion in the guide are in the following table:

Processes Must Be in Bylaws; Any Associated Procedural Details Must Be in Bylaws or Rules/ Regulations or Policies; if Procedural Details not in Bylaws, Medical Staff may delegate authority to adopt or amend to the MEC.	**Discussed in Guide Section**
Element of Performance 26 The process for credentialing licensed independent practitioners.	Basic Qualifications for Membership Application Process for New and Renewed Membership
Element of Performance 27 The process for appointment to membership on the organized medical staff.	Application Process for New and Renewed Membership
Element of Performance 28 The process for selecting and removing the organized medical staff officers.	Officer and Representatives of the Medical Staff
Element of Performance 29 The process for automatic suspension of a practitioner's medical staff membership or clinical privileges.	Automatic Suspension
Element of Performance 30 The process for summary suspension of a practitioner's medical staff membership or clinical privileges.	Summary Suspension
Element of Performance 31 The process for recommending termination or suspension of medical staff membership and/or termination, suspension, or reduction of clinical privileges.	Corrective Action Summary Suspension
Element of Performance 32 The fair hearing and appeal process (*see also* EP 15), which at a minimum shall include: • The process for scheduling hearings • The process for conducting hearings • The appeal process	Hearing Process
Element of Performance 33 If departments of the organized medical staff exist, the qualifications and roles and responsibilities of the department chair, which shall include the following: Qualifications • Certification by an appropriate specialty board or comparable competence affirmatively established through the credentialing process. Roles and responsibilities • Clinically related activities of the department. • Administratively related activities of the department, unless otherwise provided by the hospital. • Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges. • Recommending to the organized medical staff the criteria for clinical privileges that are relevant to the care provided in the department. • Recommending clinical privileges for each member of the department. • Assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization. • Integration of the department or service into the primary functions of the organization.	Departments; Director Authority; Selection of a Director; Department Leadership Orientation and Training

Procedural Details *continued*	Guide Section *continued*
• Coordination and integration of interdepartmental and intradepartmental services. • Development and implementation of policies and procedures that guide and support the provision of care, treatment, and services. • Recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services. • Determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services. • Continuous assessment and improvement of the quality of care, treatment, and services. • Maintenance of quality control programs, as appropriate. • Orientation and continuing education of all persons in the department or service. • Recommending space and other resources needed by the department or service.	

Obviously, much of the procedural detail related to these elements is significant and should not be located anywhere but in the medical staff bylaws. Traditionally, many of the details necessary for implementing issues in Elements of Performance 26–33 are basic to medical staff bylaws and are rarely if ever relegated to rules and regulations or other documents beyond the reach (and vote) of medical staff members. Further, the process of bylaws revision and the resulting medical staff documents will be more straightforward and easier to use if procedural details are right in the medical staff bylaws along with the processes those details implement.

In addition to addressing the appropriate relationship between the medical staff and the medical executive committee and the necessary content of medical staff bylaws, MS.1.20 details the effect of the medical staff bylaws upon its signatories, the medical staff and the hospital's governing body. Both the medical staff and its members, and the governing body, must follow the bylaws. Under MS.1.20, Element of Performance 5, "The governing body acts in accordance with those medical staff bylaws, rules and regulations, and policies that are adopted by the medical staff or, as delegated by the medical staff, to the medical staff executive committee, and approved by the governing body." According to MS.1.20, Element of Performance 8, "The organized medical staff and its members comply with the medical staff bylaws, rules and regulations, and policies." The governing body cannot escape its obligations to act in accordance with the medical staff bylaws by setting up competing or superseding provisions in hospital governance documents, because under MS.1.20, Element of Performance 7, "The medical staff bylaws, rules and regulations, and policies and the governing body bylaws do not conflict."

The current Joint Commission Standard MS.1.20 is in effect until the revised MS.1.20 is implemented in July 2009. The two-year lead time notwithstanding, medical staffs would be prudent to initiate bylaws revisions to meet the new and improved standard immediately. As the Joint Commission states in the introduction to Standard MS.1.20, "The significance of the medical staff bylaws cannot be overstated."

How to Get Started

Take a measure of the current medical staff bylaws to determine what physician-friendly provisions may be lacking, using Appendix D: South Dakota Medical Society Medical Staff Bylaws Checklist. Improving bylaws and responding to proposals to amend bylaws may appear to be a daunting task, but several state medical societies have promulgated model medical staff bylaws that can be tailored to create new bylaws or to use as a basis for comparison for existing bylaws provisions (see Appendix D). In addition, a compilation of the model bylaws contained throughout the text is available in Appendix H.

However, since statutes and regulations affecting medical staffs vary from state to state and accrediting standards may change, model bylaws should be used with caution.

While consultants offer various model medical staff bylaws, medical staffs must be aware that such models may not

necessarily protect medical staff interests and may, in fact, be designed to weaken them. (See the "Common Bylaws Pitfalls" chart in Appendix F for more information.) Medical society model bylaws are a valuable and reliable resource for medical staff organizations.

Consultants themselves must be carefully screened. Many companies, organizations and individuals market their services as medical staff or credentialing or quality assurance or bylaws consultants. Many consultants have considerable experience, but interpret the accreditation standards and hospital regulations from the perspective of the hospital, rather than the physician and the medical staff organization. Bylaws revision is a technical and challenging task, and professional help is appropriate. Physicians must, however, be certain that the consultant they rely on to develop this critical statement of medical staff rights and responsibilities will preserve and protect the medical staff's interests and particularly the medical staff's self-governance. Consultants should be interviewed by medical staff representatives, and should provide medical staff, as opposed to hospital, references.

Independent Medical Staff Counsel

Even the best model bylaws must be tailored to fit the needs of the individual medical staff. Bylaws are often complex documents that require legal consultation. It is critical that the medical staff use independent legal counsel and not rely on the health care entity's counsel in developing or amending the bylaws. The interests of hospitals and medical staffs often differ, particularly in preserving medical staff authority. Some medical staffs are not accustomed to retaining counsel, or are not even aware that the medical staff can hire its own lawyer; however, "[t]he AMA strongly recommends that hospital medical staffs retain their own attorneys so that the medical staff will have its own legal advocates for guidance." AMA Policy H235.992. In California, the medical staff's right to counsel has been codified in Business and Professions Code §2282.5(a), which states:

> "The medical staff's right of self-governance shall include, but not be limited to, all of the following: […]
> (3) The ability to retain and be represented by independent legal counsel at the expense of the medical staff."

Independence, however, should not be the sole criterion in hiring medical staff counsel. The medical staff should review the credentials of attorneys under consideration to ascertain their experience in drafting medical staff bylaws. State medical associations and the AMA Organized Medical Staff Section (OMSS) staff can recommend "physician-friendly" attorneys who have experience serving medical staffs.

The role of the medical staff attorney depends entirely on the medical staff. An attorney may be retained to draft amendments on specific issues or redraft the bylaws completely. If the bylaws have not been reviewed by an attorney within the last five years or there is uncertainty whether the current bylaws reflect changing law, the health care environment and the physician's role in ensuring quality care, an initial legal analysis can help the medical staff. Medical staff counsel can also prove indispensable when bylaws amendments are likely to require negotiation with the hospital or health care entity. Even short, seemingly benign or technical amendments may require some negotiation between medical staff and governing body.

Although direct involvement between medical staff counsel and the hospital is optimal, medical staff counsel can provide invaluable support, advice and strategy to the medical staff that is working directly with the hospital or governing body on bylaw issues. If considerable controversy is anticipated, the medical staff may wish to direct its counsel to negotiate directly with hospital counsel to reach mutually acceptable language that can then be put to vote by the medical staff and the governing body. The medical staff may wish to have negotiations carried out by the bylaws committee or an ad hoc committee appointed for the purpose of negotiating with a similar committee of the board. Medical staff counsel can also assist indirectly by reviewing negotiated language before it is voted on in final form. Negotiation can ease change and help in avoiding polarization. Close consultation between the medical staff leadership and its negotiating representative can achieve strong bylaws that the medical staff will support and the governing body will accept.

Bylaws: Section by Section

Preamble and Statement of Purpose

Preambles and statements of purpose in bylaws are not required. If used, however, they must be drafted with great care in order to avoid inadvertent guarantees or warranties of patient outcomes.

Preambles and statements of purpose that purport to describe the relationship between medical staff and hospital or health care entity should be checked for accuracy. For example, statements that a hospital delegates authority to

practice medicine are typical but inaccurate. The hospital can only delegate authority that it has. The hospital cannot delegate authority to practice medicine because it does not have the authority to practice medicine. Hospitals do not practice medicine; physicians do.

In addition to defining the relationship between the governing body of the hospital or health care entity and the medical staff, the preamble or statement of purpose can clarify that the document is binding on the parties. A statement of purpose can also clarify that the bylaws cannot be subrogated to contractual interests of the hospital and other parties, such as individual physicians or physician groups. A statement of purpose can also specify that members and applicants, as well as others holding or requesting clinical privileges, are bound by the bylaws.

Sample Bylaw: Purpose

The medical staff is organized to assure that patient care meets all relevant standards and to improve the quality of care delivered in this institution. Recognizing their responsibility for the overall quality of clinical services provided by its members, the medical staff organizes itself for the purpose of self-governance in conformity with these bylaws so that it can fulfill its responsibility for quality of care. These bylaws are binding on the medical staff and the hospital/health system.

Definitions

As with any complex document, definitions of key terms make the medical staff bylaws easier to use and facilitates uniform implementation. Issues or matters that are broadly or generally defined in state law can be resolved by definition in the bylaws. Offering a specific definition to clarify a position of the medical staff reduces the potential for challenge. For example, the medical staff can define allied health practitioners as members or non-members of the medical staff and as independent or dependent practitioners, in keeping with practice and state law.

Terms that are self-explanatory need not be itemized in a definitions section. For example, the definition, "medical staff bylaws are the bylaws of the medical staff," is unnecessary. The definitions that follow, however, provide needed protections for the medical staff and its members.

Clinical Privileges

In exclusive contracting situations, some hospitals argue that exclusive rights to use hospital resources, such as radiology equipment or operating rooms, can be awarded by contract to some holders of privileges, while others with the same privileges are barred from their use. This contractual device does not entitle the member to a hearing because he or she continues to have privileges. The Tennessee Supreme Court in Lewisburg Community Hospital v. Alfredson, 805 S.W.2d 756 (Tenn. 1991) rejected the hospital's contention that privileges need not include access to the resources necessary to their exercise, stating that "[w]ith hospital-based specialties such as radiology, the inability to use the hospital facilities and staff would have rendered the clinical privileges meaningless." In Illinois, the practice of barring physicians from use of some or all hospital resources without a hearing is prohibited under the statutory definition of clinical privileges, which includes "permission to use hospital resources, including equipment, facilitates, and personnel that are necessary to effectively provide medical or other patient care services. This definition shall not be construed to require a hospital to acquire additional equipment, facilities, or personnel to accommodate the granting of privileges." 210 ILCS 85/10.4(b)(4).

To prevent a hospital's use of "sham" privileges, access to resources can be assured by defining clinical privileges.

Sample Bylaw: Clinical Privileges

Clinical privileges or privileges means the permission granted to medical staff members to provide patient care and includes unrestricted access to those hospital resources (including equipment, facilities and hospital personnel) which are necessary to effectively exercise those privileges.
California Medical Association Model Medical Staff Bylaws §1.2-5.

Day

Because deadlines in the medical staff bylaws (such as 30-day deadlines applicable to notice of hearing requirements) are typically measured in days, it is good practice to define "day" to prevent any allegation that a deadline cannot toll over a weekend or holiday.

Sample Bylaw: Day

Day means a calendar day unless otherwise specified in a particular context as "working day," which day does not include weekends or state holidays.

In Good Standing

The phrase "in good standing" is common in medical staff bylaws, used typically as a qualification for holding office or serving in other leadership capacities. Without a clear definition of the phrase, duly elected leaders could be removed from office because charges even of a specious nature have been made against them. Needless interruption in service can be avoided if the bylaws define the phrase to clarify

that members who are under investigation or otherwise remain eligible to carry out membership prerogatives.

Sample Bylaw: In Good Standing

IN GOOD STANDING means a member is currently not under suspension 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.
Ohio State Medical Association Model Medical Staff Bylaws Definition #8; California Medical Association Medical Staff Bylaws §1.2-7.

Investigation

The resignation of a physician or dentist during an investigation must be reported to the National Practitioner Data Bank. Therefore, clarification of the investigation process reduces unnecessary reporting.

Sample Bylaw: Investigation

Investigation means a process specifically initiated by the medical executive committee to determine the validity, if any, of a concern or complaint raised against a medical staff member or individual holding clinical privileges. It does not include activity of the medical staff aid committee.
California Medical Association Model Medical Staff Bylaws §1.2-8.

While defining terms can be very helpful in interpreting the bylaws, the definitions need not include any and all terms that are related to the medical staff. Bylaw definitions should not include terms that are not actually used in the medical staff bylaws. Particularly, medical staffs should not be persuaded to add terms to the bylaw definitions sections just because state law uses and defines the term unless the medical staff bylaws actually use the term. Amendments to the statute will necessitate amendments to the bylaws or result in inconsistency between the law and the bylaws.

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Membership Qualifications, Rights and Responsibilities

Membership Qualifications, Rights and Responsibilities

The term "member" and "membership," rather than "appointee" and "appointment," more accurately describes the status of physicians in the medical staff organization and also recognizes the self-governing nature of the medical staff.

Bylaws should clarify that only members, or individuals with temporary privileges, can admit, treat or provide medical care to inpatients. A statement of the nature of membership may avoid any attempts by administration or the governing body to circumvent the membership requirements and credentialing procedures of the medical staff by allowing physicians to practice at the hospital without being part of the medical staff. For example, some hospitals have maintained that physicians employed or working under contract as "house doctors" or even as emergency physicians, can do so without being credentialed by the medical staff nor recommended for membership and privileges via the medical staff process. The following sample stipulates that only members or those holding privileges temporarily can take care of patients at the hospital.

Sample Bylaw: Nature of Membership

No individuals, including those in a medical administrative position by virtue of a contract or employment with the hospital, shall admit or provide medical or health-related services to patients in the hospital unless they are members of the medical staff with such privileges or have been granted such privileges on a temporary basis in accordance with the procedures set forth in these bylaws.

Missouri State Medical Association Model Medical Staff Bylaws §2.1.

The Right to Practice

Membership in the medical staff has the benefits afforded under the bylaws according to the category and prerogatives described. Overall, the medical staff as an organization has the responsibility for the quality of patient care. Each medical staff member has the inherent responsibility to advocate for quality patient care, but in some circumstances physicians find themselves under threat of disciplinary action for disruptive behavior for raising quality of care concerns. As a matter of policy, "the AMA condemns any action taken by administrators or governing bodies of hospitals or other health care delivery systems who act in an administrative capacity to reduce or withdraw or otherwise prevent a physician from exercising professional privileges because of medical staff advocacy activities unrelated to professional competence, conduct or ethics." AMA Policy H-230.965. Medical staff bylaws can promote protection of this important professional responsibility as a prerogative of medical staff membership.

Sample Bylaws: Right to Practice

Neither the Hospital nor the Medical Staff shall take any adverse action or otherwise retaliate against physicians for advocating medically appropriate treatment for patients, the appropriateness of such treatment, as determined by the Medical Staff in accordance with these Bylaws. Medical Staff Membership shall not be jeopardized nor shall the right to exercise clinical privileges be infringed except for conduct, either within or outside the Hospital, which is or is reasonably believed to be detrimental to the quality of patient care or safety, and only then in accordance with these bylaws.

Illinois State Medical Society Model Medical Staff Bylaws §XVII.B.

Basic Qualifications for Membership

Professional criteria for membership are to be specified in the medical staff bylaws, consistent with Element of Performance 11 for Joint Commission Standard MS.1.20. At a minimum, criteria should pertain to evidence of current licensure, relevant training or experience, current competence, and ability to perform the privileges requested.

Eligible Professions

According to the Joint Commission's definition of "organized medical staff," "[t]he medical staff is composed of doctors of medicine, osteopathy, and in accordance with the medical staff bylaws, may also be composed of other practitioners." State laws may limit membership on the medical staff to certain professions. Education, training and licensing credentials appropriate to each profession included in the medical staff should be stipulated in the bylaws. For example, medical staffs in California may only extend membership to physicians, dentists, podiatrists and clinical psychologists. 22 Cal. Code of Regs. §70701(a)(1)(E).

Nondiscrimination

State, federal, or municipal laws and regulations applicable to the hospital or health care entity may impose a funda-

mental requirement that membership in the medical staff cannot be denied on the basis of race, creed, nationality or other characteristics.

Sample Bylaws: Nondiscrimination

Neither the Hospital nor the Medical Staff shall discriminate in granting staff membership and/or clinical privileges on the basis of national origin, culture, race, gender, sexual orientation, gender identity, ethnic background, religion, or disability unrelated to the provision of patient care to the extent the applicant or member is otherwise qualified.

Participation in Third-Party Arrangements or Other Interests

Some hospitals may attempt to mandate contractual arrangements with certain managed care entities as a condition of medical staff membership or a basis for denial of membership. AMA Policy states that "prior to committing its medical staff to obligations to provide medical service, a hospital governing body must discuss with and obtain the expressed and documented consent of the medical staff. As appropriate, individual medical staffs should incorporate into their bylaws, rules or regulations, a procedure for medical staff involvement, and participation in hospital decisions that commit the medical staff to provide services." AMA Policy H-225.974. To prevent hospital contracting decisions from affecting membership of individual practitioners, medical staff bylaws should affirmatively state that managed care contract participation cannot be considered as a qualification or disqualification for membership.

Business interests held by physicians and other medical staff members have been used by hospitals as the bases of denial or revocation of medical staff membership and clinical privileges. This practice is opposed by the AMA as described in greater detail in the "Economic Credentialing" section (page 22). Medical staff bylaws can address the ability of medical staff members to enter into business and professional activities without risking their medical staff membership or clinical privileges.

Sample Bylaw: Third-Party Contracting

No person shall be entitled to membership in the medical staff merely because that person holds a certain degree, is licensed to practice in this or in any other state, is a member of any professional organization, is certified by any clinical board, or because such person had, or presently has, staff membership or privileges at another health care facility. Medical staff membership or clinical privileges shall not be conditioned or determined on the basis of an individual's participation or non-participation in a particular medical group, surgery center or other outpatient service facility, IPA, PPO, PHO, hospital-sponsored foundation, or other organization or in contracts with a third party which contracts with this hospital. Medical staff membership or clinical privileges shall not be revoked, denied, or otherwise infringed based on the member's professional or business interests. *California Medical Association Model Medical Staff Bylaws §2.3.*

Health Status

Element of Performance 1 for MS.4.15 calls for "evidence of physical ability to perform the requested privilege" to be among the criteria used to evaluate applicants for clinical privileges. Inquiry into an applicant's or member's ability to perform a privilege is an important area of law due to the potential applicability of the federal Americans with Disabilities Act (ADA) (42 U.S.C. §12101 et seq.) to the credentialing processes. Meeting the evaluation standard can and should be accomplished in a manner consistent with the ADA.

To the extent that the ADA is applicable, a medical staff is prohibited from asking applicants questions regarding health conditions deemed disabilities under the ADA (e.g., alcoholism, mental illness, and past drug abuse) as part of the initial application process. The safest approach may be to reserve the right to inquire about an applicant's current ability to carry out practices for which privileges were requested. Once an applicant qualifies for medical staff membership and privileges, an offer can be made conditioned upon his or her physical and mental capability to exercise the privileges requested. For in-depth analysis of the ADA's effect on credentialing, see the California Medical Association's California Peer Review Law Manual 2004.

The protections available for peer review may not be available where the ADA is implicated. The federal Health Care Quality Improvement Act provides immunity for good faith peer review, but does not apply where the physician under review claims that his/her civil rights have been violated by the review. The ADA is a civil rights act, preventing discrimination against the disabled. Those alleging discrimination based on their disabilities will not be blocked by the protections that usually apply in peer review.

Criminal/Credit Clearance

Some consulting firms and security agencies promote "passing" criminal background and even credit checks as requirement for medical staff membership. Obtaining meaningful criminal background information would necessitate verification with federal and every state's criminal justice systems, and may or may not be required under state law. Approximately half of the states' licensing agencies have authority to conduct a criminal background check as part of the medical licensing process, and some licensing agencies are required to carry out criminal background checks, making the process at the medical staff level in those states redundant. Some states require that a criminal background check be conducted on each health care provider before access to patients is permitted. State law and regulations should be consulted to determine whether criminal background checks are mandated; physicians should be aware that the law in this area is volatile. Summaries of state law and pending legislation regarding the background checks is available from the Federation of State Medical Boards (*www.fsmb.org/pdf/grpol_criminal_background_checks.pdf*). Joint Commission Standards do not require medical staffs to establish criminal or credit background requirements. Great care should be taken to comply with both federal and state law regarding notice and disclosure to the investigated person of information derived from background checks. *See* Fair Credit Reporting Act, 15 U.S.C. §1681 et seq.

Geographic Qualifications

Medical staff bylaws commonly call for physicians of certain or all categories of medical staff membership to reside and maintain an office within a specified area, such as the county or "service area" of the hospital. However, some medical staff members, such as emergency room physicians, serve only according to a set schedule that requires them to be present when they are on duty. They may have no office and do not need to reside near the hospital. Rather than maintain a restriction that is inconsistently applied, the medical staff may authorize departments to establish policies regarding response times appropriate for achieving continuity of care.

Sample Bylaw: Response Time

Medical staff members and privileges holders shall comply with department rules and regulations as approved by the medical executive committee determining response times for specified privileges and procedures.

Economic Credentialing

Economic credentialing is a dangerous practice for medical staffs and hospitals. Under AMA policy, "economic credentialing is defined as the use of economic criteria unrelated to the quality of care or professional competency in determining an individual's qualifications for initial or continuing hospital medical staff membership or privileges." The AMA strongly opposes the practice. AMA Policy H-230.975. Credentialing decisions made for reasons not related to quality of care do not qualify for immunity under the federal Health Care Quality Improvement Act of 1986 (42 U.S.C. §11101 et seq.) or many, if not all, state statutes protecting peer review.

The practice of economic credentialing occurs in medical staff bylaws in direct and indirect ways. For example, some bylaws attempt to set a quantitative floor for medical staff qualifications by requiring that members maintain more than a certain percent of their practice at the hospital, e.g., more than 90 percent. Some bylaws or "pre-applications," (see the "Pre-application Issues" section, page 34) call for a declaration of the percentage of the applicant's practice that will be dedicated to that hospital. Utilization requirements imposed for the purpose of generating hospital revenue could also be seen as violating the Medicare fraud and abuse laws. Medical staff bylaws should bar credentialing based upon any criteria other than education, experience and clinical competence. See the "Participation in Third-Party Arrangements or Other Interests" section, page 21, for sample language that includes "legitimate business interests" as a criterion that cannot be used against a physician in medical staff membership decisions.

Another way for economic credentialing to factor into privileges decisions in hospitals is through resource allocation restrictions, under the cover of a recently adopted Joint Commission standard. Joint Commission Standard MS.4.00, "Determination of Organizational Resource Availability," states that "Prior to granting of a privilege, the resources necessary to support the requested privilege are determined to be currently available, or available within a specified time frame." Element of Performance 1 for this standard provides, "There is a process to determine whether sufficient space, equipment, staffing, and financial resources are in place or available within a specified time frame to support each requested privilege." The medical staff should fold this process into its responsibility for setting criteria for each privilege, to prevent resources from being assigned by the hospital to some members, such as employees, and not others who have the same privileges.

Some hospitals have also engaged in economic credentialing by refusing to allow physicians who have investments or key roles in specialty hospitals or other entities that compete with the hospital to "qualify" for leadership positions or in some cases, by denying their medical staff applications or revoking existing memberships. Hospitals have attempted to implement this form of economic credentialing typically through hospital policy or board-adopted "conflict of interest" or "codes of conduct" requirements. The case in Murphy v. Baptist, 189 S.W.3d 438 (Ark. S.Ct. 2005), in which the court found that the hospital's "conflict of interest" policy banning physicians from holding any financial interest in any competing hospital caused irreparable harm to the physician-patient relationship because it interfered with the physician's referring patterns and ability to provide continuing care. Medical staffs should block such attempts at economic credentialing by ensuring that medical staff bylaws do not provide that hospital policy is binding on medical staff members unless affirmatively adopted by the medical staff as medical staff policy, and by limiting membership actions to grounds expressly stated in medical staff bylaws, which should not include economic grounds.

Sample Bylaw: Economic Credentialing

Medical staff membership and privileges may be granted, continued, modified or terminated by the Board only upon recommendation of the medical executive committee for reasons directly related to quality of patient care and other provisions of the medical staff bylaws, according to the procedures set forth in these bylaws. Under no circumstances shall economic criteria unrelated to quality of care be used to determine qualification for initial or continuing medical staff membership or privileges.

Exclusive Credentialing

This practice involves the granting of privileges conditioned upon the member being exclusive to that hospital and not having membership or privileges at any other hospital. Through this practice, hospitals attempt to force physicians to steer patients to their facilities instead of competing hospitals. Unlike exclusive contracting, physicians are not provided any benefit or compensation for this exclusivity.

Among the many negative aspects of exclusive credentialing, one of the most serious is the subversion of patient interests and preferences to hospital economic demands. Consequently, in 2000, the AMA adopted the following policy: "Our AMA strongly opposes the implementation of economic loyalty criteria for medical staff privileges." AMA Policy H-230.958.

Professional Liability Insurance

Professional liability coverage as a requirement for eligibility can be controversial. State law may address the issue, as in California, where hospitals are allowed, but not required, by statute to "require every member of the medical staff to have professional liability insurance as a condition to being on the medical staff." California Health and Safety Code §1319.

The AMA has adopted the following policy statement on professional liability insurance as a requirement for hospital privileges:

(1) Each hospital medical staff should determine for itself whether or not it will require professional liability insurance coverage as a condition for membership on the hospital medical staff. (2) Our AMA also believes that, if equity demands that voluntary staff members should have insurance coverage so that the burden of financial loss would not fall entirely upon the hospital, then salaried hospital physicians should likewise be covered by adequate insurance or protected financially through self-insurance mechanisms established by the hospital, so that the burden would not fall unfairly upon the members of the voluntary medical staff. AMA Policy H-230.995.

Any requirement for professional liability insurance should be stated in medical staff bylaws. Illinois medical staffs should be warned that the Illinois Appellate Court has ruled in Fabrizio v. Provena United Samaritans, that medical staff bylaws are unenforceable by physicians except in matters concerning the granting, reduction, or revocation of staff privileges based on issues of clinical competence. Physicians had sued to challenge the hospital policy requiring members to have insurance in amounts higher than the $300,000/$600,000 minimums set by the medical staff bylaws.

Sample Bylaw: Professional Liability Insurance

Each member shall maintain in force professional liability insurance in not less than the minimum amounts, if any, as from time to time may be jointly determined by the board of [trustees/directors] and medical executive committee. The medical executive committee, for good cause shown, may waive this requirement with regard to such member as long as such waiver is not granted or withheld on an arbitrary, discriminatory or capricious basis. In determining whether an individual exception is appropriate, the following facts may be considered:

(1) Whether the member has applied for the requisite insurance;
(2) Whether the member has been refused insurance and, if so, the reasons for such refusal; and
(3) Whether insurance is reasonably available to the member and, if not, the reasons for its unavailability.

California Medical Association Model Medical Staff Bylaws §2.2-1(c).

Liability insurance premiums have increased substantially for most if not all specialties. Availability at any price may be problematic in certain areas or in certain circumstances. Liability insurance premiums and availability for hospitals are similarly affected. As a result, hospitals may pressure medical staffs or may unilaterally attempt to raise the minimum amount required for medical staff membership and privileges. Medical staffs should have a voice in determining professional liability insurance requirements for membership, and, indeed, whether there are any requirements at all. See AMA Policy H-230.995; 225.995.

The professional liability crisis in some markets has also led to requirements regarding "tail coverage," i.e., insurance for liability occurring before membership commenced or for claims arising after the running of the term of a "claims-made policy." Market changes may cause or exacerbate breaks in coverage which physicians may not be able to remedy immediately. Rather than interrupt practices automatically, the medical staff bylaws could allow for lapses in tail or current coverage without immediate adverse affect on membership.

Sample Bylaws: Continuous Coverage

Where a medical staff has determined that it will require continuous professional liability insurance coverage as a condition for membership, a temporary loss of professional liability insurance coverage (whether or not limited to "tail" coverage) is not grounds for immediate termination of medical staff membership or ineligibility to serve in a medical staff leadership position. The Medical Executive Committee shall determine the length and other conditions of an individual waiver of the coverage requirement.

Board Certification and Recertification

Current Medicare conditions of participation state that "under no circumstances is the accordance of staff membership or professional privileges in the hospital dependent solely upon certification, fellowship, or membership in a specialty body or society." 42 C.F.R. §482.12(a)(7). Board certification alone cannot be the basis for granting membership. Licensure, current competence, and other basic qualifications should be included in the criteria. In some cases, however, board certification, or the lack thereof, has been the basis for denying membership or privileges, depending on the facts and laws applicable to the medical staff in question. *See* Hay v. Scripps, 183 Cal. App. 3d 753 (1986); Silverstein v. Gwinnett Hosp. Auth., 861 F.2d 1560 (11th Cir. 1988).

The Medicare conditions of participation have sometimes been interpreted literally. Reportedly, a hospital was cited in 1994 by the Health Care Financing Administration (HCFA) now known as the Centers for Medicare & Medicaid Services (CMS), for refusing medical staff membership to a physician because that physician was not board certified. Since that time, CMS has issued a directive stating, by way of clarification, that board certification can be required for membership as long as it is not the only criterion, and hospitals may not rely solely on board certification in determining membership. This directive clarifies little. In the absence of data establishing that current board certification is a measure of higher competence, medical staffs that adopt a board certification criterion should provide that physicians who are not certified can establish eligibility by providing information showing comparable experience and competence.

It is also important to relate board certification to the privileges sought. Using board certification in dermatology to obtain neurosurgery privileges cannot be supported. The medical staff, through the departments and with executive committee review, should establish which board certifications are acceptable. "The AMA believes that medical staffs should have flexibility in determining which, if any, specialty board certification will be used as a criterion to delineate clinical privileges." AMA Policy H-230.986. Board certification provisions typically apply to physician members of the medical staff. Board certification for dentists in the eight specialties recognized by the American Dental Association is rare.

Medical staff bylaws must also take into account that most medical board certifications are subject to renewal, and de-

termine the effect, if any, failure to recertify has on membership and privileges. The AMA has taken the following position: "(1) The fact that a board-certified practitioner fails to undergo the recertification examination shall not be adequate reason to modify or withhold privileges from a physician. (2) Modification or withholding of hospital privileges shall be purely on the basis of assessment of performance." AMA Policy H-230.997. Each department should advise the medical executive committee whether achieving certification once suffices or whether recertification is appropriate. A mechanism for establishing comparable qualification should be included.

Finally, medical staffs may wish to establish a mechanism for those physicians trained and board certified in Canada or other countries to meet the medical staff's board certification standard with credentials obtained outside the United States.

Sample Bylaw: Board Certification and Equivalency

Physician medical staff members and applicants shall:

1. Be currently or have been certified by a member of the American Board of Medical Specialties or the Advisory Board for Osteopathic Specialists in a specialty that encompasses the privileges held or sought; or
2. Have met the training and education requirements for and are in the process of obtaining certification from that board, which must be obtained within six years from date of initial medical staff membership to be eligible for membership renewal; or
3. Have successfully completed at least a two-year postgraduate training program in the specialty in which privileges are held or sought, which program was, at the time attended, accredited by the American Council of Graduate Medical Education or the American Osteopathic Association, and can document experience and demonstrate competence that is determined by the credentials committee and approved by the executive committee to be equivalent of that described in this subsection.

The credentials committee can recommend acceptance of comparable board certification and training programs accredited by appropriate authorities outside the United States upon its determination of equivalency with the requirements of this section.

Medical staffs faced with the prospect of imposing a board certification requirement where none has been used before could find their membership rosters suddenly diminished. Establishing the new requirement as prospective only, and "grandfathering" existing members, is a common mechanism for introducing a change in membership requirements. Grandfather clauses have been upheld in some cases, such as Smith v. Vallejo General Hosp., 170 Cal. App. 3d 450 (1985), which permitted a clause grandfathering medical staff members whose practice predated formal residency training programs in a particular specialty. Grandfathering could be subject to challenge on the grounds that different qualification requirements could adversely affect patient care. Establishing a mechanism for determining equivalent competence could alleviate such challenges.

Sample Bylaw: Board Certification Grandfathering

Applications from physicians who are medical staff members on or prior to [date] may be considered for renewed membership and privileges despite lack of current board certification if the members can document experience and demonstrate competence that is determined by the credentials committee and approved by the executive committee to be equivalent of that described in this subsection.

Emergency Department Coverage Responsibility

The Emergency Medical Treatment and Active Labor Act (EMTALA), enacted by Congress in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (42 U.S.C. §1395dd), imposes on hospitals the duty to maintain a list of physicians on-call to stabilize persons with emergency medical conditions or determine whether they are stable for transfer. 42 U.S.C. §1395cc(a)(1)(I). Medical staffs are not required by the statute to create on-call systems, nor does EMTALA require any physician to provide on-call coverage. However, if an on-call physician fails or refuses to respond when called by a hospital, the hospital and the physician may be in violation of EMTALA and subject to sanctions. Medical staffs' EMTALA-related obligations should be stated in the medical staff bylaws. They can be addressed in medical staff duties and obligations sections of the bylaws.

To promote equity, coverage requirements should be established by departments and subject to approval by the medical executive committee. Response times are best established within departments familiar with the needs of the patients, and again subject to medical executive committee approval for uniformity in privileges that cross departmental lines.

Further, on-call requirements may differ between departments that have sufficient numbers of physicians who wish to serve on call and those that have physicians available.

Revised EMTALA regulations (42 CFR Parts 413, 482, and 489) went into effect November 11, 2003, and permit hospitals flexibility in how to meet its obligations to provide coverage by volunteer or compensated call arrangements with members of the medical staff, agreements with other hospitals or otherwise taking resources into account. Detailed information on the effect of EMTALA on physicians and organized medical staffs can be found in the EMTALA Compendium published by the American Academy of Orthopaedic Surgeons, the link to which can be found in Appendix B. The AMA's "EMTALA Quick Reference Guide for On-Call Physicians" is also available on the AMA Web site.

Sample Bylaw: Emergency Coverage Requirements

Except for honorary and retired staff, the ongoing responsibilities of each member of the medical staff shall include ... (j) participating in such emergency service coverage or consultation panels as may be determined by the medical staff.

Ohio State Medical Association Model Medical Staff Bylaws §7.5.

Conduct/Behavior

Any medical staff membership requirements regarding behavior or conduct must be carefully structured. Since peer review legal protections are typically limited to actions taken to improve quality care, denials of membership based on behavior unrelated to patient care may not be protected. Broad conduct requirements may be used to cloak economic, political or discriminatory motives. A charge of "conduct disrupting hospital operations" can easily be interpreted to block a physician's participation in competing services or appropriate patient care advocacy if hospital administration considers such competition or advocacy to be disruptive to hospital operations. Conduct requirements can be addressed in the duties and obligations section or in the qualifications for membership section of the bylaws.

Medical staff bylaws should also be structured to facilitate referral for evaluation and treatment, instead of discipline, where conduct is or could be a symptom of underlying physical, emotional or psychiatric impairment, including substance abuse or addiction. An active wellness committee/medical staff assistance committee, as discussed below, can promote protecting and supporting physicians whose conduct issues are related to health problems.

Sample Bylaw: Conduct

Only physicians shall be deemed to possess basic qualifications for membership in the medical staff who are determined to be able to work cooperatively with others so as not to adversely affect patient care.

California Medical Association Model Medical Staff Bylaws §2.2-1(b)(2).

Further procedures governing conduct and behavior can be addressed in medical staff policy. A sample "Policy on Disruptive Behavior" can be found in Appendix E.

Ethical Standards

The obligation to adhere to professional ethical standards as a condition of membership should reflect the different professions that make up the medical staff.

Sample Bylaw: Ethics Adherence

All physicians who hold privileges or other members of any category of the medical staff shall abide by the *Code of Medical Ethics* of the American Medical Association or other ethical principles established by the member's profession.

Committee Service

A requirement to accept medical staff committee appointment can be included among membership rights and responsibilities. Bylaws typically limit committee service to active members. If, however, committee service is permitted to run across category lines, the medical staff can benefit from the variety of medical practices and specialties represented among different categories.

Compliance Codes Provisions

Bylaws provisions requiring the members to abide by hospital corporate compliance standards or codes of business practices may look benign. However, these documents are often drafted for employees whose relationship to the hospital is fundamentally different from the relationship between the hospital and medical staff member physicians who have their own practices, employees, and offices. A hospital might restrict physicians whom it employs to limit their work to that hospital, and to prevent its hired physicians and other employees from entering into separate relationships with vendors or insurers that have contracted with the hospital. These are common provisions in hospi-

tal compliance codes, which are drafted to apply to hospital employees. These documents do not translate well if applied to physicians who are not employed by the hospital, especially because they contain prohibitions that could negatively impact independent physicians' practices. For example, compliance codes may prohibit any business relationship with businesses in competition with the hospital, similar to the situation in the *Murphy* case discussed in the "Economic Credentialing" section, above. Such a prohibition may be acceptable for hospital employees but is not for physicians who the hospital does not compensate and who have privileges at other hospitals, ambulatory surgery centers or other outpatient facilities.

To the extent that compliance codes purport to govern medical staff members, they should be specific to the medical staff, adopted by the medical staff or its medical executive committee. Medical staffs may wish to protect their members by adding explicit language in the medical staff bylaws to protect physicians from hospital and system anti-competition measures hidden in hospital compliance codes, and to clearly acknowledge that the bylaws are not to be applied to prevent medical staff members from engaging in business activities, including those that may compete with the hospital.

Sample Bylaw: Competition Protection

Nothing in these Bylaws shall be interpreted to prohibit fair competition or pursuit of business interests on the part of practitioners.

Exclusion From Medicare

Some medical staff bylaws require participation in Medicare and state Medicaid or other federally funded health care programs as a condition of medical staff membership. Federal law does not mandate that all medical staff members serve as Medicare providers, but it does restrict hospitals from billing for services ordered or provided by professionals who have been excluded by the federally funded programs. The medical staff office can and should verify Medicare exclusion status from the Department of Health and Human Services Office of the Inspector General (*www.oig.hhs.gov/fraud/exclusions.html*).

Medical staffs should make a determination regarding the effect of Medicare exclusion on medical staff membership. The California Medical Association (CMA) has taken the position that federal law does not mandate that a physician be excluded from the medical staff solely for exclusion from Medicare. However, medical staffs may decide to exclude those physicians who have been excluded from Medicare. The CMA position paper "Medical Staff Membership for Physicians Excluded From Any Federally Funded Health Care Program" is included here as Appendix C.

Sample Bylaw: Medicare Exclusion

Immediately upon verification that a member is excluded from the federal Medicare or other federally funded health care program, medical staff membership and clinical privileges shall be automatically revoked. A former member excluded from the staff due to Medicare exclusion or any applicant denied an application due to exclusion from Medicare may apply as an initial applicant for medical staff membership when the exclusion terminates.
Ohio State Medical Association Model Medical Staff Bylaws §11.3-4.

Employed Physicians

Physicians in employment relationships with the hospital, a clinic or group practice may be perceived to be influenced by their employer. To help the medical staff organization promote equal treatment and limit bias, employment relationships should be disclosed on application and reapplication forms. Employment relationships can then be taken into consideration when selecting members to serve on committees and in peer review situations where bias or the appearance of bias should be eliminated.

Employment or exclusive contract relationships with the hospital cannot be permitted to substitute for the medical staff credentialing process. The medical staff's responsibility to determine whether a physician is adequately qualified to provide patient care applies to employed or contracted physicians also. The medical staff is accountable for the quality of patient care, regardless of the contractual arrangement between the hospital and the physicians providing that care.

Sample Bylaw: Employed or Contracted Physicians

Contracts to Practice Medicine. Before the Hospital or any Hospital Affiliate may enter into any contract or employment relationship for Physician or Independent [Allied Health Professional] (AHP) clinical services, which have been provided during the previous twelve months by any Member of a Clinical Department with clinical privileges for said clinical services, the Hospital shall obtain the approval of the Medical Executive Committee and the applicable Clinical Departments and Divisions. No individual shall be entitled to Medical Staff Membership or Clinical Privileges by virtue of such a contract or employment

relationship. Any member party to any said contract, excluding provider relationships, or any employment relationship with the Hospital or any Hospital Affiliate, shall not be eligible to serve as a Medical Staff Representative. Physician recruitment incentives consistent with this section may be allowed by Policy.
Illinois State Medical Society Model Medical Staff Bylaws §XVII.C.

Note that the above sample bylaw precludes members with hospital contracts or employment affiliations from representing the medical staff. In some medical staffs, this restriction may not be preferred or even possible. Where the medical staff permits hospital-employed or contracted members to qualify to hold medical staff leadership and representative positions, the bylaws should include means to assure that those leaders and representatives will not be subject to undue influence because of their employment or contract status.

Sample Bylaw: Protection for Leaders
Medical staff leaders and medical staff representatives shall not be terminated by the hospital from any hospital contract or employment arrangement based on their medical staff activities carried out pursuant to these bylaws.

Nonetheless, a hospital employment or contract relationship can create a conflict of interest that should be disclosed by candidates for medical staff leadership or representative positions, consistent with pending Joint Commission Standards and to assure open and informed elections. See the "Conflicts of Interest" section, page 58. For additional information regarding exclusive contracts and their ramifications for medical staffs and individual physicians, refer to the "Exclusive Contracts" section page 41.

Hospitalists

Some hospital-employed physicians are hospitalists; some but not all hospitalists are hospital employees or work under contract with the hospital. Under AMA Policy H-285.964, "hospitalist programs when initiated by a hospital or managed care organization should be developed consistent with AMA policy on medical staff bylaws and implemented with the formal approval of the organized medical staff by at least the same notification and voting threshold required to approve a bylaws change to assure that the principles and structure of the autonomous and self-governing medical staff are retained …" In addition to addressing the concerns related to employed and contract physicians described above, and to protecting admitting privileges for non-hospitalists as described below, medical staffs may wish to address the creation or continuation of hospitalist programs directly in medical staff bylaws.

Sample Bylaw: Hospitalists
Hospitalists shall meet all requirements for medical staff membership and active staff category under these bylaws. No hospitalist contract, privilege or employment relationship shall extend exclusive rights to admitting or attending patients in the hospital.

Voting Rights

A clear statement of voting rights in the medical staff bylaws can ease daily operation of medical staff committees and departments. At a minimum, voting in medical staff committees, departments, general staff meetings and elections should be limited to members of the organization. Thus, administrators and those with temporary privileges should not be allowed to vote. Some bylaws also provide that provisional members have no voting rights. Voting rights can be addressed in the appropriate staff category under rights and responsibilities.

Some medical staffs include other professions along with physicians. State law should be considered in assigning voting rights by profession or professional degree. For example, California regulations state that "Medical staff by-laws, rules and regulations shall not deny or restrict within the scope of their licensure, the voting right of staff members or assign staff members to any special class or category of staff membership, based upon whether such staff members hold an MD, DO, or DPM." California CCR §70703(b). States may or may not allow full voting rights to professionals working under a license that limits the scope of practice of that profession.

Sample Bylaws: General Exceptions to Prerogatives
Regardless of the category of membership in the medical staff, limited license members:

(a) shall only have the right to vote on matters within the scope of their licensure. In the event of a dispute over voting rights, that issue shall be determined by the chair of the meeting, subject to final decision by the medical executive committee; and
(b) shall exercise clinical privileges only within the scope of their licensure and as set forth in Section 5.4.

California Medical Association Model Medical Staff Bylaws §3.11

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Payment of Dues

Medical staffs, like other organizations, may require annual dues from their members. The obligation to pay annual dues should be stated in the medical staff bylaws.

This source of financial resources can support medical staff organizational activities such as retaining independent counsel or consultants, or meeting other extraordinary costs. An account independent of other hospital health care entity accounts gives the medical staff control, privacy and discretion of fund use. A distinct account also protects the medical staff fund from being inappropriately commingled with hospital funds and subject to liability, as in the case of hospital bankruptcy. Depositing medical staff funds into an account that does not bear interest should obviate any tax questions.

Compliance With Hospital Policy

Compliance with hospital policy should not be a general responsibility of membership or grounds for corrective action unless the hospital policy has been adopted as medical staff policy. According to Element of Performance 5 of the Joint Commission Standard MS.1.20, the governing body shall act in accordance with the medical staff bylaws. It follows that hospital corporate bylaws should not conflict with the organized medical staff bylaws, rules, regulations and policies. Where there is no conflict, the organized medical staff shall comply with the hospital bylaws, rules, regulations and policies. The organized medical staff compliance obligation is conditioned on (1) the hospital policy not being in conflict with any policy adopted by the medical staff relating to autonomy of the medical staff on clinical matters and (2) the hospital policy applying equally to all hospital personnel without regard to medical staff status. Where hospital policies are general, for example, a no-smoking policy, the medical staff can be relied upon to adopt as a responsible professional organization. (See Principle 5 of Appendix K: AMA Principles for Strengthening The Physician-Hospital Relationship.)

Medical staff members should be obligated under the bylaws to abide by medical staff policy. As stated in Joint Commission Standard MS.1.20, Element of Performance 6, "The organized medical staff enforces the medical staff bylaws, rules and regulations, and policies." See the section on "Medical Staff Policy," page 80.

Categories of Membership

Categories of Membership

Typical membership categories within the medical staff include active, consulting, courtesy, provisional and honorary. Composition, prerogatives and responsibilities of each category should be described in the bylaws. Joint Commission Standard MS.1.20 Element of Performance 16 states that medical staff bylaws include "The roles and responsibilities of each category of practitioner on the medical staff (active, courtesy, etc.)." Some state laws may limit category membership delineation. For example, California regulations state that "medical staff bylaws, rules and regulations shall not … assign staff members to any special class or category of staff membership, based upon whether such staff members hold an MD, DO, DPM, or DDS degree or clinical psychology license." 22 California Code of Regulations §70703(b).

Less typical but useful category descriptions follow and may solve specific problems for a medical staff.

Administrative Category

An administrative category for physicians providing administrative services, whether with or without privileges, reinforces their inclusion on the medical staff. However, if the medical staff elects to forgo a separate category for administrative members, it should not forgo the credentialing process for those administrative physicians who are medical staff members, whether or not they have clinical privileges. Although membership and privileges are not required for physician administrators, AMA policy recommends that "any physician hired or retained by a hospital to be involved solely in medical staff quality of care issues be credentialed by the medical staff prior to employment in the hospital." AMA Policy H-225.971(8). If membership or privileges will be held by the administrative physicians, foregoing credentialing by the medical staff is not an option.

Sample Bylaw: Administrative Staff

Qualifications

Administrative staff category membership shall be held by any physician, dentist or podiatrist who is retained by the hospital specifically to perform quality assurance activities or other administrative duties. The administrative staff shall consist of members who (a) are charged with assisting the medical staff in carrying out quality assurance functions (or other such duties), (b) document their (1) current licensure, (2) adequate experience, education and training, (3) current professional competence, (4) good judgment, (5) physical and mental health status, so as to demonstrative to the satisfaction of the medical staff that they are professionally and ethically competent to exercise their duties, (c) are determined (1) to adhere to the ethics of their respective professions, (2) to be able to work cooperatively with others so as not to adversely affect their judgment in carrying out the quality assurance functions, and (3) to be willing to participate in and properly discharge those responsibilities determined by the medical staff.

Prerogatives

The administrative staff shall be entitled to: Attend meetings of the medical staff and various departments, including open committee meetings and educational programs, (and) (but) shall have (the right) (no right) to vote at such meetings, except to the extent the right to vote is specified at the time of appointment. Administrative staff members shall (not) be eligible to hold office in the medical staff organization, admit patients (and)(or) exercise clinical privileges.

Affiliate Category

This category provides for membership for community physicians whose practice no longer includes inpatient practice, but who would like to maintain medical staff membership in order to follow patients referred to admitting physicians, to meet managed care organization requirements for hospital affiliation, and to participate in continuing medical education and other medical staff activities.

Sample Bylaw: Affiliate Staff

Practice

Affiliate members:

- do not admit patients [independently];
- refer patients to [hospitalists and other] members with admitting privileges; and
- follow and visit patients in the hospital.

Prerogatives

Affiliate staff members are entitled to:

- exercise privileges granted in accordance with these bylaws; and
- vote at medical staff meetings and in meetings of the departments [, sections] and committees of which they are members. *Medical Association of Georgia Model Medical Staff Bylaws II.K.2.*

Call Coverage Category

Categories can be established in medical staff bylaws to address a particular issue facing the medical staff. Many medical staffs struggle with the hospital's legal obligation to provide physician on-call coverage under the Emergency Medical Transfer and Active Labor Act (see the section on "Emergency Department Coverage Responsibility," page 25), which many hospitals attempt to impose on medical staff members through the medical staff bylaws. For some medical staffs, a category of call-coverage members, who serve on-call typically under contract for compensation by the hospital, may alleviate the problem without impinging on existing practices.

Sample Bylaw: Coverage Category

Call Coverage Staff

A. Qualifications

The Call Coverage Staff shall consist of practitioners who possess clinical expertise and:

(1) meet the membership qualifications set forth in these bylaws;

(2) are members in good standing of the Active Medical Staff of another hospital;

(3) come to the Hospital when so scheduled, at the request of an Active Staff member.

B. Prerogatives/Restrictions

The prerogatives of a Call Coverage Staff member shall be to:

(1) provide call coverage in his/her subspecialty and admit patients consistent with his/her privileges;

(2) exercise such clinical privileges as are granted pursuant to these bylaws;

The Call Coverage Staff member may not:

(3) hold office in the Medical Staff or in the Department of which he/she is a member, or serve on committees;

(4) vote on any Medical Staff matter.

The practitioner shall limit admissions and hospital services to those patients needing urgent and emergent treatment during the period of call. Those patients requiring ongoing treatment beyond the limits of on-call schedule could continue to be treated by the on-call practitioner at the discretion of the Active Staff Member being covered or will be treated by the Active Staff Member.

C. Responsibilities

Each Call Coverage Staff member shall fulfill the basic membership responsibilities set forth in these bylaws except that Call Coverage members shall not be required to pay staff dues or assessment.

American Academy of Orthopaedic Surgeons EMTALA Compendium [see Appendix B for additional information].

Telemedicine Category

As telemedicine capability increases, medical staff bylaws rules and regulations will need to integrate telemedicine practice with on-site practice.

For some medical staffs, the consulting staff category of membership can be tailored to include physicians at remote sites who offer telemedicine services, address their responsibilities to the medical staff and otherwise provide guidelines for telemedicine privileges. Issues of meeting attendance, geographic location, committee service and other requirements must be considered as remote-based members and privileges holders are added to the medical staff. Other medical staffs may wish to create a telemedicine category of membership. No matter how telemedicine providers are categorized, medical staffs determine the services that will be provided. Under Joint Commission Standard MS.4.130, "The medical staffs at both the originating and distant sites recommend the clinical services to be provided by licensed independent practitioners through a telemedical link at their respective sites."

Sample Bylaws: Telemedicine Category

Qualifications

Only physicians providing telemedicine who are currently licensed to practice in the state and meet the following basic qualifications shall be eligible for membership in the consulting/telemedicine medical staff of the hospital/medical care organization:

(a) documented (1) adequate experience, education, and training, (2) current professional competence, and (3) current adequate physical and mental health status to perform the clinical privileges requested, so as to demonstrate to the satisfaction of the medical staff that they are professionally and ethically competent and that patients treated by them can reasonably expect to receive quality medical care;

(b) are determined (1) to adhere to the ethics of the profession, (2) to be able to work cooperatively with others so as not to adversely affect patient care, (3) to keep as confidential, as required by law, all information or records received in the physician-patient relationship, and (4) to be willing to participate in and properly discharge those responsibilities determined by the medical staff;

(c) maintain in force professional liability insurance in not less than the minimum amounts, if any, as from time to time may be jointly determined by the governing body and medical executive committee; and

(d) are members of the active or associate medical staff of another hospital/medical care organization.

Responsibilities

The responsibilities of a consulting/telemedicine staff member shall include the following:

(a) provide patients with professional care of generally recognized quality of care meeting the professional standards of the medical staff of this hospital/medical care organization;
(b) provide telemedicine service or consultative services on a timely basis within their area of competence;
(c) supervise non-physician providers or technicians delivering services via telemedicine and have the capability to immediately contact non-physician providers or technicians delivering, as well as patients receiving, services via telemedicine;
(d) provide patient care protocols for all levels of telemedicine;
(e) ensure the legal and ethical requirements with respect to patient confidentiality and data integrity are not compromised by the use of a telemedicine modality;
(f) abide by the medical staff bylaws, medical staff rules and regulations, and policies;
(g) discharge in a responsible and cooperative manner such reasonable responsibilities and assignments as requested;
(h) prepare and complete in a timely fashion medical records entries for all the patients for whom the member provides care in the hospital/medical care organization; and
(i) abide by the ethics of the profession.

Prerogatives

The consulting/telemedicine staff member shall be entitled to:

(a) exercise such clinical privileges as are granted by the governing body of the hospital/medical care organization only upon recommendation of the medical staff; and
(b) attend meetings of the medical staff and the department of which that person is a member, including open committee meetings and educational programs.

AMA Board Report 3 (A-97), "Medical Staff Membership Category for Physician Providing Telemedicine."

At a minimum, the medical staff bylaws should include providers of telemedicine services under the credentialing and privileging processes of the medical staff, to comply with Joint Commission Standard MS.4.120. The Standard permits the originating site to grant privileges to the distant provider using credentialing information from the distant site, if it is Joint Commission–accredited.

Temporary Staff

Not to be confused with temporary privileges, temporary membership is granted to physicians serving as consultants and retained to provide an objective expert opinion in sensitive matters of peer review. Temporary staff membership for a specific specialist is typically granted to fill in a gap in expertise needed for the medical staff to assess a member's competence. Temporary members have no clinical privileges or voting rights, but they should be appointed to a medical staff committee for purposes of peer review. By virtue of medical staff and medical staff committee membership, consultants and the documents they produce may qualify for the legal protections extended under certain states' statutes. Indeed, temporary membership may be required by the specialty society or other entity contracting with the medical staff to provide expert consultation, to promote eligibility for immunity and confidentiality protections afforded medical staff members and medical staff records.

Sample Bylaw: Temporary Staff Category

When necessary for conducting peer review activities, the medical executive committee may admit a physician or other individual to the medical staff for a limited period of time. Such membership shall be solely for the stated purpose in a particular case or situation, and the temporary membership shall terminate upon the temporary member's completion of duties in connection with the peer review matter. Physicians admitted as temporary staff members shall be subject only to those appointment requirements of Article IX deemed necessary by the medical executive committee to ensure that the temporary medical staff member is qualified to conduct his or her duties.

Ohio State Medical Association Model Medical Staff Bylaws §8.8.

Changing Categories

Medical staff bylaws should describe the mechanism allowing members to change from one category to another. An application process for upgrading a medical staff category, including a medical staff generated application form and a query to the National Practitioner Data Bank, required under federal regulations, should be described. (45 C.F.R. §60.10(a)). Requests to downgrade a medical staff category need not involve more than notice to the medical staff president, department chief and medical staff services professional.

Sample Bylaw: Application for Category Upgrade

Members may apply for a higher category of membership on a form provided by the medical executive committee for that purpose. The National Practitioner Data Bank must be queried on those requesting category upgrade.

Application Process for New and Renewed Membership

The application process is the door to the hospital for all medical staff members and applicants. It should be outlined clearly in medical staff bylaws to ensure that the process is uniform and that the information sought is relevant to the medical staff's membership criteria.

Joint Commission Standards call for certain aspects of the process to be disclosed in bylaws and other documents. Specifically, Element of Performance 10 of Joint Commission MS.1.20 call for the clinical privileges process to be documented in medical staff bylaws. Further, Element of Performance 8 for Joint Commission Standard MS.4.15 lists minimal matters that the medical staff is to evaluate, including challenges to any licensure or registration, voluntary and involuntary relinquishment of any licensure or registration, voluntary and involuntary termination of medical staff membership and voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital. The voluntary relinquishing of credentials that is to be disclosed warrants specific mention not only in bylaws but should also be highlighted on medical staff application forms. Most professionals do not consider resignations for personal reasons to be of interest or concern to hospitals and medical staffs. However, failure to disclose information requested on a medical staff application form is common grounds for disciplinary action.

Professional Liability History

Element of Performance 8 for Joint Commission Standard MS.4.15 also calls for evaluation of "any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant." Clinical details about the professional liability cases should be requested in order to provide the medical staff the data necessary to effectively evaluate the pattern and number of claims.

Sample Bylaw: Professional Liability History

All applicants for new and renewed membership and privileges shall provide information on final judgments and settlements in professional liability cases in which the applicant was a defendant, including a clinical summary of the underlying claim.

Also listed in Element of Performance 8 for Joint Commission Standard MS.4.15 are "documentation as to the applicant's health status; relevant practitioner specific data which are compared to aggregate data, when available, (and) morbidity and mortality data, when available." These application elements should also be listed in the medical staff bylaws as part of the data requested of applicants and evaluated by the medical staff.

Application Deadlines

Joint Commission MS.4.15, Element of Performance 10, states that "completed applications for privileges are acted upon within the time period specified in the bylaws." Note that there is no set deadline under the standard; however, under Joint Commission Standard MS.4.20, Element of Performance 8, privileges can only be granted for up to two years. Therefore, the application process must be completed before a member's second anniversary. Joint Commission Standard MS.4.25 requires that "The decision to grant, limit, or deny an initially requested privilege or an existing privilege petitioned for renewal is communicated to the requesting practitioner within the time frame specified in the medical staff bylaws." Again, no deadline is specified, just the requirement that whatever deadline is set by the medical staff bylaws is to be met.

The Joint Commission does not require that a time period be specified for each step of the application process; a single deadline for the entire process, rather than each committee or department action, could provide needed flexibility. The schedule can also stipulate that, if action is not taken within the parameters established, favorable action will be assumed, to prevent applications from being intentionally delayed or that temporary privileges consistent with the bylaws will be extended after the current membership and privileges expire at the end of the term, until final action can be taken on the application.

Pre-application Issues

To prevent hearings on application denials, some hospitals establish pre-application procedures and permit medical staff application forms to be provided only to nonmembers who complete a pre-application form. Typically, the pre-application is not reviewed by the medical staff. The refusal to provide a medical staff application form after reviewing a pre-application form is theoretically not a denial of medical staff membership. Therefore, it is argued, procedural rights otherwise available under the bylaws do not apply.

Pre-application procedures warrant careful scrutiny, as they may be a thinly veiled means of economic credentialing. In some cases, application forms are only provided to applicants whose practices will profit the hospital. Hospitals might also include loyalty demands and disclosures in the pre-application form as part of an economic or exclusive credentialing scheme. If pre-application forms, interviews and other pre-application procedures are used, the medical staff must be involved to ensure that pre-applications are not used for economic or exclusive credentialing.

Content of Application Forms

To ensure that the medical staff maintains oversight of the application process, and to prevent administrative staff from orienting the application process towards profitability rather than quality of and access to care, medical staff bylaws should provide that the medical staff application form is promulgated by the medical staff, through the bylaws committee and reviewed by the medical executive committee. If the medical staff bylaws or rules and regulations define the characteristics of a complete application, hospital administration could not create an application form for economic credentialing purposes without running the risk of violating the medical staff bylaws. Even in states in which uniform credentialing applications have been implemented, medical staffs should have authority to review any added pages or sections used to customize the uniform application to the hospital's purposes. See the "Bylaws Committee" section, page 68.

The application form and the bylaws section describing it should take into consideration the confidential status of the medical staff application under state law. *See* May v. Wood River Township Hosp., 629 N.E.2d 170 (Ill. Ct. App., Jan. 21, 1994, *reh'g denied* March 9, 1994) (application for membership contained information not generated by the medical staff and therefore was not protected); Alexander v. Superior Court, 5 Cal. 4th 1218 (1993) (medical staff application held to be a record of medical staff committee and not subject to discovery in a malpractice action), *disapproved on other grounds by* Hassan v. Mercy Am River Hosp., 31 Ca. 4th 709 (2003).

Leave of Absence

To ensure uniform handling of requests for leaves of absence, bylaws should include appropriate procedures. Military leave of absence, in particular, should be addressed to assist physicians participating in military reserves and the National Guard.

Sample Bylaw: Leave of Absence

Leave Status

At the discretion of the medical executive committee, a medical staff member may obtain a voluntary leave of absence from the staff upon submitting a written request to the medical executive committee stating the approximate period of leave desired, which may not exceed [_____]. During the period of the leave, the member shall not exercise clinical privileges at the hospital, and membership rights and responsibilities shall be inactive, but the obligation to pay dues, if any, shall continue, unless waived by the medical staff.

Termination of Leave

At least 30 days prior to the termination of the leave of absence, or at any earlier time, the medical staff member may request reinstatement of privileges by submitting a written notice to that effect to the medical executive committee. The staff member shall submit a summary of relevant activities during the leave, if the executive committee so requests. The medical executive committee shall make a recommendation concerning reinstatement of the member's privileges and prerogatives, and the procedure provided in Section [_____] through [_____] shall be followed.

Failure to Request Reinstatement

Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the medical staff and shall result in automatic termination of membership, privileges, and prerogatives. A member whose membership is automatically terminated shall be entitled to the procedural rights provided in Article VII for the sole purpose of determining whether the failure to request reinstatement was unintentional or excusable, or otherwise. A request for medical staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial memberships.

Medical Leave of Absence

The medical executive committee shall determine the circumstances under which a particular medical staff member shall be granted a leave of absence for the purpose of obtaining treatment for a medical condition or disability. In the discretion of the medical executive committee, unless accompanied by a reportable restriction of privileges, the leave shall be deemed a medical leave which is not granted for a medical disciplinary cause or reason.

Military Leave of Absence

Requests for leave of absence to fulfill military service obligations shall be granted upon notice and review by the medical executive committee. Reactivation of membership and clinical

privileges previously held shall be granted, notwithstanding the provisions of Sections [_____] and [_____], but may be granted subject to monitoring and/or proctoring as determined by the medical executive committee.
California Medical Association Model Medical Staff Bylaws §3.8.

Peer Review

Peer review is the major function of medical staffs, used to review applicants in credentialing and privileging, and members on an ongoing basis to evaluate and improve the quality of patient care. References to peer review appear throughout this guide in numerous sections detailing medical staff peer review in its various facets.

Peer review is protected under federal and state law with a network of immunities and privileges. AMA policy is discussed and presented in Appendix J: AMA Board of Trustees Report on Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations.

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Clinical Privileges

Clinical Privileges

Clinical privileges should be granted only upon a recommendation from the medical staff. Indeed, state regulation may impose an affirmative duty on medical staffs to make recommendations, such as under Mississippi Hospitals, Minimum Standards of Operation Regulations, Title 15, Part III, Chapter 41 §105.06, which provides that "The governing body shall delegate to the medical staff the authority to evaluate the professional competence of staff members and applicants for staff privileges; it shall hold the medical staff responsible for making recommendations to the governing body concerning initial staff appointments, re-appointments, removals and assignment or curtailment of privileges." Medical staff bylaws should support the medical staff in accomplishing the duty of applying professional standards in evaluating professionals for privileges by assuring that no action regarding privileges can take place without a medical staff recommendation.

Exclusive Mechanism for Granting Privileges

To preclude the hospital governing body or the administrator from granting clinical privileges without review and recommendation by the medical staff through its committees and departments, the medical staff bylaws should stipulate that the process established in the medical staff bylaws is the sole means of granting clinical privileges. AMA Policy H-230.982(3).

Sample Bylaw: Granting Clinical Privileges

Medical staff privileges may be granted, continued, modified, or terminated by the governing body of this hospital only upon recommendation of the medical staff, only for reasons directly related to quality of patient care and other provisions of the medical staff bylaws, and only following the procedures outlined in these bylaws.

California Medical Association Model Medical Staff Bylaws §5.1.

Standards and Criteria for Granting Privileges

Medical staff bylaws should detail the means by which criteria for clinical privileges are established. Pursuant to Element of Performance 33 for Joint Commission Standard MS.1.20, among the clinical department chief's duties (which should be specified in the bylaws) is the responsibility for recommending to the medical staff the criteria for clinical privileges relevant to the care provided within the department. Some hospital consultants and attorneys recommend that the criteria be subject to governing body policy. Hospital approval of clinical criteria is not mandated by Joint Commission Standards. Clinical criteria must be determined by clinicians and should not be used by the governing body to limit privileges for contracting or other economic purposes.

Admitting Privileges

Medical staff bylaws should address privileges to admit patients as being specifically delineated, but available to qualified requestors no matter their financial relationship to the hospital.

Sample Bylaw: Admitting Privileges

Privileges to admit patients must be specifically requested and can be granted only to qualified physicians [and other qualified professionals] meeting the clinical criteria for admitting privileges. Admitting privileges are not limited and shall not be exclusive to hospital employees, members or other professionals with hospital contracts, or to any single specialty.

Privileges in More Than One Department

If an applicant seeks privileges that involve care provided by more than one department, each of the relevant departments' directors should review the application and make recommendations on the privileges sought.

Sample Bylaw: Dual Privileges

Upon receipt of the application materials from the Credentials Committee, the Chair of each department in which the applicant requests clinical privileges shall examine evidence of the licensure, character, professional competence, qualifications, and ethical standing of the applicant and shall determine whether the applicant has established and meets all of the necessary requirements for the clinical privileges requested and, in the case of a physician applying for Staff membership, for the particular category of Staff membership sought. Within 60 days of the receipt of the application materials, each department Chair shall make a written recommendation to the Credentials Committee.

Texas Medical Association Model Medical Staff Bylaws §VI.A.3.

The Right to Exercise Privileges Conferred

To anticipate the argument attempted in defense of the effect of exclusive contracts to cancel privileges held by other practitioners, medical staff bylaws may need to stipulate that practitioners have the right to exercise their privileges.

Sample Bylaws: The Right to Exercise Privileges Conferred

Unless limited or terminated consistent with these bylaws, professionals have the right to exercise any and all privileges in the hospital which they have applied for and been granted consistent with these bylaws.

Temporary Privileges

Until the application process is completed, the medical staff cannot be assured that an individual has the appropriate qualifications to practice under the clinical privileges requested. However, medical staff bylaws should define the mechanism by which temporary privileges may be granted. Joint Commission Standard MS.4.100 limits temporary privileges to two circumstances: specific patient care needs and pending applications. Granting temporary privileges for specific patient care needs recognizes that it may be necessary to allow someone who is not otherwise a member of the medical staff to care for patients for a limited time, such as situations where a specialist is needed to treat a particular patient's condition because no one on the medical staff provides those services, or when a licensed independent physician (LIP) is needed to cover a physician member's practice during illness or other absence. Temporary privileges may also be extended to applicants while the application is moving through the evaluation process, but only if certain conditions are met. Joint Commission Standard MS.4.100 establishes conditions for temporary privileges grants in the Elements of Performance for this standard, including the stipulation that temporary privileges may only be granted for a period of up to 120 days. If the medical staff elects to allow temporary privileges, the circumstances and conditions should be detailed in medical staff bylaws, under Joint Commission Standard MS.1.20, Element of Performance 10.

The following sample meets Joint Commission requirements but like all samples must be adapted to the particular medical staff bylaws, by completing the blanks with numbers that work for that medical staff, and adjusting cross-references to the appropriate provisions of the medical staff bylaws in which this language is placed.

Sample Bylaw: Temporary Privileges

5.5 Temporary Clinical Privileges

Temporary privileges are allowed under two circumstances only: to address a patient care need and to permit patient care to be provided while an application is pending.

5.5-1 Patient Care Needs

(a) *Care of Specific Patient*

Temporary clinical privileges may be granted where good cause exists to allow a physician, [dentist] [podiatrist] [clinical psychologist] to provide care to a specific patient (but not more than [_____] during a calendar year) provided that the procedure described in Section 5.5-5(a)(1) has been completed.

(b) *Locum Tenens*

Temporary clinical privileges may be granted to a person serving as a locum tenens for a current member of the medical staff to meet the care needs of that member's patients in his/her absence, provided that the procedure described in Section 5.5-5 has been completed. Such person may attend only patients of the member(s) for whom that person is providing coverage, for a period not to exceed [_____], unless the medical executive committee recommends a longer period for good cause.

(c) *Other Important Patient Care Needs*

Temporary clinical privileges may be granted to allow a physician, [dentist, podiatrist, clinical psychologist] to fulfill an important patient care treatment or service need (but not more than [_____] during a calendar year) provided that the procedure described in Section 5.5-5 has been completed.

5.5-2 Pending Application for Medical Staff Membership

Temporary clinical privileges may be granted to an applicant while that person's application for medical staff membership and privileges is completed and awaiting review and approval of the medical executive committee or the board of [trustees/directors], provided that the procedure described in Section 5.5-4(a)(2) has been completed, and that the applicant has no current or previously successful challenge to professional licensure or registration, no involuntary termination of medical staff membership at any other organization, and no involuntary limitation, reduction, denial or loss of clinical privileges. Such persons may only attend patients for a period not to exceed [120] days.

5.5-3 Temporary Membership and Temporary Priviliges Not Co-extensive

Temporary members of the medical staff pursuant to Section 6.1-3 are not, by virtue of such membership, granted temporary clinical privileges.

5.5-4 Application and Review

Upon receipt of a completed application and supporting documentation from a physician, [dentist, podiatrist, clinical psychologist] authorized to practice in California, the chief executive officer on the recommendation of either the applicable clinical department chairperson or the chief of staff, may grant temporary privileges to a member who appears to have qualifications,

ability and judgment consistent with Section 2.2-1, but only:

(1) With respect to applications by a locum tenens, or to fulfill an important patient care need, after verification of current licensure and current competence; or

(2) With respect to a new applicant awaiting review and approval of the medical staff executive committee and the governing body in compliance with the requirements in Section 5.5-3, after the following has been completed:

  (i) the National Practitioner Data Bank report regarding the applicant for temporary privileges has been received and evaluated and current California licensure has been verified.

  (ii) the appropriate department chair has interviewed the applicant and has contacted at least one person who

    (a) has recently worked with the applicant;

    (b) has directly observed the applicant's professional performance over a reasonable time; and

    (c) provides reliable information regarding the applicant's current professional competence to perform the privileges requested, ethical character, and ability to work well with others so as not to adversely affect patient care, or other criteria required by medical staff bylaws.

  (iii) the applicant's file, including the recommendation of the department chair of the applicable department when available, or the chief of staff in all other cases, is forwarded to the credentials committee and the medical executive committee.

  (iv) the medical executive committee through the chief of staff, after reviewing the applicant's file and attached materials, recommends granting temporary privileges.

    (a) If the applicant requests temporary privileges in more than one department, interviews shall be conducted and written concurrence shall first be obtained from the appropriate department chairs and forwarded to the credentials committee. In the event of a disagreement between the chief executive officer or his or her designee and the medical executive committee regarding the granting of temporary clinical privileges, the matter shall be resolved as set forth in Section 4.5-8.

5.5-5 General Conditions

If granted temporary privileges, the applicant shall act under the supervision of the department chair to which the applicant has been assigned, and shall ensure that the chair, or the chair's designee, is kept closely informed as to the applicant's activities within the hospital.

(a) Temporary privileges shall automatically terminate at the end of the designated period, unless earlier terminated or suspended under Articles VI and/or VII of these bylaws or unless affirmatively renewed following the procedure as set forth in Section 5.5-5. As necessary, the appropriate department chair or, in the chair's absence, the chair of the medical executive committee, shall assign a member of the medical staff to assume responsibility for the care of such member's patient(s). The wishes of the patient shall be considered in the choice of a replacement medical staff member.

(b) Requirements for proctoring and monitoring, including but not limited to those in Section 5.3, shall be imposed on such terms as may be appropriate under the circumstances upon any member granted temporary privileges by the chief of staff after consultation with the departmental chair or the chair's designee.

(c) All persons requesting or receiving temporary privileges shall be bound by the bylaws and rules and regulations of the medical staff.

California Medical Association Model Medical Staff Bylaws §5.5.

The Joint Commission commonly cites hospitals where medical staff memberships last more than two years. To prevent termination of privileges at the end of two years and avoid a Joint Commission citation, the member whose application has been delayed through no fault of the member should be granted temporary privileges and membership pending the completion of the application process.

Medical staff bylaws often mistakenly deny any hearing rights to those holding temporary privileges that could last more than 30 days. Another typical bylaws mistake is immediate termination for minor infractions, again with no hearing rights. The Health Care Quality Improvement Act extends antitrust immunity for peer-review activities relating to the quality of patient care, but conditions the immunity on good faith and fair process. Immunity is available and advisable for adverse actions relating to temporary privileges, but the good faith and fair hearing precondition must be met. Medical staffs may be reluctant to grant hearing rights regarding temporary privileges. But the failure to grant them unnecessarily exposes physicians involved in the decision to antitrust and other liability. Further, some state laws mandate hearings for denial of temporary privileges. *See* Cal. Bus. & Prof. Code §§805, 809 et seq.; Illinois Hospital Licensing Act, 210 Ill. Comp. Stat. 85/10.4(b)(2).

Disaster Privileges

Medical staff bylaws are to include "the process for privileging licensed independent practitioners under Element of Performance 10 for Joint Commission Standard MS.1.20. According to Joint Commission Standard MS.4.110, "The organization may grant disaster privileges to volunteers eligible to be licensed independent practitioners." Elements of Performance for MS.4.110 call for the medical staff to describe in writing the responsibilities of the individuals responsible for granting disaster privileges, and permit disaster privileges to be granted on the presentation of a valid government-issued picture identification issued by a state or federal agency in all cases with at least one other credential. While these requirements may appear minimal, the Standard provides that verification of credentials is to be pursued on a priority basis as soon as possible.

Sample Bylaw: Disaster Privileges

1. Conditions

Disaster privileges may be granted only when the hospital's Emergency Management Plan has been activated. Individuals with disaster privileges shall be identified and managed as described in the hospital's Emergency Management Plan. The Medical Staff Bylaws, rules, regulations and policies control in all matters relating to the exercise of disaster privileges.

2. Circumstances

The Chairman of the Medical Staff or the CEO, or their designees, may, on a case by case basis, grant disaster privileges upon presentation of a valid photo identification issued by a state or federal agency and any of the following:

(a) A current Hospital picture identification
(b) A current license to practice
(c) Identification establishing that the individual is a member of a Disaster Medical Assistance Team (DMAT), MRC, ESAR-VHP, or other recognized state or federal organizations or groups
(d) Identification granted by a federal, state or municipal entity establishing that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances
(e) Identification by current hospital staff or medical staff member(s) with personal knowledge regarding the practitioner's identity and ability to act as a licensed independent practitioner during a disaster.

Verification of the credentials of individuals with disaster privileges is a high priority. Verification shall be initiated as soon as the immediate situation is under control and shall follow the procedures established in these Bylaws for granting temporary privileges to meet an important care need. Disaster privileges may be withdrawn at any time by the President of the Medical Staff or the Chief Executive Officer of the hospital, or their designees. Refusal or withdrawal of such privileges does not give the right to the Fair Hearing process unless the refusal or withdrawal results in a report to any state or national agency.

Exclusive Contracts

The AMA supports "the principle of open staff privileges for physicians, based on training, experience and demonstrated competence." AMA Policy H-230.994. Recognizing that exclusive contracts are common in most hospitals, the AMA also supports an active role for the medical staff in exclusive contracting decisions. AMA Policy H-225.985. Element of Performance 2 for Joint Commission Standard LD.3.50 states, "The medical staff advises the hospital's leaders on the sources of clinical services to be provided by consultation, contractual arrangements, or other agreements." The medical staff's role should be described in the medical staff's bylaws. AMA Policy H-230.975.

Sample Bylaw: Medical Staff's Role in Exclusive Contracts Decision Making

Appropriateness of Exclusive Contracts

Privileges can be reduced or terminated as a result of a decision to close or continue closure of a department/service pursuant to an exclusive contract, or to transfer an existing exclusive contract, only following review by the medical staff of the related quality of care issues and a determination of appropriateness of the closure, continued closure or transfer as set forth below. The board of [trustees'/directors'] decision shall uphold the medical staff's determination unless the board of [trustees/directors] makes specific written findings that the medical staff's determination is arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law.

(a) The medical staff shall determine the need to close or continue closure of a department/service pursuant to an exclusive contract to be appropriate where:
    (1) a failure to provide full coverage of a needed service cannot be remedied by less extreme measures, such as mandated call schedules; or
    (2) irreconcilable differences within an existing department/service adversely affecting quality of care have not been resolved by less extreme measures; or
    (3) demonstrable efficiencies would result, producing significant improvement in the ability of the medical staff to dispense quality care, which have not been accomplished through less extreme measures.

A determination to close a department/service pursuant to an exclusive contract must be based upon the preponderance of the evidence, viewing the record as a whole, presented by any and all interested parties, following notice and opportunity for comment. A determination to continue closure of a department/service pursuant to an exclusive contract must be based upon the preponderance of the evidence presented by members of the medical staff, following notice and opportunity for comment.

(b) The medical staff shall determine the transfer of an existing exclusive contract to be appropriate only when:
  (1) continued closure of the department/service pursuant to an existing contract is found appropriate pursuant to (a) above, and
  (2) quality of care is maintained or improved by the transfer.

(c) The medical staff member(s) whose privileges may be adversely affected by the medical staff's determination of appropriateness of the closure or continued closure of a department/service pursuant to an exclusive contract, or transfer of an exclusive contract, may request a hearing before the judicial review committee. Such a hearing will be governed by the provisions of Article VII except that:
  (1) the hearing shall be limited to the following issues:
    (i) whether the medical staff's determination of appropriateness is supported by a preponderance of the evidence;
    (ii) whether the medical staff followed its requirement for notice and comment on the issue of appropriateness;
    (iii) in cases of transfer, whether the medical staff's determination of effect on quality of care was appropriate.
  (2) All requests for such a hearing will be consolidated. Should an affected medical staff member request a hearing under this subsection, the medical staff's recommendation regarding the exclusive contract will be deferred, pending the outcome of the judicial review committee hearing.

(d) A medical staff member providing professional services under a contract with the hospital shall not have medical staff privileges terminated for reasons pertaining to the quality of care provided by the medical staff member without the same rights of hearing and appeal as are available to all members of the medical staff.

(e) Except as specified in this section, the termination of privileges following the decision determined to be appropriate by the medical staff to close a department/service pursuant to an exclusive contract or to transfer an exclusive contract shall not be subject to the procedural rights set forth in Article VII.

(f) Except in cases of contemporaneous transfer of an existing exclusive contract determined to be appropriate by the medical staff, a decision to terminate an exclusive contract shall not affect the privileges of medical staff members who were performing services pursuant to that contract, except that their privileges shall no longer be exclusive.

(g) Terms of this section will take precedence over any inconsistent terms in a contract between a member of the medical staff and the hospital, including, but not necessarily limited to, any contractual provisions purporting to waive all rights of hearing and appeal provided in these bylaws.

13.9 Medical Staff Role in Exclusive Contracting

The medical staff shall review and make recommendations to the board of [trustees/directors] regarding quality of care issues related to exclusive arrangements for physician and/or professional services, prior to any decision being made, in the following situations:

(a) the decision to execute an exclusive contract in a previously open department or service;

(b) the decision to renew or modify an exclusive contract in a particular department or service;

(c) the decision to terminate an exclusive contract in a particular department or service.

California Medical Association Model Medical Staff Bylaws §7.6, 14.9.

Smaller medical staffs may find this procedure overwhelming. In every medical staff, however, exclusive contracts may not be allowed to be implemented as a way to circumvent medical staff quality assessment and improvement mechanisms. An alternative, telescoped review mechanism can instead be adopted in bylaws.

Sample Bylaw: MEC Review of Proposed Contract Arrangements

The Medical Executive Committee shall collect information from the members of medical specialties that would be affected, from the hospital administration, and from other interested parties, in order to make an informed recommendation as to whether services should be closed or discontinued, or provided through a contract, and, should a contract arrangement be recommended, what contract sources should be utilized. However, the actual terms of any contract and any financial information related to the contract, including but not limited to the remuneration to be paid to medical staff members under contract, are not relevant and therefore shall neither be disclosed to the Medical Executive Committee nor discussed as part of this contracting evaluation process. Unless the recommendation is arbitrary or capricious, the Board's action regarding the contract shall be consistent with the recommendation of the Medical Executive Committee.

Hearing Rights for Contracting Physicians

Another issue is the "clean-sweep" clause in contracts and bylaws, under which a contracting physician's privileges, membership and hearing rights are tied to the contract. When a contract is terminated, so are medical staff membership and clinical privileges, removing the physician without hearing rights. Bylaws can include a provision to prevent exclusive contracts from precluding access to hearing rights.

Sample Bylaw: Hearing Rights for Contracting Physicians
Hearing rights granted under these bylaws are not subject to waiver by contract or otherwise between [hospital/health care entity] and other parties.

An exclusive contract can affect the privileges of other medical staff members because implementation of exclusivity of privileges terminates the privileges of current members. Despite the AMA's position that "all physicians granted privileges are entitled to full due process in any attempt to abridge those privileges by grant of exclusive contracts," such hearings are rarely granted. AMA Policy H-230.987. Recent changes in Illinois statutes mandate certain notice and hearing rights for those holders of privileges affected by the award of an exclusive contract to another physician. Specifically, the affected staff member is to receive at least 60 days' prior notice of the effect on privileges and membership and may request a hearing, which must be completed within 30 days of the request. 210 Ill. Comp. Stat. 85/10.4 (b)(2)(c)(iii). State laws may mandate specific notice and hearing requirements.

Telemedicine Privileges

Providing care through telemedicine consultation is becoming more prevalent in facilities. Under Joint Commission Standard MS.4.130, the medical staff is to make recommendations as to which services are appropriately provided via telemedicine. Joint Commission Standard MS.4.120 requires the credentialing of the distant provider by the medical staff of the health care entity caring for the patient, subject to that hospital's medical staff credentialing and privileging process. State law may require state licensure of the distant provider. See the "Telemedicine Category" section in this guide, page 32.

Core Privileging

Some medical staff offices use what is marketed as a managerial tool to facilitate the credentialing process, but "core privileging" can seriously affect physicians' practices. Core privileging is a means of streamlining credentialing by bundling groups of privileges as a "core" and developing a set of qualifications for that core. The practice is justified as an alternative to long "laundry lists" of privileges that applicants are to check off when requesting membership or membership renewal. Laundry lists are reportedly difficult to monitor and are not warranted since physicians tend to select all the privileges on the list for their specialty anyway.

However, core privileging can have real clinical ramifications. Core privileges are typically set up to include basic privileges that a practitioner must hold in order to be granted other, usually more specialized, privileges. For example, in order to have hand surgery privileges, a member must not only qualify for but also hold general orthopedic privileges. Holding the privileges means holding professional liability coverage for those privileges, even if the member has no intention of exercising the privileges. Further, many medical staff on-call panels operate based on privileges held, so that a hand surgeon would be on general orthopedic back-up call for the emergency department for Emergency Medical Treatment and Active Labor Act purposes. While this approach may solve a hospital's problem in acquiring needed call coverage, the quality problem presented by requiring a member who may not have actually practiced general orthopedics in years to do so on an emergent basis is obvious. Core privileging has the effect of limiting physicians' abilities to choose which privileges they will hold, and how narrowly they can specialize.

Sample Bylaws: Core Privileges
Only privileges specifically requested by the applicant can be granted.

Histories and Physicals

Because of changes in Joint Commission Standards, medical staff bylaws should address history and physical requirements. Specifically, Joint Commission Standard MS.1.20 Element of Performance 17 calls for the medical staff bylaws to include "requirements for performing medical histories and physical examinations." Standard MS.2.10 Element of Performance 8 states "The organized medical staff requires that a practitioner who has been granted privileges by the hospital to do so performs a

patient's medical history and physical examination and required updates."

Sample Bylaw: Histories and Physicals

Every patient receives a history and physical within twenty-four hours of admission, unless a previous history and physical performed within thirty days of admission is on record, in which case that history and physical will be updated within twenty-four hours of admission. Every patient admitted for surgery must have a history and physical within 24 hours prior to surgery, unless a previous history and physical performed within thirty days prior to the surgery is on record, in which case that history and physical will be updated within twenty-four hours of the surgery. Only those granted privileges to do so conduct history and physicals or update histories and physicals. Privileges to conduct a history and physical or an update to a history and physical are granted only to:

a) Physicians
   Privileges to conduct or update histories and physicals for patients admitted solely for oral/maxillofacial surgery, consistent with the time requirements stated in this section, may be granted to qualified physicians who are members of the medical staff or seeking temporary privileges.
b) Oral/maxillofacial surgeons
   Privileges to conduct or update histories and physicals only for those patients admitted solely for oral/maxillofacial surgery, consistent with the time requirements stated in this section may be granted to qualified oral/maxillofacial surgeons who are members of the medical staff or seeking temporary privileges.

Medical Association of Georgia §V.B.6.

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Focused and Ongoing Professional Practice Evaluation

Focused and Ongoing Professional Practice Evaluation

The Joint Commission describes peer review of applicant and members as "focused" (in the case of practitioners who do not have documented evidence of performance of the particular privilege at the hospital) and "ongoing" (to maintain privileges). As stated in the introduction to the Joint Commission MS Chapter section on Focused Professional Practice Evaluation, "Information for focused professional practice evaluation may include chart review, monitoring clinical practice patterns, simulation, proctoring, external peer review, and discussion with other individuals involved in the care of each patient (e.g., consulting physicians, assistants at surgery, nursing or administrative personnel)." Many of these methods may also be used as tools for ongoing professional practice evaluation.

Proctoring

Proctoring is an underused, but helpful, means of determining whether the granting of privileges is appropriate. To provide on-site observation of current competence, new members of the medical staff or members with new privileges for recently developed procedures or recently obtained training are "proctored," or directly observed, by medical staff members holding the privileges sought. Joint Commission Standard MS.4.30 states, "The organized medical staff defines the circumstances requiring monitoring and evaluation of a practitioner's professional performance"; its Element of Performance 1 provides, "A period of focused professional practice evaluation is implemented for all initially requested privileges." Proctoring can be effectively implemented as a means of monitoring and evaluating services provided by medical staff members who are new to the staff or new to that particular privilege. Requiring proctoring as part of routine professional practice evaluation is not disciplinary in nature and is not reportable to the National Practitioner Data Bank, according to the National Practitioner Data Bank Guidebook (*www.npdb-hipdb.hrsa.gov//pubs/gb/NPDB_Guidebook_Chapter_E*) and may not be reportable under state law requirements.

Proctors do not assist in and are typically not reimbursed for procedures, but serve as part of their professional responsibility to conduct peer review. Medical staffs may establish means of compensating proctors for their time spent in proctoring and reporting their observations to the appropriate medical staff committee, just as serving on a medical staff committee or as a medical staff officer may be compensated. Compensation arrangements should not be directly between the proctor and the proctoree, but rather should be established by the medical staff and applied uniformly.

Medical staff proctoring programs should be carefully designed to assure protection for the professionals involved. Depending on state laws protecting peer review records and granting immunity to peer reviewers, it may be important for each proctor to be a member of an appropriate medical staff review committee. Proctors should be indemnified, as are other medical staff members conducting peer review in its other forms, against any exposure to liability. Finally, proctoring should be addressed in medical staff bylaws as part of the privileging process.

Sample Bylaw: Proctoring

General Provisions

Except as otherwise determined by the medical executive committee, all initial appointees to the medical staff and all members granted new clinical privileges shall be subject to a period of proctoring. Each appointee or recipient of new clinical privileges shall be assigned to a department where performance on an appropriate number of cases as established by the medical executive committee, or the department as designee of the medical executive committee, shall be observed by the chair of the department, or the chair's designee, during the period of proctoring specified in the department's rules and regulations, to determine suitability to continue to exercise the clinical privileges granted in that department. The exercise of clinical privileges in any other department shall also be subject to direct observation by that department's chair or his or her designee. The member shall remain subject to such proctoring until the medical executive committee has been furnished with:

(a) a report signed by the chair of the department(s) to which the member is assigned describing the types and numbers of cases observed and the evaluation of the applicant's performance, a statement that the applicant appears to meet all of the qualifications for unsupervised practice in that department, has discharged all of the responsibilities of staff membership, and has not exceeded or abused the prerogatives of the category to which the appointment was made; and

(b) a report signed by the chair of the other department(s) in which the appointee may exercise clinical privileges, describing the types and number of cases observed and the evaluation of the applicant's performance and a statement that the member has satisfactorily demonstrated the ability to exercise the clinical privileges initially granted in those departments.

Failure to Obtain Certification

If an initial appointee fails within the time of provisional membership to furnish the certification required, or if a member exercising new clinical privileges fails to furnish such certification within the time allowed by the department, those specific clinical privileges shall automatically terminate, and the member shall be entitled to a hearing, upon request, pursuant to Article VII. California Medical Association Model Medical Staff Bylaws §5.3.

External Peer Review

An important element of the medical staff's professional practice evaluation process is the identification of circumstances when external peer review is required. Bias in the peer-review process undermines the ability of the medical staff to reach an accurate and appropriate decision, in addition to jeopardizing peer-review protections. If no one on the medical staff can dispassionately evaluate a member or a problem, external review will enable the medical staff to fulfill its responsibilities to conduct peer review. External review can be used to support the medical staff's work in cases where expertise, rather than impartiality, is lacking. AMA Policy D-375-996 "recommends medical staffs include bylaw provisions that provide an option or alternative for external and impartial review when there is an allegation by a reviewed physician." External reviewers may be appointed as temporary medical staff members, as discussed in the "Categories of Membership" page 33, under "Temporary Staff."

Sample Bylaw: External Peer Review

External peer review will take place in the context of focused review, investigation, application processing or at any other time only under the following circumstances, if and only if deemed appropriate by the medical staff department or the Medical Executive Committee or Board of Trustees; however, a practitioner subject to focused review or investigation can require the hospital or medical staff to obtain external peer review if it is not deemed appropriate by the medical staff department or the Medical Executive Committee or Board of Trustees.

(a) Ambiguity when dealing with vague or conflicting recommendations from committee review(s) where conclusions from this review could directly impact an individual's membership or privileges;
(b) Lack of internal expertise, when no one on the medical staff has adequate expertise in the clinical procedure or area under review;
(c) When the medical staff needs an expert witness for a fair hearing, for evaluation of a credential file or for assistance in developing a benchmark for quality monitoring;
(d) To promote impartiality in peer review;
(e) Upon the reasonable request of a practitioner.

The Medical Executive Committee or Board of Trustees may require external peer review in any circumstances deemed appropriate by either of these bodies.

Corrective Action

Of the many duties of the organized medical staff, corrective action may be the most difficult. Peer review is an essential element of medical professionalism, and corrective action is the logical next step, even if it is reluctantly taken. To assure that any corrective action is the appropriate result of review by peers, medical staffs must be pro-active. Proper bylaws provisions will promote effective peer review and necessary corrective action. Where focused or ongoing evaluation or investigation indicates, corrective action may be necessary and must be carefully implemented.

State statutes may specify that corrective action procedures should be included in medical staff bylaws and may dictate the process to follow.

Corrective action provisions should be drafted with an awareness of the parameters of state confidentiality laws. Corrective action provisions should also promote protected collection and thorough review of all available data. Also, it should be noted that actions may only be eligible for immunity against defamation and other claims under state law if they are taken by committee. For example, in Doe v. St. Joseph's Hospital of Ft. Wayne, 113 F.R.D. 677 (N.D. Ind. 1987), the actions and records of the chief of staff who had imposed summary suspension were not protected because the court interpreted Indiana law as protecting the actions of the peer-review committee, as opposed to those of an individual.

Corrective action must be predicated on an effective investigation process. As stated in the definitions section, it is important to clearly define the term investigation. Furthermore, investigations must be impartial. To achieve impartiality in the investigation phase, the medical staff may need to appoint a consultant from outside the medical staff to provide an opinion. An investigation that is biased in any way compromises patient care and the "good faith" immunity granted by the Health Care Quality Improvement Act.

Initiation of Corrective Action

Clearly defined events that trigger corrective action should be responded to by a clear procedure that provides notice to members and guidance to the leadership for uniform and fair review and action. Generally, the basis for corrective action is performance below standards set by the medical staff. To enforce the rules of the medical staff organization, grounds for corrective action should include breach of medical staff policy, bylaws, and rules and regulations, including breach of confidentiality and violation of state law requirements set forth in bylaws or policy. Intentional misrepresentation on applications for membership or privileges should be specified.

Sample Bylaw: Corrective Action

Procedures and Conduct

1) Conduct Requiring

Activities or professional conduct of any practitioner detrimental to or behavior disruptive to patient safety or to the delivery of quality patient care, or conduct in violation of or contrary to these Bylaws, the Rules and Regulations of the Staff.

2) Initiation

Corrective action may be initiated by any officer of the Staff, the Chair of any clinical department, the Chair of any standing committee, the Administrator, or the Board. Additionally, members of the nursing staff, allied health professionals and hospital employees, may request such action, by communicating a request to the Medical Executive Committee as described in this paragraph [...] All requests for corrective action shall be submitted to the Medical Executive Committee in writing and supported by reference to the activities or conduct constituting grounds for the request. A copy of the request and notice of the practitioner's right to appear pursuant to Paragraph (3) (b) below shall immediately be sent to the practitioner by the Medical Executive Committee by certified mail return receipt requested or by personal service. The Chair of the Medical Executive Committee shall promptly notify the Administrator in writing of all requests for corrective action received by the Medical Executive Committee and shall continue to keep the Administrator fully informed of all action taken in connection therewith.

3) Medical Executive Committee Action

a) Time

Within thirty (30) days following receipt of a request for corrective action, unless the affected practitioner agrees to an extension of time, the Medical Executive Committee shall take action upon the request or permit an appearance by the affected practitioner.

b) Appearance by Member

If the corrective action could involve an adverse decision concerning clinical privileges, or a suspension or expulsion from the Staff, the affected practitioner shall be afforded an opportunity to make an appearance before the Medical Executive Committee prior to its taking action on such request. This appearance shall not constitute a hearing, but shall be preliminary and investigative in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply thereto.

c) Recommendation

Within ten (10) business days following an appearance by the practitioner, the Medical Executive Committee shall take action with respect to the matter. A written record of action on the request for corrective action shall be made by the Medical Executive Committee and kept on file at the Hospital. The Medical Executive Committee shall promptly notify the Administrator of its action made in regard to a request for corrective action.

d) Permitted Action

On a request for corrective action, the Medical Executive Committee of the Staff may take one of the following actions: a warning; letter of admonition; letter of reprimand; imposition of terms of probation or a requirement for consultation or continuing medical education; recommendation for reduction, suspension or revocation of clinical privileges; recommendation for alteration of already imposed restrictions; recommendation for suspension or revocation of Staff membership; absolution of the practitioner; or any alternative to the above-named deemed appropriate by the Medical Executive Committee. Action so taken may form the basis of future actions.

Illinois State Medical Society Model Medical Staff Bylaws §XI.A.

Sexual Harassment

Federal and state laws forbidding sexual harassment in the workplace warrant specific provisions in the medical staff bylaws or policies establishing harassment as a basis for corrective action.

Sample Bylaw: Harassment

Harassment by a medical staff member against any individual (e.g., against another medical staff member, house staff, hospital employee, or patient) on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex, sexual orientation, or gender identity shall not be tolerated.

"Sexual harassment" is unwelcome verbal or physical conduct of a sexual nature which may include verbal harassment (such as epithets, derogatory comments, or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and visual harassment (such as the display of derogatory cartoons, drawings, or posters).

Sexual harassment includes unwelcome advances, requests for sexual favors, and any other verbal, visual, or physical conduct of a sexual nature when (1) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion, or other aspects of employment; or (2) this conduct substantially interferes with the individual's employment or creates an intimidating, hostile, or offensive work environment. Sexual harassment also includes conduct which indicates that employment and/or employment benefits are conditioned upon acquiescence in sexual activities.

All allegations of sexual harassment shall be immediately investigated by the medical staff and, if confirmed, will result in appropriate corrective action, from reprimands up to and including termination of medical staff privileges or membership, if warranted by the facts.
California Medical Association Model Medical Staff Bylaws §2.6.

A sample disruptive behavior policy that also addresses sexual harassment is included as Appendix E.

Disruptive Behavior

Disruptive behavior by a member can become an issue within the medical staff and should be addressed in the bylaws. Caution should be exercised to ensure that disruptive behavior is subject to corrective action to the extent that patient care is affected. Medical staff bylaws provisions that broadly prohibit activities that are "disruptive to hospital operations" can be interpreted to block legitimate medical staff opposition to proposed hospital services and plans, or to terminate members who disagree with hospital administrators or compete with hospital-based services.

Disruptive behavior should be carefully assessed, including clinical examination where indicated, to determine whether a referral to the medical staff wellness committee for behavioral therapy or discipline is warranted. Due to the complexity and evolution of disruptive behavior issues, the medical staff should include provisions in the bylaws for disruptive behavior that adversely affects patient care as the basis for corrective action. Details for evaluation and resolution of disruptive behavior problems may be outlined in medical staff policy. A sample disruptive behavior policy is included as Appendix E.

Summary Suspension

Summary suspension of privileges or medical staff membership is a drastic action only justified—and only protected—under the most serious of circumstances. "AMA policy is that: (1) Summary suspension of clinical privileges is an extraordinary remedy which should be used only when the physician's continued practice presents an 'imminent danger to the health of any individual.'" AMA Policy H-375.965. Joint Commission Standard MS.1.20 Element of Performance 13 states that the medical staff bylaws include "Indications for summary suspension of a practitioner's medical staff membership or clinical privileges." In addition, under Joint Commission Standard MS.1.20 Element of Performance 30, medical staff bylaws must include "The process for summary suspension of a practitioner's medical staff membership or clinical privileges." Medical staff bylaws provisions allowing summary suspension must be constructed carefully, with particular regard to the grounds for suspension, the body or individuals permitted to impose suspension, and the process by which the person subject to the suspension may be heard.

The Health Care Quality Improvement Act conditions peer review immunity from antitrust and other civil liability on the availability of notice and hearing rights to the physician. The Act, however, explicitly states that it is not to be construed as "precluding an immediate suspension or restriction of clinical privileges, subject to subsequent notice and hearing or other adequate procedures, where the failure to take such an action may result in an imminent danger to the health of any individual." 42 U.S.C. §11112 (c)(2). This standard is advisable for inclusion in medical staff bylaws to promote protection of the summary suspension decision. Despite the Act's protections, many medical staff bylaws fail to meet the standard by permitting summary suspension for failure to comply with hospital policy or minor infraction of medical staff bylaws. Liability for failing to meet the conditions for summary suspension can be high; the trial court in Poliner v. Texas Health Systems (No. Civ.A.3:00-CV-1007-P, 2006 WL 770425 (N.D. Tex. Mar. 27, 2006)) awarded a cardiologist $360 million in damages because the summary suspension of his catheterization lab privileges was not motivated by quality improvement. Medical staffs should be wary of any attempt to circumvent the parameters the federal law lays out for protected summary suspension by renaming it "precaution-

ary suspension" or "investigative suspension," as if naming the action something else permits those involved to suspend a physician for the wrong reasons.

Medical staff bylaws should clearly identify who can impose summary suspension. Because suspension should be based on a clinical determination that the practitioner's action under privileges endangers a person's health, it is logical to allow only other clinicians, such as the chief of staff or the chief of a department, to suspend. Under AMA Policy H-375.965, "The decision to summarily suspend a member's medical staff membership or clinical privileges should be made by the chief of staff, chair or vice-chair of the member's clinical department, or medical executive committee." (See Principle 6C of Appendix K: Principles for Strengthening the Physician-Hospital Relationship.) Note that state law may define the authorities who are permitted to suspend summarily or may limit protection of summary suspension depending on who suspended. *See* Berry v. Oak Park Hosp., 628 N.E.2d 1159 (Ill. App. Ct. 1993) (suspension by administrator not covered by immunity granted to committees).

Sample Bylaw: Summary Suspension

Circumstances

The Chief of Staff, and Chair or Vice Chair of the respective department, or the Medical Executive Committee shall constitute an ad hoc committee for the limited purposes of this Section and shall have the right, whenever action must be taken immediately because continuation of practice of a practitioner constitutes an immediate danger to the public, including patients, visitors, and hospital employees and staff or for those administrative circumstances specified below, to summarily suspend all or any portion of the clinical privileges of a practitioner, effective immediately upon imposition. Where summary suspension is imposed by the Medical Executive Committee in the absence of the Chief of Staff, the Medical Executive Committee should immediately transmit notice of the suspension to the Chief of Staff.

Illinois State Medical Society Model Medical Staff Bylaws §XI. C.1.

See also Appendix J: AMA Board of Trustees Report on Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations.

The summary suspension or restriction should not be considered a final action until adopted as such by the board of trustees following exhaustion of hearing and appeal rights. The medical staff bylaws should include a clear statement that summary suspensions and other adverse actions are not to be reported to the National Practitioner Data Bank (NPDB) or relevant state agencies, if state law so permits, until taken as a final action by the board. While it is critical that procedures be followed in imposing summary suspension, the medical staff should be mindful of the 15-day deadline for reporting a summary suspension that lasts longer than 30 days. *See* 45 C.F.R. §60.5(c) and §60.9(a)(1)(i). NPDB Guidelines can be accessed online (*www.npdb-hipdb.com/guidebook.html*).

Automatic Suspension

Standard MS.1.20 calls for medical staff bylaws to include "Indications for automatic suspension of a practitioner's medical staff membership or clinical privileges," under Element of Performance 12, and, under Element of Performance 29, "The process for automatic suspension of a practitioner's medical staff membership or clinical privileges." Medical staff bylaws should provide for automatic suspension of clinical privileges when a basic substantial qualification, such as state licensure, is no longer met. Automatic suspension is appropriate when there is no subjective evaluation involved, and the suspension is based on a clear matter of fact. Automatic suspension is also employed as an enforcement tool for medical records completion.

Sample Bylaw: Automatic Suspension

1) State Board Action

Action by the Texas State Board of Medical Examiners or other appropriate licensing board revoking or suspending a practitioner's license shall automatically suspend the practitioner's Staff membership and clinical privileges. Action by the appropriate state licensing board revoking or suspending the license of a limited license professional exercising clinical privileges shall automatically suspend the limited license professional's clinical privileges. Such suspension of Staff membership and clinical privileges shall continue throughout the period during which the practitioner's license is revoked or suspended. In the absence of any corrective action which has adversely affected the practitioner's Staff membership or clinical privileges, the suspension described in this paragraph shall automatically terminate upon the reinstatement of the practitioner's license by the Texas State Board of Medical Examiners or other appropriate state licensing board.

2) Drug Enforcement Administration Action

Action by the Drug Enforcement Administration (including voluntary relinquishment by the practitioner) revoking or suspending a practitioner's controlled substances registration shall automatically suspend the Staff membership and clinical privileges to the extent necessary to be consistent with the action taken by the Drug Enforcement Administration. Action by

the Drug Enforcement Administration revoking or suspending the controlled substances registration of a limited license professional exercising clinical privileges shall automatically suspend the limited license professional's clinical privileges to the extent consistent with the action taken by the Drug Enforcement Administration. In the absence of any corrective action which has adversely affected the practitioner's Staff membership or clinical privileges, the suspension described in this paragraph shall automatically terminate upon the reinstatement of the practitioner's registration by the Drug Enforcement Administration.

3) Medical Records—Staff Generally

A Staff member may have automatic suspension imposed for failure to complete medical records in accordance with Staff Rules and Regulations and these Bylaws, in the following manner:

a) A temporary suspension in the form of withdrawal of admitting privileges (hereinafter called a "no bed status"), effective until medical records are completed, shall be imposed following the recommendation of such suspension to the Medical Executive Committee by the Medical Records Committee. Such suspension shall be imposed automatically beginning seven (7) business days after the mailing by registered mail, certified mail, or by personal service to the affected Staff member, at his or her current office address supplied by him or her to the Hospital, of a written notice from the Chief of Staff of the Staff member's delinquency in completing his or her medical records, with the Chief of Staff also sending a copy of said notice to the Medical Records Committee. During this seven (7) day period, the affected Staff member may explain any extenuating circumstances to the Chief of Staff who, in his discretion, may extend the period before the temporary suspension shall begin.
b) Remaining on no bed status in excess of thirty (30) days consecutively or forty-five (45) days total in any twelve-month period shall be grounds for immediate corrective action pursuant to Section A of this Article.

4) Medical Records—Consulting Staff and Limited License Professionals Exercising Clinical Privileges

A Consulting Staff member or limited license professional may have automatic suspension imposed for failure to complete medical records in accordance with Staff Rules and Regulations and these Bylaws, in the following manner:

a) A temporary suspension in the form of a withdrawal of all of a Consulting Staff member's consulting privileges and all of a limited license professional's clinical privileges (hereinafter referred to as "consulting status"), except as to those patients to which the affected practitioner is providing direct patient care services or is acting as a consultant at the time of the suspension, effective until medical records are completed, shall be imposed following the recommendation of such suspension to the Medical Executive Committee by the Medical Records Committee. Such suspension shall be imposed automatically beginning seven (7) business days after the mailing by registered mail, certified mail, or by personal service to the affected practitioner, at his or her current office address supplied by him or her to the Hospital, of a written notice from the Chief of Staff of the practitioner's delinquency in completing his or her medical records, with the Chief of Staff also sending a copy of said notice to the Medical Records Committee. During this seven (7) business day period, the affected practitioner may explain any extenuating circumstances to the Chief of Staff who, in his discretion, may extend the period before the temporary suspension shall begin.
b) Remaining on no consulting status in excess of thirty (30) days consecutively or forty-five (45) days total in any twelve-month period shall be grounds for immediate corrective action pursuant to Section A above.

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5) Notice

The Chief of Staff shall promptly transmit notice of any suspension based on failure to complete medical records as described in Paragraphs (3) and (4) above to the Administrator, who shall promptly notify the affected practitioner in writing of the suspension and the grounds therefore and notice of his or her rights, if any, under Article XII in the form prescribed by Section A (4) above. This notice shall be delivered to the practitioner in person, if practical; if not, then by certified or registered mail. The Administrator shall likewise transmit notice of any suspension under Paragraphs (1) or (2) above.

6) Enforcement

It shall be the duty of the Chief of Staff and the Medical Executive Committee to cooperate with the Administrator in enforcing all automatic suspensions.

Texas Medical Association Model Medical Staff Bylaws §XI.D.

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Hearing Process

Hearing Process

Joint Commission Standard MS.1.20, Element of Performance 32 outlines the need for a mechanism for a fair hearing and appeal procedure being defined in the medical staff bylaws. The practice of devising a "fair hearing plan" as separate from but cross-referenced in the medical staff bylaws may violate state law. *See* Illinois Hospital Licensing Act, 210 Ill. Comp. Stat. 85/10.4. The Joint Commission Standard calls for an appellate review in addition to a hearing, a two-tier approach common in medical staff bylaws but rarely mandated by law. *See* Colo. Rev. Stat. §12-36.5-104(8)(a), providing for appellate review before the hospital board.

The purpose of the hearing process, to test the data gathered and determine the truth, is sometimes lost in the scramble to meet technical requirements. Providing a full and fair hearing whenever warranted, subjecting its outcome to review for fairness and evidentiary support by an appellate body, and detailing the procedures in medical staff bylaws voted on by all medical staff and board members should meet the legal tests and also arrive at the truth.

Actions Resulting in Entitlement to Hearing Rights

The grounds triggering hearing rights should be unequivocally specified in the medical staff bylaws. Typically the grounds triggering a hearing include suspension, or revocation of privileges or membership, however the medical staff bylaws may state the triggering events specifically in this section of the bylaws. Federal and state law set the minimums for actions that give rise to hearing rights. The medical staff and hospital typically set higher standards.

Immunity under the Health Care Quality Improvement Act (HCQIA) is available for a "professional review action," defined as an action or recommendation of a professional review body taken or made in the course of professional review, which may adversely affect the physician's clinical privileges or membership in a professional society and is based on the physician's competence or professional conduct. "Adversely affect" is, in part, defined as "reducing, restricting, suspending, revoking, denying, or failing to renew clinical privileges or membership in a health care entity." 42 U.S.C. §11151(1). To come within the purview of the HCQIA, the physician's conduct or competence problem must affect or could adversely affect the health or welfare of a patient or patients. 42 U.S.C. §11151(9). To qualify a peer-review activity for federal immunity, medical staff bylaws at a minimum should allow hearing rights for actions or recommendations based on competence or professional conduct. State thresholds for notice and hearing rights vary. The states that attach hearing rights to actions reported to state licensing agencies (*see* Cal. Bus. & Prof. Code §809.1(b)) may generally be met by expanding the grounds for hearings to include a category for any recommendation or action that would be reportable if adopted. State law may impose no limits to hearing rights. *See* Illinois Hospital Licensing Act, 210 Ill. Comp. Stat. 85/2(b)(3) (extends hearing rights for any and all adverse actions, including those based on economics).

Sample Bylaws: Hearing Rights

When any practitioner receives notice of a recommendation of the Medical Executive Committee that if ratified by the Board will adversely affect the practitioner's appointment to or status as a member of the Staff or exercise of clinical privileges, the practitioner shall be entitled to a hearing before an ad hoc committee of the Staff.

Texas Medical Association Model Medical Staff Bylaws §XII.A.1.

Statutory Standards for Hearings

Under the HCQIA, immunity for peer review activities and actions is conditioned on good faith and fair notice and hearing procedures. The Act defines fair notice and hearing minimums in a "safe harbor" approach. Under a safe-harbor approach, any procedure meeting the Act's standards is automatically deemed fair. The standards, set forth below, should be the minimum for notice and hearing rights in medical staff bylaws. Medical staff hearings will be deemed fair if the standards for fairness are met or waived.

Standards for Fair Hearings, Health Care Quality Improvement Act of 1986

Action notice

The physician is to be given notice stating

(a) (i) That a professional review action has been proposed to be taken against the physician;
(ii) Reasons for the proposed action;
(b) (i) That the physician has the right to request a hearing on the proposed action;
(ii) Any time limit (of not less than 30 days) within which to request such a hearing, and
(c) A summary of rights in the hearing.

Hearing notice

If a hearing is requested, the physician must be given notice stating

(a) The place, time and date of the hearing, which date shall not be less than 30 days after the date of the notice; and
(b) A list of the witnesses (if any) expected to testify at the hearing on the part of the professional review body.

Hearing body

If a hearing is requested, the hearing shall be held (as determined by the hospital)

(a) Before an arbitrator mutually acceptable to the physician and the hospital;
(b) Before a hearing officer who is appointed by the entity and who is not in direct economic competition with the physician involved; or
(c) Before a panel of individuals who are appointed by the entity and are not in direct economic competition with the physician involved.

Hearing rights

In the hearing, the physician involved has the right

(a) To representation by an attorney or other person of the physician's choice,
(b) To have a record made of the proceeding, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof,
(c) To call, examine and cross-examine witnesses,
(d) To present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law, and
(e) To submit a written statement at the close of the hearing.

Hearing completion

Upon completion of the hearing, the physician has the right

(a) To receive the written recommendation of the hearing body, including a statement of the basis for the recommendation, and
(b) To receive the written decision of the hospital, including a statement of the basis for the decision.

These standards are not mandatory under the Act. A medical staff or health care entity can earn immunity without meeting the exact standards listed above but would have to prove that the process was fair.

States may require more detail in regard to fair hearing rights and procedures. For example, under the Illinois procedural standard, a requested hearing must begin 15 days after the suspension, as opposed to the Act's standard that hearings are not to begin sooner than 30 days after notice. *See* 210 Ill. Comp. Stat. 85/10.4(b)(2)(c)(i).

Other state law provisions may not conflict with the federal standards but should fill out the Act's skeletal process. For example, the Health Care Quality Improvement Act is silent on the issue of burden of proof. California's peer-review statute resolves this common procedural problem with the following mandate:

> (1) The peer review body shall have the initial duty to present evidence which supports the charge or recommended action; (2) Initial applicants shall bear the burden of persuading the trier of fact by a preponderance of the evidence of their qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning their current qualifications for staff privileges, membership, or employment. Initial applicants shall not be permitted to introduce information not produced upon request of the peer review body during the application process, unless the initial applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence; and (3) Except as provided above for initial applicants, the peer review body shall bear the burden of persuading the trier of fact by a preponderance of the evidence that the action or recommendation is reasonable and warranted. Cal. Bus. & Prof. Code §809.3(b).

"Preponderance of the evidence" can be translated simply as "more likely than not." The California approach seeks to have the burden of proof fall to the party that has the data. It is a reasonable provision for bylaws of medical staffs in other states when conflicting local standards are absent. State law governing hearing rights must be reflected in the medical staff's bylaws.

Hearing Body

To meet the requirements of the HCQIA, the hearing body must be selected by the hospital, presumably by delegating selection to the administrator or chair of the board. Medical staff bylaws predating the HCQIA, and many revised after its adoption in 1986, typically authorize the chief of staff or medical executive committee to select the hearing body. The authority of the chief medical staff officer to appoint a medical staff committee should be preserved. Further, it is critical that an impartial panel be appointed and the chief of staff is likely to be more familiar with the personalities and biases of medical staff members. To meet these ends while satisfying the requirements of the Act, the medical staff bylaws should provide that the chief of staff recommend members for the hearing panel and the administrator, as delegate of the hospital, appoint the committee.

The Act also permits the hospital or health care entity to choose one of three types of hearing bodies—an arbitrator, a hearing officer sitting alone or a hearing panel. For most medical staffs, the hearing panel provides the most impartial fact-finding by peers. In unusually small medical staffs or where there is a question regarding impartiality, an impartial panel may not be consistently possible. The small medical staff may want to preserve in its bylaws the option of choosing among the three hearing options on a case-by-case basis or seek outside physicians to participate in peer review.

Sample Bylaw: Hearing Body for Small Medical Staffs

If a hearing is requested, the chief of staff shall make a recommendation to the administrator from among the following options:

(a) Hearing Committee: The chief of staff may recommend that the administrator, on behalf of the hospital, appoint a hearing committee to be composed of no fewer than three members of the medical staff selected by the chief of staff. The chief of staff shall also designate a committee chairman from among the committee members selected.

Committee members shall gain no direct financial benefit from the outcomes and (to the extent possible) shall not have acted as accuser, investigator, fact-finder, initial decision maker, or otherwise actively participated in the consideration of the matter leading up to the recommendation or action. However, knowledge of the matter involved shall not preclude a member of the medical staff from serving as a member of the hearing committee.

In the event that it is not feasible to appoint a hearing committee from the medical staff or the request of the physician under review upon a showing of impartiality or bias, the chief of staff may select physicians or other practitioners who are not members of the medical staff and recommend them for temporary medical staff membership under these bylaws for the period of the hearing. The chief of staff may also recommend that the administrator appoint a hearing officer who meets the requirements of this article to conduct the hearing for the hearing committee. If requested by the hearing committee, the hearing officer may participate in the deliberations of such committee and be a legal advisor to it, but the hearing officer shall not be entitled to vote.

(b) Hearing Officer: The chief of staff may recommend that the administrator, on behalf of the hospital, appoint a hearing officer to conduct the hearing. The hearing officer may be an attorney at law qualified to preside over a quasi-judicial hearing, but an attorney regularly used by the hospital or medical staff for legal advice regarding its affairs and activities shall not be eligible to serve as hearing officer. The hearing officer shall gain no direct financial benefit from the outcome and must not act as a prosecuting officer or as an advocate.

(c) The chief of staff may recommend that the administrator, on behalf of the hospital, appoint an arbitrator who shall be mutually acceptable to the member under review and the medical staff and the hospital.

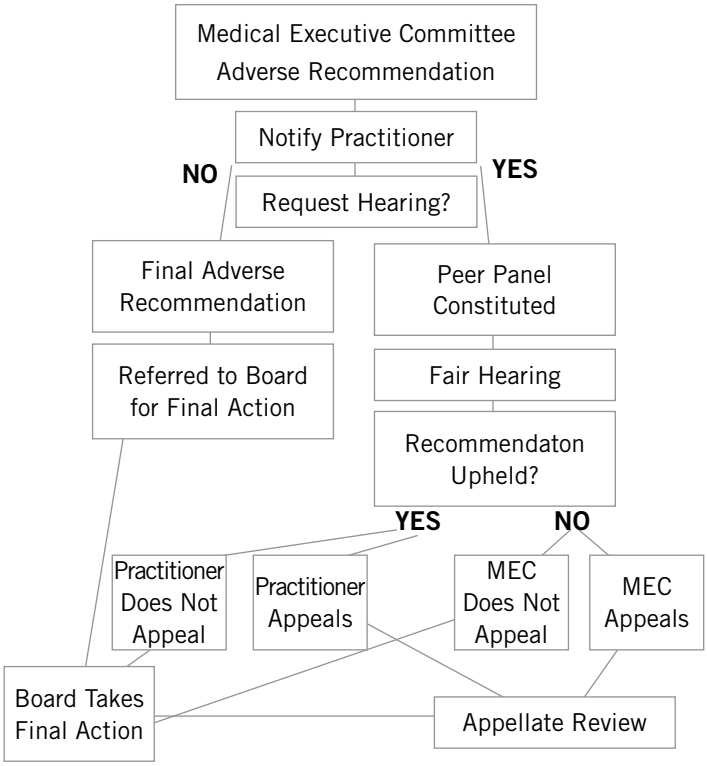
The hearing officer, hearing committee chairman, if no hearing officer is named, or arbitrator shall be the presiding officer. The administrator shall follow the chief of staff's recommendation unless it is inconsistent with these bylaws or with the law.

It is also important to preserve the purpose of the hearing committee by directing its report to the governing body for final action following exhaustion or waiver of appeal rights. Some medical staff bylaws permit the hearing committee report to be directed to the medical executive committee for action. Since, in most cases, the medical executive committee is the accuser, it should not be given the opportunity of overriding the impartial hearing body. State law may mandate that the hearing committee report directly to the governing body, as is the case in Illinois.

210 Ill. Comp. Stat. 85/10.4(b)(2)(C).

Medical Staff Fair Hearing and Due Process

Chart adapted from Dr. John Malcom's Pennsylvania Organized Medical Staff Section materials



Under Pennsylvania regulations, differences between the MEC recommendation and the Board must go to a Joint Conference Committee prior to the Board's final action. 28 Pa. Code §107.5(b)(5).

Reporting Actions to Governmental Agencies

Medical staff bylaws should include procedures to promote compliance with reporting laws and prevent unnecessary reports.

At the federal level, the National Practitioner Data Bank (NPDB) gathers adverse data about physicians and dentists and to a lesser degree, due to the fact that reporting is optional, other practitioners. Failure to report adverse actions against physicians and dentists to the NPDB jeopardizes immunity available under the Health Care Quality Improvement Act, creating an incentive to report even if filing is not clearly mandated. Proper procedures in medical staff bylaws can provide direction to prevent loss of immunity and can close loopholes and clarify ambiguities left in the regulations. The NPDB's reporting and querying requirements are found in regulations at 45 C.F.R. §60 et seq.

Although the NPDB offers the option of reporting actions taken against practitioners other than physicians and dentists, hospitals and medical staffs may choose not to report other practitioners. Whatever the determination, it should be included in the medical staff bylaws.

NPDB reports are permanent, surviving even the death of the physician reported, and must be obtained by hospitals whenever a physician applies for initial medical staff membership or seeks to renew membership or privileges. Managed care entities, medical groups, or other employers of physicians may query the NPDB regarding the physician so long as they are either a hospital or otherwise fall under the definition of "health care entity" in the Health Care Quality Improvement Act, 42 U.S.C. §11151(4). Given the potential damage that inappropriate NPDB reports may cause a physician's reputation and career, physicians and medical staffs have a clear interest in accurate NPDB reporting.

NPDB regulations have circumscribed mechanisms for correcting mistakes and misinformation. The reported individual cannot directly file a correction. Rather, the subject must attempt to persuade the reporting entity to correct its original report. To avoid a lengthy NPDB dispute process, medical staff bylaws should include a minimal dispute process between the physician and the reporting entity.

Sample Bylaw: National Practitioner Data Bank Reporting

1. Adverse Action Reports
   The medical center's authorized representative shall report an adverse action to the National Practitioner Data Bank only upon its adoption as a final action by the governing board and only using the description set forth in the final action as adopted by the governing board following completion of the hearing process in which the description has been included in the notice and has been subject to discussion by the parties. Where no hearing was requested or granted, the member shall be granted the opportunity to meet with the chief of staff and the medical center's authorized representative to review and discuss the proposed data bank report before it is filed. The medical center's authorized representative shall report any and all revisions of an adverse action, including but not limited to any expiration of the final action consistent with the terms of that final action.

2. Dispute Process
   A member who was the subject of an adverse action report may request an informal meeting to dispute the report filed. The report dispute meeting shall not constitute a hearing and shall be limited to the issue of whether the report filed is consistent with the final action issued. The meeting shall be attended by the subject of the report, the chief of staff, and the medical center's authorized representative.

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Officers and Representatives of the Medical Staff

Officers and Representatives of the Medical Staff

Under Joint Commission Standard MS.1.20, Element of Performance 28, the medical staff bylaws must provide for selection and removal of medical staff officers. Note that such provisions should be written into bylaws as opposed to a separate "organizational manual."

Elections

The Joint Commission lists election and removal of medical staff officers among the elements defining medical staff self-governance. Specifically, Element of Performance 1 for Joint Commission Standard MS.1.10 states, "The organized medical staff is self-governing as referenced in the bullets defining self-governance on page MS-5," which include "Selecting and removing medical staff officers." Board control over the outcome or interference in the process of medical staff elections for any reason contradicts accreditation standards and often generates controversy and ill will. A medical staff bylaws provision subjecting medical staff elections to board approval was the subject of litigation in the California case Eisenhower Memorial Hospital v. Stoltzman (No. E006511, Cal. Ct. App. 1989). In that case, the board sought a restraining order against the medical executive committee after the medical staff recognized its duly elected president-elect despite a board action to disapprove his election. After two years of contentious debate, the board approved the president-elect and accepted the medical staff's amendment to the bylaws deleting the board's authority to approve or disapprove elections. AMA policy confirms that selection and removal of officers is essential for medical staff self-governance. AMA Policy H-235.980. Further, AMA policy urges the Joint Commission to change the accreditation standards to require that all medical staff bylaws and hospital governing documents recognize the inherent authority of the medical staff to elect and seat its medical staff officers and that such elections of officers are not subject to hospital governing body approval, affirmation or concurrence. AMA Policy H-220.962.

In addition to officers, the medical staff should establish mechanisms for election of medical staff representatives to other bodies. The AMA supports medical staff representation at all meetings of the governing body, with the right of voice and vote, if appropriate and consistent with applicable law. AMA Policy H-225.983. Medical staffs of all hospital and health care entities are encouraged to select a representative to the AMA Organized Medical Staff Section.

Conflicts of Interest

The AMA encourages medical staffs to include in bylaws a requirement that candidates disclose any conflict of interest: "Candidates for election or appointment to medical staff offices, department or committee chairs, or the medical executive committee, should disclose in writing to the medical staff, prior to the date of election or appointment, any personal, professional or financial affiliations or responsibilities on behalf of the medical staff." AMA Policy H-235.970. Under Joint Commission Standard LD.2.20 (which goes into effect in January 1, 2009) Element of Performance 1 calls for "The governing body, senior managers and leaders of the organized medical staff work together to define, in writing, what constitutes a conflict of interest that could affect safety and quality involving individual members of leadership groups." Safety and quality could obviously be affected by a medical staff leader's conflict of interest; therefore, the medical staff bylaws should address the various situations in which conflict of interest must be considered.

Included in such disclosure should be any contractual or employment relationship with the hospital, to allow the medical staff members voting to make an informed decision as to whether the candidate will be able to act in the best interest of the medical staff. Any information disclosed, particularly personal financial information in the limited circumstances in which it is relevant, should be kept confidential and limited to the issue of election or appointment to a leadership position.

Sample Bylaw: Disclosure of Interest

All nominees for election or appointment to medical staff offices, department chairships, or the medical executive committee shall, at least [20] days prior to the date of election or appointment, disclose in writing to the medical executive committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware, including contractual, employment or other relationships with the hospital, which could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the medical staff.
California Medical Association Model Medical Staff Bylaws §14.6.

See also Appendix I: The American Medical Association Organized Medical Staff Conflict of Interest Guidelines.

Duties of Officers

Duties of elected officials of the medical staff should be clearly delineated in the medical staff bylaws and should be designed to promote medical staff self-governance.

Sample Bylaws: Duties

2.2-1 Chief of Staff

The chief of staff shall serve as the chief officer of the medical staff. The duties of the chief of staff shall include, but not be limited to:

(a) enforcing the medical staff bylaws and rules and regulations and policy, implementing sanctions where indicated, and promoting compliance with procedural safeguards where corrective action has been requested or initiated.
(b) calling, presiding at and being responsible for the agenda of all meetings of the medical staff.
(c) serving as chair of the medical executive committee, with vote.
(d) serving as a member of the joint conference committee.
(e) serving as an ex officio member of all other staff committees. As an ex officio member of such committees, the chief of staff will have no vote, unless his or her membership in a particular committee otherwise is required by these bylaws.
(f) interacting with the CEO and board of [trustees or directors] in all matters of mutual concern within the hospital. The chief of staff shall be a voting member of the board of [trustees or directors].
(g) appointing, in consultation with the medical executive committee, committee members for all standing and special medical staff, liaison, or multidisciplinary committees, except where otherwise provided by these bylaws, and designating the chair of these committees except where otherwise indicated.
(h) representing the views and policies of the medical staff to the board of [trustees or directors] and to the CEO.
(i) being a spokesperson for the medical staff in external professional and public relations.
(j) performing such other functions as may be assigned to him or her by these bylaws, by the medical staff or by the medical executive committee.
(k) serving on liaison committees with the board of [trustees or directors] and administration, as well as outside licensing or accreditation agencies.

2.2-2 Chief of Staff-elect

The chief of staff-elect shall assume all duties and authority of the chief of staff in the absence of the chief of staff. The chief of staff-elect shall be a member of the medical executive committee of the medical staff and of the joint conference committee, and shall perform such other duties as the chief of staff may assign or as may be delegated by these bylaws or by the medical executive committee.

2.2-3 Secretary-treasurer

The secretary-treasurer shall be a member of the executive committee. The duties shall include, but not be limited to:

(a) maintaining a roster of members.
(b) keeping accurate and complete minutes of all medical executive committee and medical staff meetings.
(c) calling meetings on the order of the chief of staff or medical executive committee.
(d) attending to all appropriate correspondence and notices on behalf of the medical staff.
(e) receiving and safeguarding all funds of the medical staff.
(f) excusing absences from meetings on behalf of the medical executive committee.
(g) performing such other duties as ordinarily pertain to the office or as may be assigned from time to time by the chief of staff or medical executive committee.

Ohio State Medical Association Model Medical Staff Bylaws §2.2.

Duties of Medical Staff Representatives

In addition to elected officers, medical staffs may structure its governance to include electing individuals whose leadership role is limited to representing the organized medical staff to outside entities. This spreads out the duties of leadership among more members, which may help to alleviate the burden and time commitment for officers.

Participation in the AMA Organized Medical Staff Section (OMSS) and in some states, a state medical society organized medical staff section, provides the medical staff with a powerful connection to other medical staffs who are facing the same challenges. Networking and education through the AMA-OMSS is an efficient and effective means of promoting professionalism and preserving medical staff self-governance. The medical staff bylaws should describe the duties of the AMA-OMSS representative.

Sample Bylaw: Organized Medical Staff Representative and Alternate

The duties of the organized medical staff representative shall include, but not be limited to:

(a) representing the organized medical staff in the [Ohio State Medical Association (OSMA)] OMSS general assembly.
(b) reporting OSMA-OMSS activities to the chief of staff.
(c) such other duties as may be assigned from time to time by the chief of staff or the medical executive committee.

The duties of the organized medical staff representative alternate shall include, but not be limited to assuming all duties and authority of the organized medical staff representative in the

absence of the representative.
Ohio State Medical Association Model Medical Staff Bylaws §2.2.

Membership on the board of trustees is specifically encouraged by the AMA, which states, "(1) It is the policy of the AMA that physicians who are members of the medical staff shall be eligible for, and should be included in, full membership on hospital governing bodies and their action committees in the same manner as are other knowledgeable and effective individuals. Other physicians also should be considered eligible for membership on the governing body. The hospital medical staff should have the right of representation at all meetings of the governing body by medical staff members elected by the medical staff having the right of attendance, voice and, if appropriate, vote. Compensation to medical staff members for service to the hospital should not preclude the physician's membership on the hospital governing board. (2) Hospital conflict of interest policies should include physician medical staff members of hospital governing boards." AMA Policy H-225.983. Hospitals should not have conflict-of-interest policies that apply solely to medical staff members on the governing body. Hospital board membership is also encouraged by the Joint Commission. Element of Performance 10 of Joint Commission Standard LD.1.30 states, "Organized medical staff members are eligible for full membership in the [organization's] governing body, unless legally prohibited." (See Principle 10 of Appendix K: AMA Principles for Strengthening the Physician-Hospital Relationship.)

Sample Bylaw: Hospital Board of [Trustees or Directors] Representative and Alternate

The duties of the medical staff's representative on the hospital board of [trustees or directors] shall include, but not be limited to:

(a) representing the medical staff on the hospital board and any board committees to which the representative is named, with vote.
(b) reporting board activities to the medical executive committee.
(c) such other duties as may be assigned from time to time by the chief of staff or the medical executive committee.

The duties of the medical staff representative and alternate shall include, but not be limited to assuming all duties and authority of the medical staff representative on the hospital board in the absence of the representative.
Ohio State Medical Association Model Medical Staff Bylaws §2.2.

Orientation and Training of Officers

Medical staff officers incur great responsibility when assuming office. Expectation that the duties require no introduction is unrealistic and incorrect. Medical staffs should support effective leadership by requiring and financing medical staff officer training.

Medical staff leadership seminars are available commercially and through professional associations. The medical staff should carefully screen seminars before accepting the offerings as appropriate training for medical staff leadership, as some commercial seminars denigrate medical staff rights, responsibilities and self-governance. Medical staffs should consult the AMA-OMSS staff and leadership regarding suitable medical staff leadership training. Further, AMA-OMSS educational sessions, usually held in conjunction with the semiannual AMA-OMSS Assembly meetings, provide physician-oriented sessions designed to assist medical staff leadership. Information is available at the AMA-OMSS Web site (*www.ama-assn.org/go/omss*).

Removal of Officers

The medical staff bylaws include "the process for selecting and removing the organized medical staff officers," under Element of Performance 28 of Joint Commission Standard MS.1.20. Both the process and the basis of removal should be stipulated. As with medical staff elections, removal of elected officers should be the sole prerogative of the medical staff. Authorizing the governing body to remove officers is inconsistent with medical staff self-governance.

Sample Bylaws: Officer Removal

An officer of the Staff may be removed by two-thirds (2/3) vote of the regular Active Staff members eligible to vote for Staff officers. Removal may be based only upon failure to perform the duties of the office held as described in these Bylaws or upon failure to otherwise adhere to the requirements of these Bylaws.
Illinois State Medical Society Model Medical Staff Bylaws §VII.F.

Departments

It is customary for medical staffs organized by department to follow clinical specialty. The medical staff may want to refrain from naming the departments in the bylaws to give the medical staff flexibility in merging, eliminating or creating departments. A directory of departments can be maintained in the medical staff office. Under this approach, the medical staff controls a key aspect of its organizational structure without hospital or health care entity interference. Further, this approach also streamlines the medical staff organizational structure and offers more

latitude in medical staff reengineering. Because departments are not listed in the bylaws, changes in departments would not be submitted to the governing body for approval.

Sample Bylaw: Formation, Merger, or Elimination of Departments or Services

A medical staff department or service can be formed, merged, or eliminated only after a determination by the medical executive committee of the appropriateness of the action.

(a) The medical executive committee shall determine the formation, merger, or elimination of a department or service to be appropriate based on consideration of its effects on the quality of care in the facility and/or community. A determination of the appropriateness must be based upon the preponderance of the evidence, viewing the record as a whole, presented at an open forum before an ad hoc committee appointed by the chief of staff, by any and all interested parties, following notice and opportunity for comment.

(b) The medical staff member(s) whose privileges may be adversely affected by the medical staff's determination of the appropriateness of department or service elimination may request a hearing. Such a hearing will be governed by the hearing procedure under these bylaws, except that (1) The hearing shall be limited to the following issues: (A) whether the medical executive's determination of appropriateness is supported by the preponderance of the evidence; and (B) whether the medical staff followed by its requirements for notice and comment on the issue of appropriateness. (2) All requests for such a hearing will be consolidated. Should an affected medical staff member request a hearing under this subsection, the medical executive committee's action regarding the elimination of the department or service will be deferred, pending the outcome of the hearing.

(c) Except as specified in this section, the termination of privileges pursuant to the elimination of a department or service determined to be appropriate by the medical staff shall not be subject to the procedural rights otherwise set forth in these bylaws.

Director Authority

Medical staffs should seriously consider the scope of authority granted to department directors. Joint Commission MS.1.20, Element of Performance 33, requires that the medical staff department director's responsibilities be specified in the medical staff bylaws and sets forth a list of minimum responsibilities. These duties include the recommendation of privileges for each department member, all administrative responsibilities and all clinically related activities of the department.

While the standards do not require that a single individual carry out these responsibilities, they may be interpreted as allowing all clinical duties usually performed by departments (collectively) to be carried out by a chair, who may be appointed or employed by the hospital or health care entity. State laws may not adhere to Joint Commission Standards. Some states' legal protections for peer review and quality improvement are granted to committees or departments and may not protect activities carried out by an individual.

Selection of a Director

It is important that the department director represent the department and, as a medical staff official, be accountable to and selected by the medical staff department or at least by the Medical Executive Committee. "The AMA supports amendment of the Joint Commission on Accreditation of Healthcare Organizations Medical Staff Standard by addition of the words and selection, so as to read: 'Responsibilities and selection of department chairmen (referred to as director in 1997 Standards) are specified in the medical staff bylaws, rules and regulations.' " AMA Policy H-220.963. (See Principle 6.l of Appendix K: AMA Principles for Strengthening The Physician-Hospital Relationship.)

Medical staffs should be aware that the heads of some or all departments may be required by state law, state regulation or the Medicare conditions of participation to be board certified, eligible for board certification, or have other qualifications. Specific eligibility requirements for department heads should be set forth in the medical staff bylaws.

Department Leadership Orientation and Training

As with medical staff officers, department leaders should be supported by requirements for orientation and training. Again, the medical staff should carefully screen seminars to ensure medical staff rights, responsibilities and self-governance issues are included in the program. Medical staffs should consult the AMA-OMSS staff and leadership regarding suitable medical staff leadership training. Further, AMA-OMSS educational sessions, usually held in conjunction with the semiannual AMA-OMSS Assembly meetings, provide physician-oriented sessions designed to assist medical staff leadership. Information is available at the AMA-OMSS Web site (*www.ama-assn.org/go/omss*).

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Committees

Committees

Medical staff bylaws should establish the authority of the medical executive committee or the president or chief of staff in forming committees of the medical staff and assigning appropriate tasks as necessary. By keeping the number of medical staff committees stipulated in the bylaws to a minimum, the medical staff organization gains flexibility to carry out its functions in a structure responsive to current needs.

To maximize legal protections, however, certain functions should be carried out by a duly constituted committee of the medical staff. Federal law provides broad protection for both hospital and medical staff officials, assistants and committees. The Health Care Quality Improvement Act's protections apply to a professional review body, which it defines as "a health care entity and the governing body or any committee of a health care entity which conducts professional review activity, and includes any committee of the medical staff of such an entity when assisting the governing body in a professional review activity." 42 U.S.C. §11151(11). Persons assisting, contracting, or acting as a member of the professional review body are also eligible for the Act's protections. 42 U.S.C. §11111(a)(1).

Some state laws may establish a higher threshold for immunity. To maximize the protections available, critical functions should be assigned in the medical staff bylaws. The medical staff must be aware of limitations of confidentiality or immunity protections under state law. For instance, peer-review actions may be covered under state law only if carried out by committee. In one case, a summary suspension imposed by an administrator was held to fall outside the immunity granted to committee actions. Berry v. Oak Park Hosp., 628 N.E.2d 1159 (Ill. App. Ct. 1993). Composition of the committee may or may not preserve confidentiality or immunity. In Santa Rosa Memorial Hosp. v. Superior Court, 174 Cal. App. 3d 711 (1985), Cal. Evid. Code §1157's protection for records and proceedings of medical staff committees was held to apply to committees whose members included administration representatives and other non-medical staff personnel. Other state laws, however, may vary.

Bylaws provisions describing each committee should specify its membership, its duties, including reporting responsibilities, and meeting frequency.

Budget Committee

Medical staff organizations should budget and manage the funds they receive from application fees and membership dues. Particularly because funds are involved, a committee (e.g., Medical Staff Executive Committee or Medical Staff Budget Committee), rather than an individual, responsible for oversight and accounting is an appropriate mechanism for the medical staff organization. The organized medical staff works with the hospital governing board to develop a budget to satisfy those requirements and related administrative activities, which the hospital shall fund, based upon the financial resources available to the hospital.(See principle 8 of Appendix K: AMA Principles for Strengthening the Physician-Hospital Relationship.)

Sample Bylaw: Budget Committee

Composition

The budget committee consists of [two] members of the medical staff and the medical staff treasurer [secretary-treasurer] who will serve as committee chair. Members shall serve three (3) year terms on a staggered basis, subject to re-appointment.

Duties

The budget committee:

- recommends the annual medical staff budget to the medical executive committee;
- recommends the amount of annual dues and, if appropriate, assessments to the medical executive committee;
- meets at the call of the chair but no less frequently than monthly; and
- fulfills other responsibilities as established in these bylaws or as are appropriately delegated by the medical executive committee or the medical staff.

Medical Association of Georgia §II.C.2.

Credentials Committee

A credentials committee is not mandated by Joint Commission standards but is common in medical staff bylaws as a useful means of performing the key medical staff function of credentialing. Credentials committees should include a broad spectrum of specialties represented on the medical staff to provide informed review of applicants.

Sample Bylaw: Credentials Committee

(1) Composition

The Credentials Committee shall consist of one member from each department who are regular Active Staff members [or may be a committee of the whole if the Staff is non-departmentalized].

(2) Duties

The Credentials Committee shall:

(a) Review and evaluate the qualifications of each practitioner applying for initial appointment, reappointment, or modification of and for clinical privileges, and, in connection therewith, obtain and consider the recommendations of the appropriate departments;

(b) Submit required reports and information on the qualifications of each practitioner applying for Staff membership or particular clinical privileges including recommendations with respect to appointment, membership, category, department affiliation, clinical privileges and special conditions;

(c) Investigate, review and report on matters referred by the Chief of Staff or the Medical Executive Committee regarding the qualifications, conduct, professional character or competence of any applicant or Staff member, in order to maintain and improve the quality of medical care rendered by the Staff; and

(d) Submit periodic reports to the Medical Executive Committee on its activities and the status of the pending applications.

(3) Meetings

The Credentials Committee shall meet as often as necessary, but at least once a month. The Committee shall maintain a record of its proceedings and actions and shall report to the Medical Executive Committee.

Texas Medical Association Model Medical Staff Bylaws §X.C.

Executive Committee

Under Joint Commission Standard MS.1.20 Elements of Performance 20, medical staff bylaws are to include "the medical staff executive committee's function, size, and composition; the authority delegated to the medical staff executive committee by the organized medical staff to act on its behalf; and how such authority is delegated or removed." Under MS.1.20 Element of Performance 23, the bylaws are to provide "That the medical staff executive committee acts on the behalf of the organized medical staff between meetings of the organized medical staff, within the scope of its responsibilities as defined by the organized medical staff." The medical executive committee (MEC) must be accountable to the medical staff.

Medical staff bylaws listing the duties of the medical executive committee should stipulate that the duties are delegated by the medical staff to more clearly meet the standard. Medical staff bylaws also should clarify how the medical staff can withdraw the MEC's authority, in addition, obviously, to amending the medical staff bylaws description of the medical executive committee's duties.

Sample Bylaw: Removal of MEC Authority

The Medical Staff may, at a regular or special meeting at which a quorum is achieved, remove and reassign any of the authority here delegated to the Executive Committee for a stated period of time, for a reason identified and supported by the meeting, by a vote of two-thirds (2/3) of the voting members.

Functions stipulated by Joint Commission Standard MS.1.40, and its Rationale and Elements of Performance, include the "primary authority for activities related to self-governance of the medical staff" and responsibility for recommendations made directly to the board regarding the medical staff's structure and mechanisms for reviewing credentials, delineating privileges, terminating membership, and extending fair hearing rights, membership, and clinical privileges for each individual, as well as for participating in hospital improvement activities. The medical executive committee should also receive and act on reports from medical staff committees, departments and "assigned activity groups" under Joint Commission Standard MS.1.40, Element of Performance 12. Establishing in the medical staff bylaws that all medical staff committees and departments report only to the medical executive committee addresses these standards. More important, setting up such a structure allows the medical staff's activities to be coordinated.

Composition of the medical executive committee is critical to medical staff self-governance. To comply with Joint Commission Standards, under MS.1.40 Element of Performance 4, "the majority of voting medical staff executive committee members are fully licensed physician actively practicing in the hospital"; however, "all members of the organized medical staff, of any discipline or specialty, are eligible for membership on the medical staff executive committee" under Element of Performance 3 of MS.1.40. AMA policy supports election of the voting members of the executive committee by the medical staff membership, in the case of members at large, or by departments, in the case of department representatives. AMA Policy H-220.943. The executive committee would thus be representative of the membership as opposed to being limited to department chiefs who might be employed by, under contract to, or otherwise appointed to that position by the hospital. In addition, at its 1993 interim meeting, the AMA-OMSS adopted substitute resolution 29, a policy asking that the AMA-OMSS encourage all hospital medical staffs to include their AMA-OMSS representative on the medical executive committee.

Joint Commission Standard MS.1.20 Element of Performance 21 calls for the bylaws to address not only how medical executive committee members are selected but also how they are removed from the committee.

Sample Bylaw: Removal of MEC Members

Members shall be removed from the Medical Executive Committee upon resigning or being removed by operation of these Bylaws from the Medical Staff leadership position qualifying for Committee membership. At-large members may be removed for any reason by action of the medical staff, by majority vote of the members in which fifty percent of the voting membership participates.

Joint Commission Standard MS.1.40, Element of Performance 2, states that "the chief executive officer (CEO) of the hospital or his or her designee attends each executive committee meeting on an ex-officio basis, with or without vote." The AMA supports amending this standard to state that the chief executive officer or designee "may be invited to attend meetings of the Executive Committee of the medical staff." AMA Policy H-220.978.

Arguably, an MEC meeting going into executive session which excludes the CEO or designee from that portion of the meeting would not violate this AMA policy. Despite the Joint Commission Standard, the MEC and all medical staff committees would be prudent to retain the authority to go into executive session whenever the presence of the administrator or other nonmember may impede the fulfillment of the committee's responsibilities.

Sample Bylaw: Medical Executive Committee

(1) Composition

The Medical Executive Committee shall consist of the officers of the Staff and the department Chair. The Administrator or his or her designee shall not be members but may be invited to attend meetings.

The majority of the members of the Medical Executive Committee must be regular Active Staff members.

(2) Duties

The Duties of the Medical Executive Committee shall include, but not be limited to:

(a) Representing and acting on behalf of the Staff in the intervals between Staff meetings, subject to such limitations as may be imposed by these Bylaws;
(b) Coordinating and implementing the professional and organizational activities and policies of the Staff;
(c) Receiving and acting upon reports and recommendations from the Staff departments and committees;
(d) Recommending action to the Board on matters of a medical-administrative nature;
(e) Establishing the structure of the Staff, the mechanism to review credentials and delineate individual clinical privileges, the organization of quality assurance activities and mechanisms of the Staff, termination of Staff membership and fair hearing procedures, as well as other matters relevant to the operation of an organized Staff;
(f) Evaluating the medical care rendered to patients in the Hospital;
(g) Participating in the development of all Staff and Hospital policy, practice, and planning;
(h) Reviewing the qualifications, credentials, performance and professional competence and character of applicants and Staff members and making recommendations to the Board regarding Staff appointments and reappointments, assignments to departments, clinical privileges, and corrective action;
(i) Adopting such Staff Rules and Regulations as may be necessary for the proper conduct of the Staff consistent with these Bylaws;
(j) Taking reasonable steps to promote ethical conduct and competent clinical performance on the part of all Staff members including the initiation of and participation in corrective or review measures when warranted;
(k) Taking reasonable steps to develop continuing education activities and programs for the Staff;
(l) Designating such committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the Staff and approving or rejecting appointment to those committees by the Chief of Staff;
(m) Reporting to the Staff at each regular Staff meeting;
(n) Assisting in the obtaining and maintaining of accreditation;
(o) Appointing such special or ad hoc committees as may seem necessary or appropriate to assist the Medical Executive Committee in carrying out its functions and those of the Staff;
(p) Reviewing actions of the Board as such actions affect the Staff as a whole or individual members thereof;
(q) Reviewing actions of the Board as such actions affect the quality of patient care, including the right and duty to communicate to the Board the opinion, from a quality of care standpoint, of the Staff regarding any contract, whether proposed or in effect, between the Board or the Hospital on the one hand and one or more Staff members, other practitioners exercising clinical privileges, or any entity representing such Staff member(s) or other practitioner(s) on the other hand; and
(r) Reporting appropriate matters and making recommendations to the Board at each regular meeting.

(3) Meetings
The Medical Executive Committee shall meet as often as necessary as called by the Chief of Staff, but at least once a month, and shall maintain a record of its proceedings and actions.
Texas Medical Association Model Medical Staff Bylaws §X.B.

Joint Conference Committee

To establish a forum for hospital and medical staff communication on a regular basis or to handle disagreement or an impasse between the two, the medical staff may consider establishing a joint conference committee of medical staff members and board members in equal numbers, with alternating chairs or co-chairs to enhance communication. Equal numbers ensure that the committee is evenly weighted and encourage consensus as the basis for action. Both the medical staff and governing body can bring matters to the conference through their representatives. The joint conference committee's conflict resolution function can serve to meet elements of performance for the pending Joint Commission Standard LD.2.40, "The organization manages conflict between leadership groups to protect the quality and safety of care." Joint Commission Standard LD.2.40 is effective as of January 1, 2009.

Depending on state statute, the joint conference committee should be described in both medical staff and corporate bylaws as a committee of the medical staff, to enable the committee to benefit from the legal protections that may be limited to medical staff committees. "Hospitals should establish a committee consisting of an equal number of board of trustees/directors and medical staff representatives such as a joint conference committee, to address conflicts and attempt to resolve them as they arise." AMA Policy H-225.979. Strategic planning may be assigned to the joint conference committee to ensure medical staff representation in an area from which medical staffs are commonly excluded.

Generally, peer-review responsibilities should not be assigned to the joint conference committee to preserve the impartiality needed for the hearing process, which involves both the medical executive committee and governing body. State law may dictate otherwise, as in Pennsylvania, which provides for "[a] review by joint committee of the active medical staff and the governing body in cases where the governing body does not concur with the medical staff's recommendation regarding the granting or refusing of clinical privileges. Such review shall occur prior to the rendering of a final decision by the governing body." 28 Pa. Ad. Code §107.5(b)(5).

Sample Bylaw: Duties of the Joint Conference Committee
The joint conference committee shall serve as the review body for all the health-care entity's strategic planning. The committee shall review all strategic plans before the plans are sent to the board for approval in accordance with the committee's recommendations. The committee may request additional information from management before acting to approve or disapprove such plans. The committee shall serve as the conflict resolution forum for all conflicts arising between the medical staff and the hospital, which may be brought to the committee by the medical staff or medical executive committee, hospital management, or by the board. The committee shall also constitute a forum for the discussion of matters of hospital and medical staff policy, practice, and a forum for interaction between the board and the medical staff on such matters as may be referred by the executive committee or the board. To preserve the impartiality of the hearing process, however, individual peer review issues shall not be referred to the joint conference committee. The joint conference committee shall fulfill other responsibilities set forth in these bylaws.

Infection Control Committee

"AMA Policy states that (1) the hospital medical staff should have a multidisciplinary committee to oversee the surveillance, prevention and control of infection; (2) the infection control committee should report to the hospital medical staff executive committee; and (3) the medical staff's role, responsibility, and authority in the infection control activities should be included in the medical staff bylaws." AMA Policy H-235.969.

Quality Assurance/Performance Improvement Committee

"It is the policy of the AMA: (1) that the hospital medical staff be recognized within the hospital as the entity with the overall responsibility for the quality of medical care; (2) that hospital medical staff bylaws reaffirm the Joint Commission Standard that medical staffs have 'overall responsibility for the quality of the professional services provided by individuals with clinical privileges'; (3) that each hospital's quality assurance, quality improvement, and other quality-related activities be coordinated with the hospital medical staff's overall responsibility for quality of medical care; (4) that the hospital governing body, management, and medical staff should jointly establish the purpose, duties, and responsibilities of the hospital administrative personnel involved in quality assurance and other

quality-related activities; establish the qualifications for these positions; and provide a mechanism for medical staff participation in the selection, evaluation, and credentialing of these individuals; (5) that the hospital administrative personnel performing quality assurance and other quality activities related to patient care report to and be accountable to the medical staff committee responsible for quality improvement activities; (6) that the purpose, duties, responsibilities, and reporting relationships of the hospital administrative personnel performing quality assurance and other quality-related activities be included in the medical staff and hospital corporate bylaws; (7) that the general process and polices related to patient care and used in a hospital quality assurance system and other quality-related activities should be developed, approved, and controlled by the hospital medical staff." AMA Policy H-225.971.

Wellness Committee/Medical Staff Assistance Committee

Medical staff assistance committees are not commonly mandated by state law, with the notable exception of California, where medical staff bylaws, rules, and regulations must provide for assisting medical staff members in obtaining rehabilitation for impairment by chemical dependency or mental illness. 22 Cal. Code of Regs. §70703(d). Joint Commission Standard MS.4.80 calls upon the medical staff to implement a process to identify and manage individual practitioner health matters separate and apart from the disciplinary process and to promote medical staff education on impairment and other practitioner health issues.

Medical staff assistance committees can serve invaluable purposes for every medical staff. Properly structured committees afford impaired medical staff members a non-punitive opportunity to recover while preserving their valuable skills through monitored practice. If the purview of the committee is sufficiently broad, it can be used to monitor the work of practitioners with infectious diseases if needed. Further, members whose limited ability to work well with others affects patient care can be helped through appropriate intervention and education provided by such a committee. A common mistake in medical staff bylaws is to refer to "physician assistance committees." Not only does this reference suggest that only physicians are in need of assistance, it could be construed to exclude non-physician members of the medical staff unnecessarily.

The Illinois State Medical Society operates and administers Illinois' only Physician Assistance Program and has published "Guidelines For Hospital Committees To Assist Impaired Physicians" for hospital committees. Medical staffs should consult the medical association of their state or county regarding guidelines, referral sources and other assistance available for physician and medical staff wellness activities.

Sample Bylaw: Medical Staff Assistance Committee

(1) Composition

In order to improve the quality of care and promote the competence of the medical staff, there is hereby established a Medical Staff Assistance Committee comprised of no less than [_____] Active Staff members appointed by the Chief of Staff, a majority of whom, including the chair, shall be physicians. Except for initial appointments, each member shall serve a term of [_____] years, and the terms shall be staggered as deemed appropriate by the Medical Executive Committee to achieve continuity. Insofar as possible, members of this committee shall not serve as active participants on the Executive Committee, any Disciplinary Committee, if any, or any other peer review or quality assurance committees while serving on this committee.

(2) Duties

The Medical Staff Assistance Committee shall have as its purpose the improvement of the quality of care and the promotion of competence among Staff members. The Committee may receive reports related to the health, well-being or impairment of medical staff members and, as it deems appropriate, may investigate such reports. The Committee's duties shall be:

(a) To recognize the responsibility of the staff for the provision of competent patient care and to provide assistance to those members who, because of a physical, emotional, or mental impairment, are in need of assistance and monitoring in order to restore of optimal functioning and competent patient care.

(b) To develop a written impaired Staff member policy that addresses appropriate intervention, denial, revocation, or limitation of clinical privileges, follow-up assessments, and the reinstatement of clinical privileges for impaired applicants or Staff members upon their re-entry; to obtain the approval of the Medical Staff for such policy; and to implement such policy;

(c) To receive any report relating to the mental or physical health, well-being, or impairment of any applicant or Staff member, as relevant to such person's ability to exercise the clinical privileges granted to, or requested by, such person;

(d) To investigate such reports to the extent necessary to protect the health, welfare, and safety of patients, other Staff members, and hospital personnel;

(e) To provide such advice, counseling, or referrals as it determines may be necessary;

(f) Upon the occurrence of any accident or incident in which a Staff member's performance cannot be discounted as a contributing factor, to request such chemical test or tests of blood, breath, urine, or other bodily substances as it may deem necessary for the purpose of determining alcoholic or other drug content of the Staff member's system, as relevant to such Staff member's ability to exercise the clinical privileges granted to, or requested by, such Staff member; and further to request such psychiatric or other medical evaluations as it shall deem necessary to determine the Staff member's ability to exercise the clinical privileges granted to, or requested by, such Staff member;

(g) Upon receipt of documentation of specific, contemporaneous physical, behavioral or performance indicators consistent with probable substance abuse, psychiatric or other medical conditions so as to create a reasonable suspicion that an applicant or a Staff member is using or is under the influence of alcohol or other drugs while rendering or participating in patient care or the exercise of clinical privileges or is suffering from some other psychiatric disorder, to request such tests or evaluations described in Paragraph (e) above as it deems necessary;

(h) To consider, in conjunction with the Credentials Committee and the Quality Assessment and Improvement Committee, the results of any such tests or evaluations or the refusal to consent to such testing or evaluation; to implement any intervention or other action in accordance with the impaired member policy as adopted by the Staff; and to request corrective action in accordance with the provisions of Article XI when appropriate; and

(i) To study matters relating to the general health and well-being of the Staff and to develop such educational programs as may be approved by the Medical Executive Committee.

The activities of the Medical Staff Assistance Committee shall be confidential. The refusal to consent to such testing or evaluation as is requested by the Medical Staff Assistance Committee shall constitute grounds for denial of an application for Staff membership or clinical privileges or for immediate suspension or revocation of all or any portion of a member's Staff membership or clinical privileges; however, any member against whom any action is taken with respect to Staff membership or clinical privileges as a result of the refusal to consent to testing or as a result of any test results shall have the right to a hearing and appellate review in accordance with Article XII.

(3) Meetings

The Medical Staff Assistance Committee shall meet as often as necessary as called by its Chair, but at least [six times per year]. The Medical Staff Assistance Committee shall maintain such records of its proceedings and actions as it deems advisable, but shall report its activities in their entirety to the Medical Executive Committee. Reports shall be as brief as possible relating to actions taken by the Committee and protecting the confidentiality of all proceedings. Confidentiality is imperative: No identifying data shall be included in a report.

Illinois State Medical Society Model Medical Staff Bylaws §X.N.

Bylaws Committee

To promote ongoing review and updating of bylaws, applications and other forms, a standing bylaws committee should be named. New officers should be rotated through the bylaws committee in order become thoroughly familiar with the bylaws.

Sample Bylaws: Bylaws Committee

Bylaws Committee

11.11-1 Composition

The bylaws committee shall consist of at least [_____] members of the medical staff, including at least the vice chief of staff or chief of staff-elect and immediate past chief of staff.

11.11-2 Duties

The duties of the bylaws committee shall include:

(a) conducting an annual review of the medical staff bylaws, as well as the rules and regulations and forms promulgated by the medical staff, its departments and divisions;

(b) submitting recommendations to the medical executive committee for changes in these documents as necessary to reflect current medical staff practices; and

(c) receiving and evaluating for recommendation to the medical executive committee suggestions for modification of the items specified in subdivision (a).

3.3-3 Meetings

The bylaws committee shall meet as often as necessary at the call of its chair but at least [annually]. It shall maintain a record of its proceedings and shall report its activities and recommendations to the medical executive committee.

California Medical Association Model Medical Staff Bylaws §11.11.

Continuing Medical Education Committee

Some states may require that continuing medical education (CME) be overseen by a committee in order for the hospital to qualify for accreditation as a CME provider. Committees should take precaution to align CME offering with the federal "Stark" fraud and abuse laws.

Sample Bylaws: CME Committee

11.17 Medical Education Committee

11.17-1 Composition

The continuing medical education committee shall be composed of physician members and other health professionals of the medical staff whose number shall be appropriate to the size of the hospital and amount of program activities produced annually. The composition shall be a chairperson, who shall serve for at least two years, and committee members who shall serve staggered terms in order to assure continuity. If the hospital has a Director of Medical Education, that individual should be at least an ex-officio member of the committee.

11.17-2 Duties

The continuing medical education committee shall perform the following duties:

(a) plan, implement, coordinate and promote ongoing special clinical and scientific programs for the medical staff. This includes:
(1) identifying the educational needs of the medical staff;
(2) formulating clear statements of objectives for each program;
(3) assessing the effectiveness of each program;
(4) choosing appropriate teaching methods and knowledgeable faculty for each program; and
(5) documenting staff attendance at each program.
(b) assist in developing processes to assure optimal patient care and contribute to the continuing education of each practitioner.
(c) liaison with the quality assessment and improvement program of the hospital in order to be apprised of problem areas in patient care, which may be addressed by a specific continuing medical education activity.
(d) maintain close liaison with other hospital medical staff and department committees concerned with patient care.
(e) make recommendations to the medical executive committee regarding library needs of the medical staff.
(f) advise administration of the financial needs of the continuing medical education program.

11.17-3 Meetings

The continuing medical education committee shall meet as often as necessary, but at least quarterly. It shall maintain minutes of the program planning discussions and report to the medical executive committee.

California Medical Association Model Medical Staff Bylaws Section 11.17.

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Meetings

Meetings

Medical staffs should determine the minimum requirements for attendance, number and timing of general staff meetings needed to ensure the accomplishment of medical staff business. These requirements should be set forth in the medical staff bylaws. Department and committee meeting requirements must similarly be designed to enable practicing clinicians to fulfill peer-review and other ongoing duties. To maintain control of medical staff functions, the bylaws should set requirements for a minimum number of meetings. Non-functioning medical staff committees and departments in effect relinquish control to non-clinical administrative staff and thereby forgo the legal protections reserved for committee activities.

Medical staffs would be prudent to enable "virtual" meetings to facilitate broader participation in medical staff activities.

Sample Bylaw: Electronic Participation

Notice, attendance, and actions including voting and participation may be accomplished by email or other electronic and/or telephonic means where permitted by the chair of the meeting on either an individual or group basis.

Attendance Requirements

Many hospital consultants and attorneys encourage elimination of attendance requirements, arguing that administrative time is used monitoring attendance, and members are demeaned by being forced to add meetings to already busy schedules. Common attendance provisions state that attendance is "encouraged but not required." Lack of an attendance requirement does not encourage attendance. For the most part, eliminating attendance requirements reduces member participation. While the functions of meetings can be fulfilled with fewer clinical participants, it more than likely would be done by administrative personnel rather than medical staff members. Medical staff leaders are advised to make meetings meaningful and efficient and to lessen the burden of required attendance while preserving broad participation.

The risk to this streamlining activity, however, is the forfeiture of opportunities to influence decision making around medical practice and governance issues. Meetings are often the only vehicle medical staff members have for voicing opinions and concerns. They also give physicians the chance to become familiar with colleagues who may otherwise seek leadership positions. Without this involvement and exposure, medical staff members have less control in actions by their medical executive committee or hospital/health care entity administrators. Attendance at medical staff meetings, traditionally, is a responsibility of each staff member.

Sample Bylaw: Attendance Requirements

Regular Active Staff members and all provisional Staff members shall be required to attend one-half (1/2) of the regular meetings within any fiscal year or fraction thereof, unless absences are excused. A list of acceptable excuses shall be set forth in the Rules and Regulations of the Staff, pursuant to Article XV. Failure to meet the attendance requirements shall be grounds for immediate corrective action pursuant to Article XI.
Texas Medical Association Model Medical Staff Bylaws §VIII.F.

Voting

To prevent misunderstandings and procedural confusion, medical staff bylaws should stipulate who has the right to vote at general staff meetings and elections, at department and section meetings and elections, and in committees. Logically, membership in the medical staff should be a minimum requirement for eligibility for voting rights within the medical staff organization. A general enfranchisement statement can be inserted into the medical staff bylaws article describing membership rights and responsibilities.

State law may limit the kinds of restrictions a medical staff can place on voting rights. In California, for example, "Medical staff bylaws, rules and regulations shall not deny or restrict within the scope of their licensure, the voting rights of staff members or assign staff members to any special class or category of staff membership, based upon whether such staff members hold an MD, DO, DPM, or DDS degree or clinical psychology license." 22 Cal. Code of Regs. §70703(b).

Sample Bylaw: Voting Rights

Only members of the medical staff may vote in departmental, sectional or general medical staff elections and at committee, department and medical staff meetings, unless otherwise specified in these bylaws.

Medical staffs may also ban proxy voting, consistent with the AMA policy, which states that "proxy voting prior to or at medical staff meetings should not be permitted in medical staff bylaws." AMA Policy H-235.972. Means of voting should be tailored to the needs of the particular

medical staff but should be designed to promote participation in medical staff affairs. In addition to voting electronically, as discussed on page 71 in the Meetings section, the medical staff can choose to cast votes by hand or voice count in meetings, or by paper ballot at meetings by mail. Votes can take place within the confines of a physical meeting, or over the course of a day or days, as the bylaws describe.

Executive Session

All committees, departments, and the medical staff as a whole should reserve the right to meet in executive session. "The AMA (1) supports the right of any hospital medical staff committee to meet in executive session, with only voting members of the medical staff present, in order to permit open and free discussion of issues such as peer review and to maintain confidentiality; and (2) encourages individual medical staffs to incorporate provisions in their bylaws to affirm this right." AMA Policy H-235.987.

Sample Bylaw: Executive Session

At the call of the presiding officer, any medical staff committee, section or department, or the medical staff as whole, may meet in executive session with attendance restricted to medical staff members, a recording secretary and such advisors or other attendees as the presiding officer may specifically request to attend.

Quorum Requirements

Quorum should be set at levels allowing the business of the meeting to be accomplished. The medical staff should be wary of setting a low quorum, particularly if attendance requirements are dropped, lest a small minority be authorized to take actions affecting the membership.

Release, Immunity and Indemnification

Typically, medical staff bylaws enumerate the agreements by an applicant for initial or renewed membership to release information and to hold harmless representatives of the hospital and members of the medical staff in the credentialing process and in any ongoing review. The release and immunity provisions in the medical staff bylaws should be consistent with the same provisions set forth on medical staff membership and application forms for clinical privileges. The medical staff should determine whether release and waiver clauses should be limited to "good faith" activities.

Release and waiver clauses should provide some protection to those conducting peer review. By fulfilling a responsibility to review other practitioners for the hospital, as required for the hospital's licensure and accreditation, individual reviewers may be exposed to antitrust and other liabilities. Further, if hospital and medical staff policies provide for physician review of non-physician practitioners, those medical staff members may be providing services not considered professional-review activities under state law or individual professional liability insurance polices. Such activities are not protected under federal law. The Health Care Quality Improvement Act specifically exempts physician or dentist review of non-physicians from its conditional protections. 42 U.S.C. §11115(c). The Act's immunity is available only to review among physicians and dentists. Thus, physicians and dentists conducting review of practitioners who are not physicians and dentists have no assurance that their review activities will be immune from liability.

Hospital general liability or directors' and officers' liability insurance policy coverage may not apply to all physicians. Some hospital insurance policies do not include medical staff officers, department chiefs, committee chairs and members, and those providing information to the relevant committees or authorities, as covered individuals under the insurance policy. Even if the hospital policy provides coverage for physicians, it is subject to cancellation. Consequently, medical staff bylaws should provide for indemnification by the hospital to ensure consistent coverage for peer reviewers. The AMA's position is that "every physician who serves as medical staff president, head of a medical staff department, a member of a medical staff peer review or quality review committee or acts in any hospital and/or medical staff administrative capacity, absent malice, should be fully indemnified and held harmless by the hospital." AMA Policy H-225.976.

Sample Bylaw: Indemnification

The hospital shall defend, or assume the costs incurred for defense and pay any settlements, judgments and damages on behalf of any member of the medical staff arising out of service on any hospital or medical staff committee or assisting in peer and professional review or quality management activities involving care provided at the hospital, so long as the member of the medical staff acted in good faith.

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Confidentiality Protections and Obligations

Confidentiality Protections and Obligations

Medical Staff Records

Medical staff records, including the agenda, minutes, reports or other documents generated in meetings of the general staff, departments, committees, along with member credentials and quality assurance files, should be treated in a manner that preserves their status under state confidentiality statutes. Under some state laws, the release of records to the hospital board may waive confidentiality. *See* Shelton v. Morehead Mem. Hosp., 347 S.E.2d 824 (N.C. 1986). Medical staff bylaws should clarify that the medical staff controls its records and obligate hospital personnel and medical staff members to maintain confidentiality. They should also prevent the hospital from releasing information that may serve its business interests but threaten the medical staff's peer-review system and provide for release or disclosure of records pursuant to medical staff bylaws, policies or pursuant to a legitimate order of a court. Medical staff policy on confidentiality should define the documents covered and the means, if any, by which release or disclosure is authorized. Breach of confidentiality should be included among the grounds for corrective action.

Medical staff records need to survive the hospital in order to allow medical staff members to be credentialed by their subsequent medical staffs. In case the hospital is sold, closed, or merged into another entity, medical staff bylaws should provide for preserving medical staff credentials files; in Illinois, preservation of the files in the event of hospital closure is a matter of law. 77 Il Admin Code 250.310.

Sample Bylaw: Confidentiality

Medical staff members and applicants and hospital representatives shall maintain the confidential nature of all medical staff records. No medical staff, department, section or committee minutes, files or records, including information contained in the credentials file of any member or applicant to this medical staff, shall be disseminated except as provided in this section. Dissemination of such information and records shall only be made where expressly required by law or pursuant to officially adopted policies of the medical staff.

Member Credentials Files

Members should be granted access to their credentials files. AMA policy supports specifying in medical staff bylaws the members' rights to inspect their own credentials file and rebut information it contains. AMA Policy H-225.992.

Sample Bylaw: Medical Staff Credentials Files

Insertion of Adverse Information

The following applies to actions relating to requests for insertion of adverse information into the medical staff member's credentials file:

(a) As stated previously, in Section [_____], any person may provide information to the medical staff about the conduct, performance or competence of its members.

(b) When a request is made for insertion of adverse information into the medical staff member's credentials file, the respective department chair and chief of staff shall review such a request.

(c) After such a review a decision will be made by the respective department chair and chief of staff to:
  (1) not insert the information;
  (2) notify the member of the adverse information by a written summary and offer the opportunity to rebut this assertion before it is entered into the member's file; or
  (3) insert the information along with a notation that a request has been made to the medical executive committee for an investigation as outlined in Section [_____] of these bylaws.

(d) This decision shall be reported to the medical executive committee. The medical executive committee, when so informed, may either ratify or initiate contrary actions to this decision by a majority vote.

Review of Adverse Information at the Time of Reappraisal and Reappointment

The following applies to the review of adverse information in the medical staff member's credentials file at the time of reappraisal and reappointment.

(a) Prior to recommendation on reappointment, the credentials committee, as part of its reappraisal function, shall review any adverse information in the credentials file pertaining to a member.

(b) Following this review, the credentials committee shall determine whether documentation in the file warrants further action.

(c) With respect to such adverse information, if it does not appear that an investigation and/or adverse action on reappointment is warranted, the credentials committee shall so inform the medical executive committee.

(d) However, if an investigation and/or adverse action on reap-

pointment is warranted, the credentials committee shall so inform the medical executive committee.

(e) No later than 60 days following final action on reappointment, the medical executive committee shall, except as provided in (g):
  (1) initiate a request for corrective action, based on such adverse information and on the credentials committee's recommendation relating thereto, or
  (2) cause the substance of such adverse information to be summarized and disclosed to the member.

(f) The member shall have the right to respond thereto in writing, and the medical executive committee may elect to remove such adverse information on the basis of such response.

(g) In the event that adverse information is not utilized as the basis for a request for corrective action, or disclosed to the member as provided herein, it shall be removed from the file and discarded, unless the medical executive committee, by a majority vote, determines that such information is required for continuing evaluation of the member's:
  (1) character;
  (2) competence; or
  (3) professional performance.

Confidentiality

The following applies to records of the medical staff and its departments and committees responsible for the evaluation and improvement of patient care:

(a) The records of the medical staff and its departments and committees responsible for the evaluation and improvement of the quality of patient care rendered in the hospital shall be maintained as confidential.

(b) Access to such records shall be limited to duly appointed officers and committees of the medical staff for the sole purpose of discharging medical staff responsibilities and subject to the requirement that confidentiality be maintained.

(c) Information which is disclosed to the governing body of the hospital or its appointed representatives—in order that the governing body may discharge its lawful obligations and responsibilities—shall be maintained by that body as confidential.

(d) Information contained in the credentials file of any member may be disclosed with the member's consent, to any medical staff or professional licensing board, or as required by law. However, any disclosure outside of the medical staff shall require the authorization of the chief of staff and the concerned department chair and notice to the member.

(e) A medical staff member shall be granted access to his/her credentials file, subject to the following provisions:
  (1) timely notice of such shall be made by the member to the chief of staff or the chief of staff's designee;
  (2) the member may review, and receive a copy of, only those documents provided by or addressed personally to the member. A summary of all other information—including peer review committee findings, letters of reference, proctoring reports, complaints, etc.—shall be provided to the member, in writing, by the designated officer of the medical staff (at the time the member reviews the credentials file)/(within a reasonable period of time, as determined by the medical staff). Such summary shall disclose the substance, but not the source, of the information summarized;
  (3) the review by the member shall take place in the medical staff office, during normal work hours, with an officer or designee of the medical staff present.

(f) In the event a notice of action or proposed action is filed against a member, access to that member's credentials file shall be governed by Section _____.

Member's Opportunity to Request Correction/Deletion of and to Make Addition to Information in File

(a) After review of the file as provided under Section _____ the member may address to the chief of staff a written request for correction or deletion of information in the credentials file. Such request shall include a statement of the basis for the action requested.

(b) The chief of staff shall review such a request within a reasonable time and shall recommend to the medical executive committee, after such review, whether or not to make the correction or deletion requested. The medical executive committee, when so informed, shall either ratify or initiate action contrary to this recommendation, by a majority vote.

(c) The member shall be notified promptly, in writing, of the decision of the medical executive committee.

(d) In any case, a member shall have the right to add to the individual's credentials file, upon written request to the medical executive committee, a statement responding to any information contained in the file.

California Medical Association Model Medical Staff Bylaws §14.8.

Generally, credentialing information should be retained in a single, member-specific file, not scattered among various departments and information systems, to promote inclusion of the information in credentialing processes and to preserve confidentiality.

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Allied Health Professionals

Allied Health Professionals

Medical Staff Role in Review of AHPs

The AMA recommends that medical staff bylaws enable the medical staff to retain the prerogative and responsibility for credentialing physicians and other licensees who apply for privileges, including those who seek to contract with hospitals. AMA H-230.993. In reviewing professionals other than physicians and dentists, physicians must be aware that the antitrust immunity, otherwise available under the Health Care Quality Improvement Act, does not apply to the review of allied health professionals (AHPs). In addition, peer review may be defined so narrowly under the hospital or health care entity's liability insurance and individual physician's professional liability insurance to exclude the physician's review of non-physicians. Consequently, medical staff review of allied health professionals should be explicitly indemnified in the medical staff bylaws.

AHP Hearing and Appeal Rights

Medical staff bylaws are to include hearing and appeal processes under Element of Performance 32 of Joint Commission Standard MS.1.20. Under Joint Commission Standard MS.4.50, "There are mechanisms including a fair hearing and appeal process for addressing adverse decisions regarding reappointment, denial, reduction, suspension, or revocation of privileges that may relate to quality of care, treatment, and service issues," however, Element of Performance 1 of Joint Commission Standard MS.4.50 states that the process "may differ for members and non-members of the medical staff." Further, the standards for fair hearings under the Health Care Quality Improvement Act need not be met in hearings for AHPs, as the immunity the Act provides is not applicable to review of AHPs. Consequently, medical staff bylaws may provide a more streamlined hearing and appeal process for AHPs.

Supervision

On November 13, 2001, the Centers for Medicare & Medicaid Services announced the long-standing federal rule requiring physician supervision of certified registered nurse anesthetists (CRNAs) was made optional. (66 FR 56762). Thus, Medicare conditions of participation require physician supervision of CRNAs unless the state exempts itself from the requirement, consistent with state law supervision requirements. The rule does permit individual hospitals to establish supervision requirements that exceed state law requirements. Medical staff bylaws are the appropriate location for supervision requirements designed to preserve and promote quality patient care.

Sample Bylaw: Supervision of Allied Health Practitioners
All procedures performed in the hospital by [NAME OF ALLIED HEALTH PROFESSIONAL] must be under the direct supervision of a licensed physician who is a member of the medical staff. *Illinois State Medical Society §V.G.3(m).*

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Amendment of Medical Staff Bylaws, Rules and Regulations, and Policies

Amendment of Medical Staff Bylaws, Rules and Regulations, and Policies

Medical staff bylaws must keep pace with changes in the law as well as changes in the needs and interests of the medical staff. Under Joint Commission Standard MS.1.20, Elements of Performance 1 and 2, the medical staff develops, adopts and amends the medical staff bylaws.

Neither the medical staff nor the governing body may unilaterally amend the medical staff bylaws under Joint Commission Standard MS.1.30, a standard the AMA strongly supports. AMA Policy H-220.971. Despite this long-standing standard, hospital documents sometimes flout the standard and contradict provisions in the medical staff bylaws by creating authority in the hospital board to unilaterally amend medical staff bylaws. In addition to amendment processes in the medical staff bylaws themselves to clearly prohibit unilateral amendment, the medical staff bylaws can address unilateral amendment provisions in hospital bylaws.

Sample Bylaw: Unilateral Amendment Provisions In Hospital Documents

No medical staff governing document and no hospital corporate bylaws or other hospital governing document shall include any provision purporting to allow unilateral amendment of the medical staff bylaws or other medical staff governing document.
California Medical Association Model Medical Staff Bylaws §15.5(c).

Amendment

The process to amend bylaws can be time-consuming and contentious, but a direct, member-oriented process is most effective and efficient. A good way to begin the process is to give all medical staff members reasonable notice of the proposed amendment. This allows time to consider the amendment and to convene a special meeting if necessary. The provision for amending the bylaws should further clarify that the procedures as set forth in the bylaws constitute the only means of amending medical staff documents to preclude unilateral amendment by any party. As a tactical matter, if the medical staff has strong bylaws favoring medical staff interests, it may consider requiring a super-majority of voting members to amend bylaws.

Medical staffs must be allowed to directly recommend amendments to the hospital board, without medical executive committee involvement, under Joint Commission standards. Element of Performance 4 of MS.1.20 states, "Regardless of whether the medical staff executive committee is empowered to act on behalf of the organized medical staff, the organized medical staff as a whole has the ability to adopt medical staff bylaws, rules and regulations, and policies, and amendments thereto, and propose them directly to the governing body."

Sample Bylaw: Direct Amendment by Medical Staff

In addition to the amendment processes for medical staff bylaws, rules and regulations, and policies, the medical staff may recommend amendments to the medical staff bylaws, rules and regulations, or policies, for adoption by the Board. To be adopted, such changes must receive a two-thirds (2/3) vote, with quorum present, cast by the voting members of the Medical Staff.

Approval of Amendments

Most authorities require medical staff bylaws to be subject to approval by the hospital governing body. Joint Commission Standard MS.1.20 Element of Performance 2 states that "the medical staff adopts and amends, and the governing body approves, medical staff bylaws"; Joint Commission Standard MS.1.20 Element of Performance 5 states that "The governing body acts in accordance with those medical staff bylaws, rules and regulations, and policies that are adopted by the [Hospital Accreditation Program (HAP)] (HAP organized) medical staff or, as delegated by the (HAP: organized) medical staff, the medical staff executive committee, and approved by the governing body." Some state regulations explicitly state that governing body approval "shall not be withheld unreasonably." 22 Cal. Code of Regs. §70701(a)(8); 28 Pa. Code §103.4(8); Miss. Regs. Title 15, Chap. 41, Part 1, §105.14.

Sample Bylaw: Adoption by Staff and Approval by Board

These bylaws shall be adopted after notice of proposed adoption has been given in writing at least thirty days prior to the meeting at which such adoption is proposed. Adoption shall require a two-thirds majority vote of the regular active staff members present and voting at any regular or special meeting of the staff at which a quorum is present, shall replace any previous bylaws, and shall become effective when approved by the board, which approval shall not be unreasonably withheld or delayed. These bylaws shall be deemed approved by the board if not disapproved within thirty-five days after being presented to the board.
Medical Association of Georgia Model Medical Staff Bylaws §XVI.A.

Rules and Regulations

Under Joint Commission Standard MS.1.30, the medical staff rules and regulations cannot be unilaterally amended; typically rules and regulations must be adopted by the medical staff and approved by the governing body before becoming effective.

Medical staffs must be allowed to directly recommend amendments to the hospital board, without medical executive committee involvement, under Joint Commission standards. Element of Performance 4 of Joint Commission Standard MS.1.20 states, "Regardless of whether the medical staff executive committee is empowered to act on behalf of the organized medical staff, the organized medical staff as a whole has the ability to adopt medical staff bylaws, rules and regulations, and policies, and amendments thereto, and propose them directly to the governing body."

Sample Bylaw: Direct Amendment by Medical Staff

In addition to the amendment processes for medical staff bylaws, rules and regulations, and policies, the medical staff may adopt amendments to the medical staff bylaws, rules and regulations, or policies, for adoption by the Board. To be adopted, such changes must receive two-thirds (2/3) of the votes, with quorum present, cast by the voting members of the Medical Staff.

Often, rules and regulations provide more detailed protocols for clinical practice issues, such as medical records, general medical staff emergency department backup or autopsy requests. See Appendix G: Medical Staff Rules and Regulations Checklist. Under MS.1.20, procedural details related to certain processes that are set forth in the medical staff bylaws may, but are not required to be, in rules and regulations or policies, which may be voted on by the medical executive committee if delegated by the medical staff. See the discussion of MS.1.20, page 11.

Medical Staff Policy

Medical staff policy appropriately addresses issues that are unsettled by statute or standards. "The AMA (1) believes strongly in the autonomy of the hospital medical staff and does not support automatic inclusion of the medical staff in hospital personnel polices and programs; (2) believes hospital medical staffs should develop personnel policies and programs for members of the medical staff and incorporate these policies in the medical staff bylaws or rules and regulations." AMA Policy H-235.974.

Unlike medical staff bylaws and rules and regulations, medical staff policy generally is not subject to approval by the hospital governing body. Typically, medical staff policy is promulgated by the medical executive committee as delegated by the medical staff through the medical staff bylaws. Notice of changes in policy should be provided to the medical staff members as a practical matter. Medical staff members and delineated clinical privileges holders should be given revised texts of the documents where any significant changes in medical staff bylaws, rules and regulations, and policies are made.

Sample Bylaw: Medical Staff Policy

The medical executive committee shall review, develop and adopt policies that will be binding on the medical staff and its members and those holding clinical privileges. Such policies must be consistent with the medical staff bylaws and rules and regulations. Only policies adopted by the medical executive committee are binding on the medical staff and its members. Amendments to medical staff policies will be distributed in writing to medical staff members and those otherwise holding clinical privileges in a timely and effective manner.

Under Standard MS.1.20, procedural details related to certain processes that are set forth in the medical staff bylaws may, but are not required to be, in rules and regulations or policies, which may be voted on by the medical executive committee if delegated by the medical staff. Element of Performance 3 of MS.1.20 requires policies regarding procedural details related to certain processes to be approved by the board. See the discussion of MS.1.20, page 11.

External Effects on the Bylaws

Hospital Transactions

Hospital transactions such as sales to and mergers with other hospitals, affiliation with a health care system, and other combinations, or separations can affect medical staff bylaws. These transactions may be undertaken without medical staff involvement. To maintain the integrity of medical staff bylaws in hospital transactions, successor-in-interest and affiliation sections are needed.

Sample Bylaw: Successor in Interest

These bylaws, and clinical privileges accorded under these bylaws, will be binding upon the hospital and medical staff of any successor in interest in this hospital.

Sample Bylaw: Affiliation

The hospital's affiliation with other hospitals, health care systems or similar entities shall not in and of itself affect these medical staff bylaws.

Hospital Bylaws

Under Joint Commission Standard MS.1.20 Element of Performance 5, "The governing body acts in accordance with those medical staff bylaws, rules and regulations, and policies that are adopted by the medical staff or, as delegated by the medical staff, the medical staff executive committee, and approved by the governing body." The Joint Commission also calls upon hospital bylaws to comport with the medical staff bylaws in Element of Performance 7 of Joint Commission Standard MS.1.20, which states, "The medical staff bylaws, rules and regulations, and policies and the governing body bylaws do not conflict." Medical staffs should be proactive regarding the hospital's bylaws. "The AMA encourages hospital medical executive committees to: (1) regularly examine the hospital/corporate bylaws, rules and regulations for any conflicts with the medical staff bylaws, rules and regulations or practices; (2) request that their hospital board of trustees/directors notify them of any proposed or impending changes in the hospital/corporate bylaws; and (3) advise members/applicants of the medical staff of the effect of these hospital/corporate bylaws rules and regulations." AMA Policy H-225.984. In case the medical staff is not able to stay apprised of hospital documents, medical staff bylaws can address the inadvertent or direct conflicts that might be created by hospital documents.

Sample Bylaw: Hospital Bylaws Conflicts

Hospital corporate bylaws, policy, rules, or other hospital requirements that conflict with medical staff bylaw provisions, rules, regulations and/or policies and procedures, shall not be given effect and shall not be applied to the medical staff or its individual members.

California Medical Association Model Medical Staff Bylaws §15.5(d).

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Appendixes

Appendix A

The Joint Commission Standards, Rationale and Elements of Performance on Hospital Medical Staff Bylaws

Excerpted from the Joint Commission 2007 Hospital Accreditation Standards

MS.1.10 Element of Performance 1
The organized medical staff is self-governing, as referenced in the bullets defining self-governance on page MS-5 (which state): Self-governance of the organized medical staff includes the following and is located in the medical staff's bylaws:

- Initiating, developing, and approving medical staff bylaws and rules and regulations;
- Approving or disapproving amendments to the medical staff bylaws and rules and regulations;
- Selecting and removing medical staff officers;
- Determining the mechanism for establishing and enforcing criteria for delegating oversight responsibilities to practitioners with independent privileges;
- Determining the mechanism for establishing and maintaining patient care standards and credentialing and delineation of clinical privileges; [and]
- Engaging in performance improvement activities.

Standard MS.1.20
Effective July 1, 2009
Introduction for Standard MS.1.20 [Critical Access Hospital (CAH)], [Hospital Accreditation Program (HAP)]
The (HAP: organized) medical staff and the governing body work together, reflecting clearly recognized roles, responsibilities, and accountabilities, to enhance the quality and safety of care, treatment, and services provided to patients. To support this work, the (HAP: organized) medical staff creates a written set of documents that describes the organizational structure of the medical staff and the rules for its self-governance. These documents are called medical staff bylaws. The medical staff bylaws create a system of rights, responsibilities, and accountabilities between the (HAP: organized) medical staff and the governing body, and between the (HAP: organized) medical staff and the medical staff members.

In addition to the medical staff bylaws, the (HAP: organized) medical staff may create other medical staff governance documents such as rules and regulations and policies. In doing so, the (HAP: organized) medical staff may recommend that the procedural details of those requirements listed in Elements of Performance 26–33 of this standard be retained in the medical staff bylaws, or in rules and regulations or policies, in accordance with applicable law and regulation.

In developing its bylaws, the (HAP: organized) medical staff may include within the scope of responsibilities of the medical staff executive committee the authority to adopt, on the behalf of the entire (HAP: organized) medical staff, any procedural details associated with Elements of Performance 26–33 appearing in rules and regulations or policies. The (HAP: organized) medical staff can also propose medical staff bylaws, rules and regulations, and policies, and amendments thereto, directly to the governing body.

When approval of procedural details associated with Elements of Performance 26–33 appearing in rules and regulations or policies is delegated to the medical staff executive committee, it is to represent to the governing body the organized medical staff's views on issues of patient safety and quality of care. The organized medical staff can take action to revise the authority it has delegated to the medical staff executive committee to act on its behalf. The organized medical staff is urged to determine what steps it will take if it does not agree with an action taken by the medical staff executive committee. Such steps might include a process that would allow the organized medical staff, at its discretion, to extract and consider an action by the medical staff executive committee prior to the action becoming effective.

To understand these requirements, the difference between "process" and "procedural detail" needs to be explained. A *process* is a series of steps taken to accomplish a goal. A *procedural* detail describes in detail how each step in the process is to be carried out. For example, the process for credentialing licensed independent practitioners (see Element of Performance 26) can be stated in several steps such as collecting information on a physician, evaluating the information, and making a decision about the information. That process will be contained in the medical staff bylaws. The procedural details associated with this process might include who collects the information, how files are kept, what organizations need to be contacted to collect all the necessary information, etc. For Elements of Performance 26–33, the medical staff decides whether such procedural details will be retained in the medical staff bylaws (which must be approved by the entire organized medical staff), or in rules and regulations or policies (whose ap-

proval may be delegated to the medical staff executive committee).

The significance of the medical staff bylaws cannot be overstated. For this reason, the medical staff leaders should assure that all medical staff members understand the content and purpose of the bylaws, and the bylaws adoption and amendment processes.

Note: If conflicts regarding the medical staff bylaws, rules and regulations, or policies arise between the governing body and the (HAP: organized) medical staff, the organization's conflict management process is implemented, as set forth in Standard LD.2.40.

Standard MS.1.20 (CAH, HAP)
Medical staff bylaws address self-governance and accountability to the governing body.
Note regarding Elements of Performance 9–33: All requirements appearing in Elements of Performance 9–33 must be in the medical staff bylaws. These requirements may have associated procedural details. Any procedural details associated with the requirements in Elements of Performance 9–25 must also be in the medical staff bylaws. Any procedural details associated with Elements of Performance 26–33 must be either in the medical staff bylaws, or in rules and regulations or policies. All requirements and procedural details addressed in the medical staff bylaws must be adopted and amended by the whole of the (HAP: organized) medical staff and approved by the governing body. All procedural details addressed in rules and regulations or policies must be adopted and amended by either the whole of the medical staff or the medical staff executive committee, if so delegated by the (HAP: organized) medical staff, and approved by the governing body.

Elements of Performance for Standard MS.1.20
1. (CAH, HAP) The (HAP: organized) medical staff develops medical staff bylaws, rules and regulations, and policies.
2. (CAH, HAP) The (HAP: organized) medical staff adopts and amends, and the governing body approves, medical staff bylaws.
3. (CAH, HAP) The (HAP: organized) medical staff, or the medical staff executive committee as delegated by the (HAP: organized) medical staff, adopts and amends, and the governing body approves, any rules and regulations and policies that address procedural details of the requirements in Elements of Performance 26–33.
4. (HAP) Regardless of whether the medical staff executive committee is empowered to act on behalf of the organized medical staff, the organized medical staff as a whole has the ability to adopt medical staff bylaws, rules and regulations, and policies, and amendments thereto, and propose them directly to the governing body. Note: Please see the Introduction to this standard for further discussion of the organized medical staff's relationship to the medical staff executive committee.
5. (CAH, HAP) The governing body acts in accordance with those medical staff bylaws, rules and regulations, and policies that are adopted by the (HAP: organized) medical staff or, as delegated by the (HAP: organized) medical staff, the medical staff executive committee, and approved by the governing body.
6. (HAP) The organized medical staff enforces the medical staff bylaws, rules and regulations, and policies.
7. (HAP) The medical staff bylaws, rules and regulations, and policies and the governing body bylaws do not conflict.
8. (CAH, HAP) The organized medical staff and its members comply with the medical staff bylaws, rules and regulations, and policies.

The medical staff bylaws must include the requirements and any associated procedural details in Elements of Performance 9–25.
9. (CAH, HAP) The structure of the (HAP: organized) medical staff.
10. (CAH, HAP) The process for privileging licensed independent practitioners.
11. (CAH, HAP) Qualifications for appointment to the (HAP: organized) medical staff.
12. (HAP) Indications for automatic suspension of a practitioner's medical staff membership or clinical privileges.
13. (HAP) Indications for summary suspension of a practitioner's medical staff membership or clinical privileges.
14. (HAP) Indications for recommending termination or suspension of medical staff membership, and/or termination, suspension, or reduction of clinical privileges.
15. (HAP) The composition of the fair hearing committee. (See also Element of Performance 32.)
16. (CAH, HAP) The roles and responsibilities of each category of practitioner on the medical staff (active, courtesy, etc.).
17. (CAH, HAP) Requirements for performing medical histories and physical examinations.
18. (HAP) Those practitioners who are eligible to vote on the medical staff bylaws and their amendments.
19. (HAP) A list of all the officer positions for the organized medical staff.
20. (HAP) The medical staff executive committee's func-

tion, size, and composition; the authority delegated to the medical staff executive committee by the organized medical staff to act on its behalf; and how such authority is delegated or removed. (See also Standard MS.1.40.)

21. (HAP) The process for selecting and removing the medical staff executive committee members.
22. (HAP) That the medical staff executive committee includes physicians and may include other practitioners as determined by the organized medical staff.
23. (HAP) That the medical staff executive committee acts on the behalf of the organized medical staff between meetings of the organized medical staff, within the scope of its responsibilities as defined by the organized medical staff. (See also Standard MS.1.40.)
24. (HAP) The process for adopting and amending the medical staff bylaws.
25. (HAP) The process for adopting and amending medical staff rules and regulations, and policies.

The medical staff bylaws must include the requirements in Elements of Performance 26–33. The procedural details, if any, associated with Elements of Performance 26–33 must appear either in the medical staff bylaws, or in rules and regulations or policies (see Elements of Performance 1–4).

26. (CAH, HAP) The process for credentialing licensed independent practitioners.
27. (HAP) The process for appointment to membership on the organized medical staff.
28. (HAP) The process for selecting and removing the organized medical staff officers.

Corrective Actions

29. (HAP) The process for automatic suspension of a practitioner's medical staff membership or clinical privileges.
30. (HAP) The process for summary suspension of a practitioner's medical staff membership or clinical privileges.
31. (HAP) The process for recommending termination or suspension of medical staff membership and/or termination, suspension, or reduction of clinical privileges.

Fair Hearing and Appeal

32. (HAP) The fair hearing and appeal process (*see also* Element of Performance 15), which at a minimum shall include:
    - The process for scheduling hearings
    - The process for conducting hearings
    - The appeal process

Qualifications and Roles and Responsibilities of the Department Chair

33. (HAP) If departments of the organized medical staff exist, the qualifications and roles and responsibilities of the department chair, which shall include the following:

Qualifications

Certification by an appropriate specialty board or comparable competence affirmatively established through the credentialing process.

Roles and responsibilities

- Clinically related activities of the department.
- Administratively related activities of the department, unless otherwise provided by the hospital.
- Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges.
- Recommending to the organized medical staff the criteria for clinical privileges that are relevant to the care provided in the department.
- Recommending clinical privileges for each member of the department.
- Assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization.
- Integration of the department or service into the primary functions of the organization.
- Coordination and integration of interdepartmental and intradepartmental services.
- Development and implementation of policies and procedures that guide and support the provision of care, treatment, and services.
- Recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services.
- Determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services.
- Continuous assessment and improvement of the quality of care, treatment, and services.
- Maintenance of quality control programs, as appropriate.
- Orientation and continuing education of all persons in the department or service.
- Recommending space and other resources needed by the department or service.

MS.1.30
Neither the organized medical staff nor the governing body may unilaterally amend the medical staff bylaws or rules and regulations.

Rationale for MS.1.30
A hospital with an organized medical staff and governing body that cannot agree on amendments to critical documents has evidenced a breakdown in the required collaborative relationship.

MS.1.30 Element of Performance
1. The medical staff bylaws, rules, and regulations are not unilaterally amended.

MS.1.40
MS.1.40 Elements of Performance
1. The structure and function of the medical staff executive committee conforms to the medical staff bylaws.

The medical staff executive committee makes recommendations, as defined in the medical staff bylaws, directly to the governing body on at least the following:
6. Medical staff membership
9. The organized medical staff's structure
10. The process used to review credentials and delineate privileges
11. The delineation of privileges for each practitioner privileged through the medical staff process
12. The executive committee reviews and acts on reports of medical staff committees, departments and other assigned activity groups

MS.4.10
MS.4.10 Elements of Performance
4. The credentialing process is outlined in the medical staff bylaws (see also Standard MS.1.20)

MS.4.45
The organized medical staff, pursuant to the medical staff bylaws, evaluates and acts upon reported concerns regarding a privileged practitioner's clinical practice and/or competence.

MS.4.50
MS.4.50 Element of Performance
The organized medical staff has developed a fair hearing and appeal process addressing quality of care issues that has the following characteristics:
5. with the governing body provides a mechanism to appeal adverse decisions as provided in the medical staff bylaws

MS.4.100
MS.4.100 Rationale
[...] Medical staff bylaws or other documents may stipulate that in an emergency, any medical staff member with clinical privileges is permitted to provide any type of patient care, treatment, and services necessary as a life-saving measure or to prevent serious harm—regardless of his or her medical staff status or clinical privileges—provided that the care, treatment, and services provided are within the scope of the individual's license.

Elements of Performance for MS.4.100
1. Temporary privileges are granted to meet an important patient care need for the time period defined in the medical staff bylaws.

MS.4.110
Elements of Performance for MS.4.110
2. As described in the bylaws, the individual(s) responsible for granting disaster privileges is identified.

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Appendix B

Additional Resources for the Medical Staff

Current Model Medical Staff Bylaws

- California Medical Association
  1201 J Street, Suite 200
  Sacramento, CA 95814
  www.cmanet.org
  (916) 444-5532

- Medical Association of Georgia
  1849 The Exchange, Suite 200
  Atlanta, GA 30339
  www.mag.org
  (678) 303-9290

Emergency Medical Treatment and Active Labor Act (EMTALA)

The EMTALA Compendium is published online by the American Academy of Orthopaedic Surgeons.

- American Academy of Orthopaedic Surgeons
  6300 North River Road
  Rosemont, IL 60018
  www.aaos.org
  (847) 823-7186

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Appendix C

California Medical Association "Medical Staff Membership for Physician Excluded from Any Federally Funded Health Care Program"

Document #1207	CMA Legal Counsel
Medical Staff Membership for Physician Excluded from Any Federally Funded Health Care Program	**January 2005**

A number of medical staffs throughout California have been told that they must amend medical staff bylaws to provide for the automatic termination of medical staff membership and privileges for physicians who have been excluded from any federally funded health care program, such as Medicare and Medi-Cal. California Medical Association (CMA) legal counsel has reviewed the pertinent federal laws and regulations and does not believe that automatic suspension is required, let alone warranted, by the law.

Federal Law Re: Exclusion
What law allows sanctions against hospitals for contracting with persons excluded from a health care program?

For many years, claims to Medicare or state health programs for items or services furnished by an excluded person or entity have been prohibited. In the Balanced Budget Act of 1997, however, the law was expanded to allow civil monetary penalties to be imposed against any person (including an organization, agency, or other entity such as a hospital or medical group) who:

> Arranges or contracts (by employment or otherwise) with an individual or entity that the person knows or should know is excluded from participation in a federal health care program . . . for the provision of items or services for which payment may be made under such a program. (42 U.S.C. §1320a-7a(a)(6).)

Automatic Suspension of Excluded Physicians Not Required
Does the law require automatic suspension of staff privileges of physicians so excluded?

No. Because of initial uncertainties in how this law would be interpreted, some attorneys have recommended that, in order to ensure full compliance with federal law, physicians who have been excluded from federally funded health care programs should automatically lose their medical staff membership and privileges.[1] This approach is not valid for two reasons. First, a claim must be submitted to the federal health program for services rendered by an excluded physician before the penalties are triggered under the statute. As long as an excluded physician under contract with a health care entity does not perform services for the federal health program which are billed to the program, there is no violation of the statute. Second, clarification from the government enforcement agency, the DHHS Office of Inspector General ("OIG"), demonstrates that the "automatic suspension" approach is not mandated by federal law, nor is it necessary to ensure compliance. The OIG issued a final rule implementing in part the Balanced Budget Act provision at issue on July 22, 1999. In its comments to the regulation that it ultimately adopted, the OIG shed considerable light on the scope and nature of the prohibition.

Medical Staff Privileges Held by Excluded Physician
Do medical staff privileges alone trigger the prohibition?

No, the OIG made it absolutely clear that absent a separate employment or contractual relationship, medical staff privileges alone do not trigger the statute. In response to the Notice of Proposed Rule-making interpreting section 1320a-7a(a)(6), the OIG received a number of comments, which it summarized and responded to in the final rule. *See* 64 Fed.Reg. 39420, (July 22, 1999). One of the commentators specifically recognized the problems created by the statute and its implementation since:

> "it is both possible and common for a physician to have medical staff privileges at a hospital without having either an employment or contractual relationship with the hospital, particularly in states that prohibit the corporate practice of medicine. The commentator further stated that a physician's medical staff privileges

1. We are also aware that some attorneys have pointed to language in settlement agreements between the OIG and hospitals that have violated the law as requiring this approach. Requirements imposed on those who have violated Medicare billing rules are often more onerous than those applicable to law abiding health care facilities and professionals.

at a hospital and his or her provision of items or services covered by Medicare mean that the hospital and the physician are "arranging" for the provision of such services."

The OIG understood the commentator's concern and agreed. As the OIG responded:

"a medical staff relationship, in the absence of any employment or contractual relationship or arrangement, in and of itself, remains outside the scope of these regulations." *See* 64 Fed.Reg. at 39423-39424.

How Penalties Are Triggered

Must a claim be submitted for the statute to be triggered?

Yes, the scope of the OIG rule makes it unequivocal that a claim must be submitted to a federal health care program before sanctions are triggered under the statute. Specifically, the penalty only applies against entities that submit, or cause to submit, claims for items or services rendered by employees or other individuals with whom they contract, and whom they know, or should know, have been excluded from participation in the federal health care program. The law states:

> The OIG may impose a penalty and assessment against any person with whom it determines in accordance with this part *has presented or caused to be presented a claim* which is for—
>
> an item or service for which the person knew, or should have known, that the claim was false or fraudulent, including a claim for any item or service furnished by an excluded individual employed by or otherwise under contract with that person; [or]
>
> an item or service furnished during a period in which the person was excluded from participation in the Federal health care program to which the claim was made. (42 C.F.R. §1003.102(a)(2) and (3).)

Thus, for the prohibition to be triggered, a claim must be submitted.

Exclusion Inquiry on Applications for Privileges

Should a medical staff inquire as to whether a physician applying or reapplying for staff privileges is excluded?

It is prudent to do so. Even though the statute itself does not expressly create an affirmative obligation for physicians (hospitals and other covered entities) to investigate whether an individual is excluded, the OIG did state in its response to comments that providers and contracting parties do "have a duty to check the sanction report on the OIG website prior to entering into any employment or contractual arrangements with new hires or run the risk of CMP (civil monetary penalty) liability if they fail to do so." (Fed.Reg. at 39423.) Exclusion information is maintained on the OIG website (*www.oig.hhs.gov*) and is updated on a regular basis. The OIG also noted that hospitals are under an affirmative obligation to query the National Practitioner Data Bank (NPDB) when they grant privileges and subsequently at two-year intervals to determine whether actions have been taken against physicians that they employ. The NPDB contains exclusion information dating back to 1979 provided to it by the Centers for Medicare & Medicaid.[2]

Further, Medicare law prohibits Medicare providers, including hospitals and physicians, from billing for any services which were rendered at the direction or upon the prescription of a physician or other individual who has been excluded from the Medicare program. (42 U.S.C. §1395y(e).) Thus, hospitals face denial of reimbursement for billed services *rendered at the direction* of an excluded physician.

In sum, while hospitals have an affirmative obligation not to bill these federally funded programs for services provided, ordered or prescribed by physicians on staff who are excluded, there is no affirmative obligation on hospitals to exclude automatically such physicians. Medical staffs, with their hospitals, should work toward setting up a reasonable system for ensuring that physicians who have been excluded from the Medicare/Medi-Cal programs do not bill those federal programs for patients that they have treated, or order or prescribe any services to be provided by the hospital for patients by these programs. Such a system should ensure both that: 1) the hospital is notified of a physician's exclusion, and 2) the excluded physician does not order, prescribe or bill for services for patients who are beneficiaries of these federal programs. The California Participating Physician Application (CPPA) can be of assistance in this regard.

Developed by the California Medical Association, as well as others, the CPPA requires that physicians notify the health care organization in writing, but promptly no later

2. National Practitioner Data Bank Guidebook, Sept. 2001, p. E-27.

than fourteen (14) days from the occurrence of, among other things, a "receipt of written notice of any adverse action against [him/her] under the Medicare or Medicaid programs, including but not limited to, fraud and abuse proceedings or convictions." Affirmative notification procedures, as well as proper procedures in place at the hospital or medical staff, can be used to maintain compliance with the law yet not require automatic suspension. Given the draconian penalties an excluded provider faces if that provider continues to bill Medicare or order or prescribe services for covered patients, excluded medical staff members will have every incentive to comply with these procedures. *See* 42 U.S.C. §1320a-7a(a)(1)(D).

We hope this information is helpful to you. CMA is unable to provide specific legal advice to each of its more than 30,000 members. For a legal opinion concerning a specific situation, consult your personal attorney.

For information on other legal issues, use CMA ON-CALL, or refer to CMA's *California Physician's Legal Handbook*. This book contains legal information on a variety of subjects of everyday importance to practicing physicians. Written by CMA's Legal Department, the book is available on a fully searchable CD-ROM, or in a six-volume, softbound format. To order your copy, call (800) 882-1262.

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Appendix D

SOUTH DAKOTA STATE MEDICAL ASSOCIATION
MODEL MEDICAL STAFF BYLAWS CHECKLIST

Provision	Yes, Included	No, Not Included
General		
Assure the medical staff bylaws include appropriate authority		
Examine four primary sources when developing medical staff bylaws • State peer review laws (Appendix A) • Federal law (Health Care Quality Improvement Act of 1986) (HCQIA) (Appendix B) • Joint Commission on Accreditation of Healthcare Organization (JCAHO) standards (Appendix C) • CMS Medical Staff Requirements (Appendix D)		
Assure the medical staff bylaws address seven areas: • Medical staff composition and how to join • Department and committee structure, and composition and functioning of executive committee • Medical staff responsibilities • Process for credentialing and clinical privileges • Procedures for fair hearings and appeals • Relationship between medical staff and hospital board • Procedures for adopting and amending medical staff bylaws, rules and regulations		
When a conflict arises, obtain independent legal advice when developing bylaws, when a conflict arises, to assure medical staff's interest is given due consideration		
Preamble		
Describe the purpose of the medical staff bylaws: to provide for organization of the medical staff, establish a framework for self-governance, establish a professional and legal structure for medical staff operations, and provide for organized medical staff relations		

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Provision	Yes, Included	No, Not Included
Emphasize the self-governing character of the medical staff and include, within the content of the bylaws, the 6 essentials of self governance: • Initiate, develop, adopt, approve or disapprove amendments • Select, select, and remove medical staff officers • Establish and enforce criteria and standards for membership • Establish and maintain patient care standards • Use independent legal counsel • Credential and delineate clinical privileges		
Assure the medical staff bylaws may not be unilaterally amended or repealed, and are binding and enforceable		
Definitions		
Clearly define critical terms used in the medical staff bylaws		
Assure the definition for 'clinical privileges' includes use of equipment, facilities and personnel, as well as the right to exercise the clinical privileges		
Include a definition of economic or exclusive credentialing and, in the content of the bylaws, prohibit the practice which ties medical staff privileges to an agreement to refer or utilize facilities		
Include definitions for executive session and investigation, among others		
Name		
Include the name of the medical staff in the medical staff bylaws, along with the term 'unincorporated association'		
Membership		
Assure the bylaws describe who is eligible for membership, the qualifications for membership, and the basic responsibilities of medical staff membership		
If a requirement for professional liability insurance is included in the medical staff bylaws,		

SOUTH DAKOTA STATE MEDICAL ASSOCIATION
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Provision	Yes, Included	No, Not Included
the medical staff should determine the amount and the hospital board should not direct which company should be used		
Do not include vague terms such as 'cooperatively' in the medical staff bylaws		
Assure that membership or privileges are not conditioned upon a physician's participation or non-participation in another organization, third party contracts, or acceptance of Medicare contracts		
Assure that properly completed applications must be considered		
Categories of Membership		
Assure that medical staff bylaws describe the categories of medical staff membership, and the qualifications and rights for each category		
Appointment and Reappointment		
Assure the medical executive committee makes credentialing recommendations to the hospital board		
Include language to prohibit economic credentialing and exclusive contracting		
Assure that the medical staff determine the criteria that may indicate a quality problem and it is peer reviewed, not reviewed by hospital administrative staff		
If a pre-application form is used, assure that it does not include a waiver of due process rights		
Assure that the medical staff makes the decision as to whether or not professional liability insurance should be required		
Do not include a provision on the application stating the applicant or member agrees to abide by hospital bylaws or policies		
Clinical Privileges		
Verify that medical staff bylaws address procedures for evaluation, appointment, specific privileges that may be exercised, modifications, temporary and emergency privileges and monitoring competency		

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Provision	Yes, Included	No, Not Included
Assure that clinical privileges may be granted, continued, modified or terminated only after a recommendation by the medical staff and that privileges include access to hospital resources essential to the full exercise of privileges		
Do not include a provision that provides for termination of staff privileges simultaneously with termination of a contract without full due process		
Consider whether or not to include an expedited credentialing process		
Limit the use of temporary privileges to fulfill an important patient care need and when awaiting review and approval of the medical staff executive committee and hospital board		
Corrective Action		
Assure that corrective action procedures are included in the medical staff bylaws and qualify for immunities under the state peer review statutes and HCQIA		
Assure that procedures for initiation of corrective action are clearly and unambiguously stated in the medical staff bylaws, and that hospital board members and administrators are not allowed to initiate action unless emergency		
Assure that the medical staff bylaws establish clear and objective standards and criteria for the imposition of a summary suspension		
Include language in the medical staff bylaws that when there is a summary suspension, no professional review action by a professional review body shall occur until completion of the hearing and appeals process or waiver by the affected physician		
Hearings and Appellate Reviews		
Assure the notice of proposed action provision includes the proposed action, the reasons for the action, the right to request a hearing within 30 days, and a summary of rights		
If a hearing is scheduled, include a provision that the notice includes the place, date, time, member's right to obtain legal representation, reasons for the action, charts in question, and list of witnesses		
During the pre-hearing, assure the affected member has the right to access all evidence and to question and challenge the impartiality of the hearing panel and hearing officer		
Include language in the medical staff bylaws to allow the member the right to legal		

SOUTH DAKOTA STATE MEDICAL ASSOCIATION
MODEL MEDICAL STAFF BYLAWS CHECKLIST

Provision	Yes, Included	No, Not Included
representation, be provided with all information made available to the hearing officer, have a record made of the proceedings, call and examine/cross-examine witnesses, present and rebut evidence, and submit a written statement at the close of the hearing		
Except for applicants who bear the burden of persuading the committee of his/her qualifications by a preponderance of the evidence, assure that the committee bringing charges against a physician has the duty to present evidence and support of its action or recommendation		
Include a provision in the medical staff bylaws so an attorney from the firm used by the hospital, medical staff, or involved staff member or applicant may not serve as the hearing officer		
Assure the hearing committee report includes the decision, reasons for the decision, the connection between the evidence and decision, and appeal procedures		
Assure that hearing and appellate review rights apply to all physicians on the medical staff, including those providing professional services under contract		
Assure that credentialing, corrective action, and hearing and appeal processes are included in the medical staff bylaws		
Officers		
Assure that the medical staff bylaws include provisions for identification, qualifications, nominations, election, terms of office, recall, vacancies, and duties of officers (chief of staff, vice chief of staff, immediate chief of staff, and secretary-treasurer)		
Assure the medical staff has the right to select, elect and remove officers (chief of medical staff, officers of the medical staff, department chairs, and committee chairs)		
Clinical Departments and Divisions		
Assure that the organizational structure of the medical staff (departments and divisions) is decided upon by the medical executive committee with concurrence by the medical staff		
To provide peer review protections, include language that departments and divisions come under the definition of committees		

7/5/02

SOUTH DAKOTA STATE MEDICAL ASSOCIATION
MODEL MEDICAL STAFF BYLAWS CHECKLIST

Provision	Yes, Included	No, Not Included
Committees		
Review medical staff bylaws to include composition, duties, vacancies, meetings for committees (examples: Medical Executive Committee, Credentials Committee, Joint Conference Committee, Quality Assessment and Improvement Committee, Utilization Review Committee, Pharmacy and Therapeutics Committee, Infection Control Committee, Tissue Committee, Bylaws Committee, Medical Records Committee, Medical Staff Aid Committee, Bioethics Committee, Limited License Professional and Allied Health Professional Committee, and Technical Advisory Committees)		
Assure that the medical staff executive committee can meet in executive session with only voting members of the medical staff present		
Examine the responsibilities of the Limited License Professional and Allied Health Professional Committee		
Meetings		
Assure the medical staff bylaws describe the frequency of meetings, the number of meetings medical staff members must attend, and what constitutes a quorum		
Confidentiality, Immunity and Releases		
Include 'good faith' and 'without malice' in immunity section of the medical staff bylaws		
Include language that the hospital board agrees to indemnify and hold harmless the medical staff, individually and collectively, from loss, damage or expenses incurred in connection with the performance of medical staff member functions		
Review the hospital insurance policy to be sure there is coverage for the actions of members of the medical staff and include language in the medical staff bylaws that any proposed changes in the insurance must be approved by the medical executive committee prior to implementation		
General Provisions		
Assure that the medical staff bylaws provide that the medical staff rules and regulations, when adopted by the medical staff and approved by the hospital board, become part of		

SOUTH DAKOTA STATE MEDICAL ASSOCIATION
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Provision	Yes, Included	No, Not Included
the bylaws		
Assure that the medical staff has the right of access to one's own medical staff file, the right to make additions to the credentials file, request deletion of some materials in the file, and to rebut adverse entries		
Assure that there is only one credentials file per physician and it is maintained in the medical staff office		
Assure that the medical staff bylaws include hearing and appeal rights to physicians facing denial, revocation or restriction of privileges for non-quality, as well as for quality reasons		
Assure that the medical staff has meaningful involvement in any decision, whether or not quality is the issue, about exclusive contracts		
Assure that due process rights are afforded to all physicians and that these provisions in the medical staff bylaws take precedence over any inconsistent provisions in a contract		
Assure that the medical executive committee reviews the non-financial provisions of exclusive contracts (excluding remuneration except to the extent issues of fraud and abuse compliance are addressed)		
Adoption and Amendment of Bylaws		
Assure that the sole mechanism for adopting or altering the medical staff bylaws resides within the medical staff bylaws and nowhere else		
Include an inconsistency provision to prevent the hospital from bypassing the medical staff bylaws by contract or provisions in the hospital bylaws		
Include a provision in the medical staff bylaws to prevent unreasonable delay by the hospital board in adopting bylaw changes		
Include provisions concerning EMTALA		

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Appendix E

Sample Policy on Disruptive Behavior

Medical Staff Policy #_____
Disruptive Behavior Involving Members of the Medical Staff

Definitions
"Harassment" means verbal or physical activity directed against any individual (e.g., against another medical staff member, house staff, hospital employee or patient) on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex or sexual orientation shall not be tolerated.[3]

"Member" and "medical staff member" is defined as an individual who has been granted medical staff membership or, although not a member, has been granted temporary or disaster privileges. The term does not include medical students or residents, or allied health professionals with or without clinical privileges.

"Sexual harassment" is defined as unwelcome sexual advances, requests for sexual favors, or verbal or physical activity through which submission to sexual advances is made an explicit or implicit condition of employment or future employment-related decisions; unwelcome conduct of a sexual nature which has the purpose or effect of unreasonably interfering with a person's work performance or which creates an offensive, intimidating or otherwise hostile work environment.[4]

I. Purpose[5]
To promote patient safety and quality improvement through facilitating communication and cooperation among health care professionals[6] by describing and prohibiting disruptive behavior involving medical staff members and delineating the response to be followed in all cases of allegations of disruptive behavior involving medical staff members.[7] Disruptive behavior by members of the medical staff, or refusal of members to cooperate with the procedures described in this Policy, may result in corrective action, which shall be carried out according to the medical staff bylaws.

Disruptive behavior by members of the medical staff that affects or may affect patient care[8], or refusal of members to cooperate with the procedures described in this Policy, may result in corrective action, which shall be carried out according to the medical staff bylaws.[9]

II. Policy
Behavior by medical staff members while on Hospital property[10] that generates a complaint by another medical staff member, a member of the hospital clinical or administrative staff, or individuals in contact with the medical staff member at the hospital other than patients,[11] will be responded to according to this policy. Behavior that indicates that the medical staff member suffers from a physical, mental or emotional condition will be referred to the Well-being Committee or otherwise evaluated to promote assisting the medical staff member. Sexual harassment, harassment and other disruptive behavior is not acceptable to the medical staff and will be corrected, or if correction fails or the initial conduct warrants, disciplined.

A. "Disruptive behavior" means any conduct or behavior including, without limitation, sexual harassment or other forms of inappropriate behavior, which:

i. jeopardizes or is inconsistent with quality patient care or with the ability of others to provide quality patient care at the hospital;
ii. is unethical; or
iii. constitutes the physical or verbal abuse of patients or others involved with providing patient care at the hospital.[12]

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3. Based on the California Medical Association Model Medical Staff Bylaws definition.
4. Based on federal law prohibiting sexual harassment.
5. Joint Commission Standard MS.4.80 states "The medical staff implements a process to identify and manage matters of individual health for licensed independent practitioners. This identification process is separate from actions taken for disciplinary purposes." This policy includes not only physicians but also non-physician members of the medical staff.
6. The behavior to be addressed by the medical staff has to fall within the purview of the medical staff organization-professionalism and patient care quality. If the behavior is not related to patient care or professional ethics, the legal protections provided for peer review are not likely to apply.
7. The policy should clearly state that all cases alleging disruptive behavior must be handled under this policy, lest a two-tier response develop.
8. Patient care related review activities may qualify for peer review protection.
9. To protect the action under peer review law, hearing and appeal procedures should apply where applicable.
10. The behavior of members outside the hospital is not regulated by medical staff policy; however, behavior in the hospital parking garage or on the lawn should be included.
11. Problems between the member and his/her patient are addressed by the standards applicable to the physician (or other professional)/patient relationship.
12. The behavior to be addressed by the medical staff has to fall within the purview of the medical staff organization-professionalism and patient care quality. If the behavior is not related to patient care or professional ethics, the legal protections provided for peer review are not likely to apply.

B. Disruptive behavior occurs in varying degrees, which are classified here into three levels of severity. Level I behavior is the most severe violation of this Policy. Any corrective action will be commensurate with the nature and severity of the disruptive behavior. Repeated instances of disruptive behavior will be considered cumulatively, and action shall be taken accordingly.

C. Classification of severity shall follow these guidelines:

Level I: Physical violence or other physical abuse which is directed at people. Sexual harassment or harassment involving physical contact. Possession of weapons on hospital property.[13]

Level II: Verbal abuse such as unwarranted[14] yelling, swearing or cursing; threatening, humiliating, sexual or otherwise inappropriate comments directed at a person or persons; visual abuse such as threatening, humiliating, sexual or otherwise inappropriate writing or picture(s) directed at a person or person, or physical violence or abuse directed in anger at an inanimate object.

Level III: Verbal abuse which is directed at-large, but has been reasonably perceived by a witness to be disruptive behavior as defined above.

D. The medical staff shall promote continuing awareness of this Policy among the medical staff and the hospital community, including the following efforts:

i. sponsoring or supporting educational programs on disruptive behavior to be offered to medical staff members and hospital employees;[15]

ii. disseminating this Policy to all current members upon the adoption of the Policy and to all new members of the medical staff upon joining the staff.

iii. requiring the Medical Staff Well-Being Committee[16] to assist a member of the medical staff exhibiting disruptive behavior to obtain education, behavior modification, or other treatment to prevent further violations.

III. Procedure

Complaints about a member of the medical staff regarding alleged disruptive behavior must be in writing, signed and directed to the President of the Medical Staff. The President of the Medical Staff or designee must review the complaint immediately, and provide the complainant with a written acknowledgement of the complaint and this policy. The President of the Medical Staff or designee shall make an initial determination of authenticity and severity,[17] and act accordingly. In all cases, the member involved shall be provided with a copy of this policy and a copy of the complaint.[18] If no corrective action is taken, a confidential memorandum summarizing the disposition of the complaint shall be retained in the member's credentials file for one year, and then expunged, if no related action is taken or pending.

At the discretion of the President of the Medical Staff or at the discretion of the Medical Executive Committee, the duties here assigned to the President of the Medical Staff can be delegated to a different officer of the Medical Staff, on a case-by-case basis or for the President's term of office.[19]

A. Level I

The President of the Medical Staff shall interview the complainant and, if possible, any witnesses within 24 hours of receiving the complaint. The President of the Medical Staff and another member of the medical executive committee shall interview the medical staff member within 24 hours. The President of the Medical Staff shall provide the member the opportunity to respond in writing. The President of the Medical Staff shall do one or more of the following:

i. determine that no action is warranted.
ii. issue a warning.
iii. require a written apology to the complainant.
iv. refer member to the Medical Staff Well-Being Committee.
v. initiate corrective action pursuant to the medical staff bylaws.

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13. Possession of weapons on hospital grounds is inherently threatening and potentially disastrous.
14. Recognizing that in emergency situations, calling out for instruments, drugs, or help may actually be appropriate.
15. "Education of LIPs (licensed independent practitioners) and other organization staff about illness and impairment recognition issues specific to LIPs (at-risk criteria)" is to be included in the design of process under Joint Commission Standard MS.4.80, according to the Standard's Element of Performance 1.
16. The Medical Staff Well-Being Committee can be particularly helpful in monitoring a troubled member, enabling the member to be helped while preserving the member's practice. A Medical Staff Well-being Committee should be designed to meet the Joint Commission Standard and maximize the legal protections available to medical staff committees in most states.
17. To allow the President to screen out false reports. Element of Performance 6 for Joint Commission Standard MS.4.80 states that the process should address "evaluation of the credibility of a complaint, allegation or concern."
18. To permit the accused member to prepare a meaningful response.
19. A particular President may not be well suited to or comfortable with the particular duties assigned under this policy. If the President recognizes this, he/she may delegate the duties personally; if the President does not recognize this but the Medical Executive Committee does, the duties may be reassigned to a more appropriate officer.

B. Level II

The President of the Medical Staff shall interview the complainant and, if possible, any witnesses within five working days of receiving the complaint. The President of the Medical Staff and another member of the medical executive committee shall interview the medical staff member within five working days. The President of the Medical Staff shall provide the member the opportunity to respond in writing. The President of the Medical Staff shall do any of the following:

i. determine that no action is warranted.
ii. issue warning.
iii. require a written apology to the complainant.
iv. refer member to the Medical Staff Well-being Committee.
v. initiate corrective action pursuant to the medical staff bylaws.

C. Level III

The President of the Medical Staff shall interview the complainant and, if possible, any witnesses within 10 days of receiving the complaint. The President of the Medical Staff shall provide the member the opportunity to respond in writing. The President of the Medical Staff shall do one or more of the following:

i. determine that no action is warranted.
ii. issue warning.
iii. require a written apology to the complainant.
iv. refer member to the Medical Staff Well-being Committee.
v. initiate corrective action pursuant to the medical staff bylaws.

IV. Disruptive Behavior Against a Medical Staff Member

Disruptive behavior which is directed against a medical staff member by a hospital employee, board member, contractor, or other member of the hospital community shall be reported by the member to the hospital pursuant to hospital policy governing conduct.

V. Other Behavior

Behavior by a medical staff member towards a hospital employee, board member, contractor or other member of the hospital community, which does not fall within the definition of disruptive behavior above, but violates hospital policy governing conduct, shall be dealt with according to that hospital policy, so long as the hospital policy has been approved by the medical executive committee.

VI. Abuse of Process

Threats or actions directed against the complainant by the subject of the complaint will not be tolerated under any circumstance. Retaliation or attempted retaliation by members against complainants will give rise to corrective action pursuant to the medical staff bylaws. Individuals who submit a complaint or complaints which are determined to be false shall be subject to corrective action under the medical staff bylaws or hospital employment policies, whichever applies to the individual.

Adopted by the Medical Executive Committee _____, 2007

Disseminated to Medical Staff Members and Privileges Holders_____, 2007

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Appendix F

Common Bylaws Pitfalls and How to Avoid Them

Common Bylaws Pitfalls	And How to Avoid Them
Adopting Consultants' Template	National consultants' use templates, which results in a cookie-cutter approach—all bylaws look alike, all across the country. Instead, individual state laws should be considered and used to protect the medical staff and its members. Every medical staff is different—models and templates must be tailored to that medical staff's interests.
Including a "Physicians' Bill of Rights"	Physicians might be told that the bylaws are pro-physician because they include a "Physicians' Bill of Rights." Often the "Physicians' Bill of Rights" just summarizes rights that are contained in the bylaws because of a legal requirement or Joint Commission standard. Sometimes, the "Physicians' Bill of Rights" contradicts or even short-changes rights elsewhere in the bylaws or in the statutes. The "Physicians' Bill of Rights" should be very carefully reviewed to be certain it actually benefits physicians. And of course, the entire bylaws document should be reviewed carefully to be sure that it is physician-friendly.
Applications can be accepted or denied or disciplinary action can be taken by hospital "without benefit of Medical Executive Committee [MEC] recommendation."	Some bylaws are structured on the presumption that the purpose of MEC action in peer review is simply to help the hospital board. The medical staff organization has the professional obligation to account for patient care quality, which includes the very important clinical duty to determine which clinician should be allowed to do what clinical activity. Further, the Elements of Performance for Joint Commission Standard MS.1.40 calls for the MEC to make recommendations on privileges and membership. Barring specific state statute permitting unilateral action if the medical staff fails to act, disciplinary or privileging or membership actions should never take place without medical staff participation.
Hospital Board MUST have authority to unilaterally amend because it is "ultimately responsible" under state corporate law.	Ultimate is not the same as absolute. State law does not mandate that hospital or any other corporate board had authority to unilaterally amend medical staff bylaws or any other contract.
Indemnification of medical staff leaders is contingent upon board approval of those leaders.	Hospitals' insurance policies do not condition coverage of medical staff leaders upon board approval. This is just a means for the hospital to control the leadership selection process. Medical staff self-governance is undermined by hospital involvement in leadership selection.

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Appendix G

Medical Staff Rules and Regulations Checklist

Typically, medical staff rules and regulation address clinical processes and procedures. Details tend to vary greatly based on state law and regulation, and on the practices of the particular medical staff. This checklist covers the issues usually covered in rules and regulations and provides some background for addressing these issues.

Check your state law and regulations on each issue.

	Issue	Background
☐	Amendment of Rules and Regulations	The Joint Commission definition of medical staff self-governance includes: • "Initiating, developing and approving medical staff bylaws and rules and regulations • Approving or disapproving amendments to the medical staff bylaws and rules and regulations."
☐	Autopsy	• Element of Performance 9 for Joint Commission Standard MS.3.10 calls for the medical staff to be actively involved in the use of developed criteria for autopsies. • According to the College of American Pathologists (CAP), "Deaths in which an autopsy should be especially encouraged are: 1. Deaths in which autopsy may help to explain unknown and unanticipated medical complications to the attending physician. 2. All deaths in which the cause of death or a major diagnosis is not known with reasonable certainty on clinical grounds. 3. Cases in which autopsy may help to allay concerns of the family and/or the public regarding the death, and to provide reassurance to them regarding same. 4. Unexpected or unexplained deaths occurring during or following any dental, medical or surgical diagnostic procedures and/or therapies.
☐	Autopsy *continued*	5. Deaths of patients who have participated in clinical trials (protocols) approved by institutional review boards. 6. Unexpected or unexplained deaths which are apparently natural and not subject to a forensic medical jurisdiction. 7. Natural deaths which are subject to, but waived by, a forensic medical jurisdiction such as (a) persons dead on arrival at hospitals (b) deaths occurring in hospitals within 24 hours of admission, and (c) deaths in which the patient sustained or apparently sustained an injury while hospitalized. 8. Deaths resulting from high-risk infectious and contagious diseases. 9. All obstetric deaths. 10. All perinatal and pediatric deaths. 11. Deaths at any age in which it is believed that autopsy would disclose a known or suspected illness which also may have a bearing on survivors or recipients of transplant organs. 12. Deaths known or suspected to have resulted from environmental or occupational hazards. The CAP position on autopsies is provided for information purposes. While the CAP makes general recommendations as to when autopsies are desirable, every institution should establish their specific recommendations by means of consultation between the pathologist and the rest of the medical staff. Proper personnel and other resources must be committed in support of this activity." For more information refer to CAP Practice Guidelines (*www.cap.org/apps/docs/committees/comm_autopsy.htm*).

	Issue *continued*	**Background** *continued*
☐	Consultation Requirement	Joint Commission MS.2.20 Element of Performance 3. The organized medical staff, through its designated mechanism, determines the circumstances under which consultation or management by a physician or other licensed independent practitioner is required and consultation is obtained as required.
☐	Countersigning for Residents	• Element of Performance 4 for Joint Commission Standard MS.2.30 states, "Organized medical staff rules and regulations and policies delineate participants in professional education programs who may write patient care orders, the circumstances under which they may do so (without prohibiting LIPs from writing orders), and what entries, if any, must be countersigned by a supervising LIP."
☐	Resident supervision process	• Joint Commission Standard MS.2.30 states, "In hospitals participating in a professional graduate education program(s), the organized medical staff has a defined process for supervision by a licensed independent practitioner with appropriate clinical privileges of each member in the program in carrying out his or her patient care responsibilities."
☐	Verbal orders	• "Verbal medication orders should be reserved only for those situations in which it is impossible or impractical for the prescriber to write the order or enter it in a computer. Verbal orders should be dictated slowly, clearly, and articulately to avoid confusion. The order should be read back to the prescriber by the recipient (e.g., nurse, pharmacist); when read back, the recipient should spell the drug name and avoid abbreviations when repeating the directions. A written copy of the verbal order should be placed in the patient's medical record and later confirmed by the prescriber in accordance with applicable state regulations and hospital policies. …" *AMA Policy Compendium H-120.968* • Under Element of Performance 1 for Joint Commission Standard IM.6.50, "Qualified personnel are identified, as defined by hospital policy and, as appropriate, in accordance with state and federal law, and authorized to receive and record verbal orders."

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Appendix H

Compiled Sample Bylaws

Bylaws as a Contract
As of the date on which these Bylaws become effective through adoption by the Medical Staff and approval by the Board as provided in Article XVI, in consideration of the mutual promises and agreements herein contained, the sufficiency of which are hereby acknowledged, the parties intending to be legally bound agree that these Bylaws shall constitute part of the contractual relationship existing between the Hospital and the Staff Members, both individually and collectively. These Bylaws may be amended only as provided in Article XVI and may not be unilaterally amended by any action of the Board, the Administration, medical staff or any other entity.
Illinois State Medical Society Model Medical Staff Bylaws §II.D.

In spite of the direction of the case law, hospitals and health care entities may continue to argue that the bylaws are not enforceable and reject any attempt by the medical staff to clearly identify the bylaws as a contract. The debate about whether bylaws are contracts may be defused by including a statement that the bylaws are binding on the hospital, the medical staff and its members. This bylaws provision can be inserted in a "purposes" clause or in an article of general provisions at the conclusion of the bylaws.

Binding Effect
These bylaws are intended to be binding upon the hospital, the medical staff, its members and applicants.

Direct Medical Staff Amendment Process
In addition to the processes established in this Article, amendments to the medical staff bylaws, rules and regulations and policies can be adopted by action of the medical staff, without action by the medical executive committee (MEC), at any general medical staff meeting or any special medical staff meeting called for the purpose of amending the bylaws, provided a quorum is present, by a majority vote of those active members present. Amendments adopted under this mechanism shall become effective when approved by the board, which shall not be unreasonably withheld.
Medical Association of Georgia Model Medical Staff Bylaws §X.C.

MEC Authority From the Medical Staff
The MEC is accountable to the Medical Staff, and, except for recommendations regarding individual membership, privileges and corrective actions, subject to reversal of its decisions by a majority vote of the Active Staff. Except for corrective action recommendations, it shall make available to the Medical Staff a record of all actions taken, and shall limit annual expenditures to a Medical Staff-approved budget.

Duties of the Medical Executive Committee
The duties of the medical executive committee shall include, but not be limited to:
(a) representing and acting on behalf of the medical staff in the intervals between medical staff meetings, subject to such limitation as may be imposed by these bylaws …
California Medical Association Model Medical Staff Bylaws §11.3-2(a).

Purpose
The medical staff is organized to assure that patient care meets all relevant standards and to improve the quality of care delivered in this institution. Recognizing their responsibility for the overall quality of clinical services provided by its members, the medical staff organizes itself for the purpose of self-governance in conformity with these bylaws so that it can fulfill its responsibility for quality of care. These bylaws are binding on the medical staff and the hospital/health system.

Clinical Privileges
Clinical privileges or privileges means the permission granted to medical staff members to provide patient care and includes unrestricted access to those hospital resources (including equipment, facilities and hospital personnel) which are necessary to effectively exercise those privileges.
California Medical Association Model Medical Staff Bylaws §1.2-5.

Day
Day means a calendar day unless other specified in a particular context as "working day," which day does not include weekends or state holidays.

In Good Standing
IN GOOD STANDING means a member is currently not under suspension 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.
Ohio State Medical Association Model Medical Staff Bylaws Definition #8; California Medical Association Medical Staff Bylaws §1.2-7.

Investigation
Investigation means a process specifically initiated by the medical executive committee to determine the validity, if any, of a concern or complaint raised against a medical staff member or individual holding clinical privileges. It does not include activity of the medical staff aid committee.
California Medical Association Model Medical Staff Bylaws §1.2-8.

Nature of Membership
No individuals, including those in a medical administrative position by virtue of a contract or employment with the hospital, shall admit or provide medical or health-related services to patients in the hospital unless they are members of the medical staff with such privileges or have been granted such privileges on a temporary basis in accordance with the procedures set forth in these bylaws.
Missouri State Medical Association Model Medical Staff Bylaws §2.1.

Right to Practice
Neither the Hospital nor the Medical Staff shall take any adverse action or otherwise retaliate against physicians for advocating medically appropriate treatment for patients, the appropriateness of such treatment, as determined by the Medical Staff in accordance with these Bylaws. Medical Staff Membership shall not be jeopardized nor shall the right to exercise clinical privileges be infringed except for conduct, either within or outside the Hospital, which is or is reasonably believed to be detrimental to the quality of patient care or safety, and only then in accordance with these bylaws.
Illinois State Medical Society Model Medical Staff Bylaws §XVII.B.

Nondiscrimination
Neither Hospital nor the Medical Staff shall discriminate in granting staff membership and/or clinical privileges on the basis of national origin, culture, race, gender, ethnic background, religion, legitimate business interests, or disability unrelated to the provision of patient care to the extent the applicant or member is otherwise qualified.

Third-Party Contracting
Medical staff membership or clinical privileges shall not be conditioned or determined on the basis of an individual's participation or nonparticipation in a particular medical group, IPA, PPO, PHO, hospital-sponsored foundation, or other organization or in contracts with a third party which contracts with this hospital.
California Medical Association Model Medical Staff Bylaws §2.3.

Response Time
Medical staff members and privileges holders shall comply with department rules and regulations as approved by the medical executive committee determining response times for specified privileges and procedures.

Economic Credentialing
Medical staff membership and privileges may be granted, continued, modified or terminated by the Board only upon recommendation of the medical executive committee for reasons directly related to quality of patient care and other provisions of the medical staff bylaws, according to the procedures set forth in these bylaws. Under no circumstances shall economic criteria unrelated to quality of care be used to determine qualification for initial or continuing medical staff membership or privileges.

Professional Liability Insurance
Each member shall maintain in force professional liability insurance in not less than the minimum amounts, if any, as from time to time may be jointly determined by the board of [trustees/directors] and medical executive committee. The medical executive committee, for good cause shown, may waive this requirement with regard to such member as long as such waiver is not granted or withheld on an arbitrary, discriminatory or capricious basis. In determining whether an individual exception is appropriate, the following facts may be considered:
(1) Whether the member has applied for the requisite insurance;
(2) Whether the member has been refused insurance and, if so, the reasons for such refusal; and
(3) Whether insurance is reasonably available to the member and, if not, the reasons for its unavailability.
California Medical Association Model Medical Staff Bylaws §2.2-1(c).

Continuous Coverage
Where a medical staff has determined that it will require continuous professional liability insurance coverage as a condition for membership, a temporary loss of professional liability insurance coverage (whether or not limited to "tail" coverage) is not grounds for immediate termination of medical staff membership or ineligibility to serve in a medical staff leadership position. The Medical Executive Committee shall determine the length and other conditions of an individual waiver of the coverage requirement.

Board Certification and Equivalency
Physician medical staff members and applicants shall:

1. Be currently or have been certified by a member of the American Board of Medical Specialties or the Advisory Board for Osteopathic Specialists in a specialty that encompasses the privileges held or sought; or

2. Have met the training and education requirements for and are in the process of obtaining certification from that board, which must be obtained within six years from date of initial medical staff membership to be eligible for membership renewal; or

3. Have successfully completed at least a two-year postgraduate training program in the specialty in which privileges are held or sought, which program was, at the time attended, accredited by the American Council of Graduate Medical Education or the American Osteopathic Association, and can document experience and demonstrate competence that is determined by the credentials committee and approved by the executive committee to be equivalent of that described in this subsection.

Board Certification Grandfathering
Applications from physicians who are medical staff members on or prior to [date] may be considered for renewed membership and privileges despite lack of current board certification if the members can document experience and demonstrate competence that is determined by the credentials committee and approved by the executive committee to be equivalent of that described in this subsection.

Emergency Coverage Requirements
Except for honorary and retired staff, the ongoing responsibilities of each member of the medical staff shall include ... (j) participating in such emergency service coverage or consultation panels as may be determined by the medical staff.
Ohio State Medical Association Model Medical Staff Bylaws §7.5.

Conduct
Only physicians … shall be deemed to possess basic qualifications for membership in the medical staff who are determined … to be able to work cooperatively with others so as not to adversely affect patient care.
California Medical Association Model Medical Staff Bylaws §2.2-1(b)(2).

Ethics Adherence
Except for honorary and retired staff, the ongoing responsibilities of each member of the medical staff include … Abiding by the American Medical Association Code of Medical Ethics or other ethical principles established by the member's profession.
Ohio State Medical Association Model Medical Staff Bylaws §7.5(c).

Competition Protection
Nothing in these Bylaws shall be interpreted to prohibit fair competition or pursuit of business interests on the part of practitioners.

Medicare Exclusion
Immediately upon verification that a member is excluded from the federal Medicare or other federally funded health care program, medical staff membership and clinical privileges shall be automatically revoked. A former member excluded from the staff due to Medicare exclusion or any applicant denied an application due to exclusion from Medicare may apply as an initial applicant for medical staff membership when the exclusion terminates.
Ohio State Medical Association Model Medical Staff Bylaws §11.3-4.

Employed or Contracted Physicians
Contracts to Practice Medicine. Before the Hospital or any Hospital Affiliate may enter into any contract or employment relationship for Physician or Independent (AHP) [Allied Health Professional] clinical services, which have been provided during the previous twelve months by any Member of a Clinical Department with clinical privileges for said clinical services, the Hospital shall obtain the approval of the Medical Executive Committee and the applicable Clinical Departments and Divisions. No individual shall be entitled to Medical Staff Membership or Clinical Privileges by virtue of such a contract or employment relationship. Any member party to any said contract, excluding provider relationships, or any employment relationship with the Hospital or any Hospital Affiliate, shall not be eligible to serve as a Medical Staff Representative. Physician recruitment incentives consistent with this section may be allowed by Policy.
Illinois State Medical Society Model Medical Staff Bylaws §XVII.C.

Protection for Leaders
Medical staff leaders and medical staff representatives shall not be terminated by the hospital from any hospital contract or employment arrangement based on their medical staff activities carried out pursuant to these bylaws.

Hospitalists
Hospitalists shall meet all requirements for medical staff membership and active staff category under these bylaws.

No hospitalist contract, privilege or employment relationship shall extend exclusive rights to admitting or attending patients in the hospital.

Administrative Staff

Qualifications

Administrative staff category membership shall be held by any physician, dentist or podiatrist who is retained by the hospital specifically to perform quality assurance activities or other administrative duties. The administrative staff shall consist of members who:

(a) are charged with assisting the medical staff in carrying out quality assurance functions (or other such duties),

(b) document their:
- (1) current licensure,
- (2) adequate experience, education and training,
- (3) current professional competence,
- (4) good judgment,
- (5) physical and mental health status, so as to demonstrative to the satisfaction of the medical staff that they are professionally and ethically competent to exercise their duties,

(c) are determined:
- (1) to adhere to the ethics of their respective professions,
- (2) to be able to work cooperatively with others so as not to adversely affect their judgment in carrying out the quality assurance functions, and
- (3) to be willing to participate in and properly discharge those responsibilities determined by the medical staff.

Prerogatives

The administrative staff shall be entitled to: Attend meetings of the medical staff and various departments, including open committee meetings and educational programs, (and) (but) shall have (the right) (no right) to vote at such meetings, except to the extent the right to vote is specified at the time of appointment. Administrative staff members shall (not) be eligible to hold office in the medical staff organization, admit patients (and)(or) exercise clinical privileges.

Affiliate Staff

Practice

Affiliate members:
- do not admit patients [independently];
- refer patients to [hospitalists and other] members with admitting privileges; and
- follow and visit patients in the hospital.

Prerogatives

Affiliate staff members are entitled to:
- exercise privileges granted in accordance with these bylaws; and
- vote at medical staff meetings and in meetings of the departments [, sections] and committees of which they are members.

Medical Association of Georgia Model Medical Staff Bylaws II.K.2.

Call Coverage Category

Call Coverage Staff

A. Qualifications

The Call Coverage Staff shall consist of practitioners who possess clinical expertise and:
- (1) meet the membership qualifications set forth in these bylaws;
- (2) are members in good standing of the Active Medical Staff of another hospital;
- (3) come to the Hospital when so scheduled, at the request of an Active Staff member.

B. Prerogatives/Restrictions

The prerogatives of a Call Coverage Staff member shall be to:
- (1) provide call coverage in his/her subspecialty and admit patients consistent with his/her privileges;
- (2) exercise such clinical privileges as are granted pursuant to these bylaws;

The Call Coverage Staff member may not:
- (3) hold office in the Medical Staff or in the Department of which he/she is a member, or serve on committees;
- (4) vote on any Medical Staff matter.

The practitioner shall limit admissions and hospital services to those patients needing urgent and emergent treatment during the period of call. Those patients requiring ongoing treatment beyond the limits of on-call schedule could continue to be treated by the on-call practitioner at the discretion of the Active Staff Member being covered or will be treated by the Active Staff Member.

C. Responsibilities

Each Call Coverage Staff member shall fulfill the basic membership responsibilities set forth in these bylaws except that Call Coverage members shall not be required to pay staff dues or assessment. American Academy of Orthopaedic Surgeons EMTALA Compendium at 28 (See Appendix B for additional information).

Telemedicine Category

Qualifications

Only physicians providing telemedicine who are currently licensed to practice in the state and meet the following basic qualifications shall be eligible for membership in the consulting/telemedicine medical staff of the hospital/medical care organization:

(a) documented
   (1) adequate experience, education, and training,
   (2) current professional competence, and
   (3) current adequate physical and mental health status to perform the clinical privileges requested, so as to demonstrate to the satisfaction of the medical staff that they are professionally and ethically competent and that patients treated by them can reasonably expect to receive quality medical care;

(b) are determined:
   (1) to adhere to the ethics of the profession,
   (2) to be able to work cooperatively with others so as not to adversely affect patient care,
   (3) to keep as confidential, as required by law, all information or records received in the physician-patient relationship, and
   (4) to be willing to participate in and properly discharge those responsibilities determined by the medical staff;

(c) maintain in force professional liability insurance in not less than the minimum amounts, if any, as from time to time may be jointly determined by the governing body and medical executive committee; and

(d) are members of the active or associate medical staff of another hospital/medical care organization.

Responsibilities

The responsibilities of a consulting/telemedicine staff member shall include the following:

(a) provide patients with professional care of generally recognized quality of care meeting the professional standards of the medical staff of this hospital/medical care organization;
(b) provide telemedicine service or consultative services on a timely basis within their area of competence;
(c) supervise nonphysician providers or technicians delivering services via telemedicine and have the capability to immediately contact nonphysician providers or technicians delivering, as well as patients receiving, services via telemedicine;
(d) provide patient care protocols for all levels of telemedicine;
(e) ensure the legal and ethical requirements with respect to patient confidentiality and data integrity are not compromised by the use of a telemedicine modality;
(f) abide by the medical staff bylaws, medical staff rules and regulations, and policies;
(g) discharge in a responsible and cooperative manner such reasonable responsibilities and assignments as requested;
(h) prepare and complete in a timely fashion medical records entries for all the patients for whom the member provides care in the hospital/medical care organization; and
(i) abide by the ethics of the profession.

Prerogatives

The consulting/telemedicine staff member shall be entitled to:

(a) exercise such clinical privileges as are granted by the governing body of the hospital/medical care organization only upon recommendation of the medical staff; and
(b) attend meetings of the medical staff and the department of which that person is a member, including open committee meetings and educational programs.

AMA Board Report 3 (A-97), "Medical Staff Membership Category for Physician Providing Telemedicine."

Temporary Staff Category

When necessary for conducting peer review activities, the medical executive committee may admit a physician or other individual to the medical staff for a limited period of time. Such membership shall be solely for the stated purpose in a particular case or situation, and the temporary membership shall terminate upon the temporary member's completion of duties in connection with the peer review matter. Physicians admitted as temporary staff members shall be subject only to those appointment requirements of Article IX deemed necessary by the medical executive committee to ensure that the temporary medical staff member is qualified to conduct his or her duties.
Ohio State Medical Association Model Medical Staff Bylaws §8.8.

Application for Category Upgrade

Members may apply for a higher category of membership on a form provided by the medical executive committee for that purpose. The National Practitioner Data Bank must be queried on those requesting category upgrade.

Professional Liability History

All applicants for new and renewed membership and privileges shall provide information on final judgments

and settlements in professional liability cases in which the applicant was a defendant, including a clinical summary of the underlying claim.

Leave of Absence

Leave Status

At the discretion of the medical executive committee, a medical staff member may obtain a voluntary leave of absence from the staff upon submitting a written request to the medical executive committee stating the approximate period of leave desired, which may not exceed [_____]. During the period of the leave, the member shall not exercise clinical privileges at the hospital, and membership rights and responsibilities shall be inactive, but the obligation to pay dues, if any, shall continue, unless waived by the medical staff.

Termination of Leave

At least 30 days prior to the termination of the leave of absence, or at any earlier time, the medical staff member may request reinstatement of privileges by submitting a written notice to that effect to the medical executive committee. The staff member shall submit a summary of relevant activities during the leave, if the executive committee so requests. The medical executive committee shall make a recommendation concerning reinstatement of the member's privileges and prerogatives, and the procedure provided in Section _____ through _____ shall be followed.

Failure to Request Reinstatement

Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the medical staff and shall result in automatic termination of membership, privileges, and prerogatives. A member whose membership is automatically terminated shall be entitled to the procedural rights provided in Article VII for the sole purpose of determining whether the failure to request reinstatement was unintentional or excusable, or otherwise. A request for medical staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial memberships.

Medical Leave of Absence

The medical executive committee shall determine the circumstances under which a particular medical staff member shall be granted a leave of absence for the purpose of obtaining treatment for a medical condition or disability. In the discretion of the medical executive committee, unless accompanied by a reportable restriction of privileges, the leave shall be deemed a medical leave which is not granted for a medical disciplinary cause or reason.

Military Leave of Absence

Requests for leave of absence to fulfill military service obligations shall be granted upon notice and review by the medical executive committee. Reactivation of membership and clinical privileges previously held shall be granted, notwithstanding the provisions of Sections _____ and _____, but may be granted subject to monitoring and/or proctoring as determined by the medical executive committee.

California Medical Association Model Medical Staff Bylaws §3.8.

Granting Clinical Privileges

Medical staff privileges may be granted, continued, modified, or terminated by the governing body of this hospital only upon recommendation of the medical staff, only for reasons directly related to quality of patient care and other provisions of the medical staff bylaws, and only following the procedures outlined in these bylaws.

California Medical Association Model Medical Staff Bylaws §5.1.

Admitting Privileges

Privileges to admit patients must be specifically requested and can be granted only to qualified physicians [and other qualified professionals] meeting the clinical criteria for admitting privileges. Admitting privileges are not limited and shall not be exclusive to hospital employees, members or other professionals with hospital contracts, or to any single specialty.

Dual Privileges

Upon receipt of the application materials from the Credentials Committee, the Chair of each department in which the applicant requests clinical privileges shall examine evidence of the licensure, character, professional competence, qualifications, and ethical standing of the applicant and shall determine whether the applicant has established and meets all of the necessary requirements for the clinical privileges requested and, in the case of a physician applying for Staff membership, for the particular category of Staff membership sought. Within 60 days of the receipt of the application materials, each department Chair shall make a written recommendation to the Credentials Committee.

Texas Medical Association Model Medical Staff Bylaws §VI.A.3.

The Right to Exercise Privileges Conferred

Unless limited or terminated consistent with these bylaws, professionals have the right to exercise any and all privi-

leges in the hospital which they have applied for and been granted consistent with these bylaws.

Temporary Privileges

5.5 Temporary Clinical Privileges

Temporary privileges are allowed under two circumstances only: to address a patient care need and to permit patient care to be provided while an application is pending.

5.5-1 Patient Care Needs

(a) Care of Specific Patient
Temporary clinical privileges may be granted where good cause exists to allow a physician, [dentist, podiatrist, clinical psychologist] to provide care to a specific patient (but not more than [_____] during a calendar year) provided that the procedure described in Section 5.5-5(a)(1) has been completed.

(b) Locum Tenens
Temporary clinical privileges may be granted to a person serving as a locum tenens for a current member of the medical staff to meet the care needs of that member's patients in his/her absence, provided that the procedure described in Section 5.5-5 has been completed. Such person may attend only patients of the member(s) for whom that person is providing coverage, for a period not to exceed [_____], unless the medical executive committee recommends a longer period for good cause.

(c) Other Important Patent Care Needs
Temporary clinical privileges may be granted to allow a physician, [dentist] [podiatrist] [clinical psychologist] to fulfill an important patient care treatment or service need (but not more than [_____] during a calendar year) provided that the procedure described in Section 5.5-5 has been completed.

5.5-2 Pending Application for Medical Staff Membership

Temporary clinical privileges may be granted to an applicant while that person's application for medical staff membership and privileges is completed and awaiting review and approval of the medical executive committee or the board of [trustees/directors], provided that the procedure described in Section 5.5-4(a)(2) has been completed, and that the applicant has no current or previously successful challenge to professional licensure or registration, no involuntary termination of medical staff membership at any other organization, and no involuntary limitation, reduction, denial or loss of clinical privileges. Such persons may only attend patients for a period not to exceed [120] days.

5.5-3 Temporary Membership and Temporary Privileges Not Co-Extensive

Temporary members of the medical staff pursuant to Section 6.1-3 are not, by virtue of such membership, granted temporary clinical privileges.

5.5-4 Application and Review

Upon receipt of a completed application and supporting documentation from a physician, [dentist, podiatrist, clinical psychologist] authorized to practice in California, the chief executive officer on the recommendation of either the applicable clinical department chairperson or the chief of staff, may grant temporary privileges to a member who appears to have qualifications, ability and judgment consistent with Section 2.2-1, but only:

(1) With respect to applications by a locum tenens, or to fulfill an important patient care need, after verification of current licensure and current competence; or

(2) With respect to a new applicant awaiting review and approval of the medical staff executive committee and the governing body in compliance with the requirements in Section 5.5-3, after the following has been completed:
   (i) the National Practitioner Data Bank report regarding the applicant for temporary privileges has been received and evaluated and current California licensure has been verified.
   (ii) the appropriate department chair has interviewed the applicant and has contacted at least one person who
      (a) has recently worked with the applicant;
      (b) has directly observed the applicant's professional performance over a reasonable time; and
      (c) provides reliable information regarding the applicant's current professional competence to perform the privileges requested, ethical character, and ability to work well with others so as not to adversely affect patient care, or other criteria required by medical staff bylaws.
   (iii) the applicant's file, including the recommendation of the department chair of the applicable department when available, or the chief of staff in all other cases, is forwarded to the credentials committee and the medical executive committee.
   (iv) the medical executive committee through the chief of staff, after reviewing the applicant's file and attached materials, recommends granting temporary privileges.
      (a) If the applicant requests temporary privileges in more than one department, interviews shall be conducted and written concurrence shall first be obtained from the appropriate depart-

ment chairs and forwarded to the credentials committee. In the event of a disagreement between the chief executive officer or his or her designee and the medical executive committee regarding the granting of temporary clinical privileges, the matter shall be resolved as set forth in Section 4.5-8.

5.5-5 General Conditions

If granted temporary privileges, the applicant shall act under the supervision of the department chair to which the applicant has been assigned, and shall ensure that the chair, or the chair's designee, is kept closely informed as to the applicant's activities within the hospital.

(a) Temporary privileges shall automatically terminate at the end of the designated period, unless earlier terminated or suspended under Articles VI and/or VII of these bylaws or unless affirmatively renewed following the procedure as set forth in Section 5.5-5. As necessary, the appropriate department chair or, in the chair's absence, the chair of the medical executive committee, shall assign a member of the medical staff to assume responsibility for the care of such member's patient(s). The wishes of the patient shall be considered in the choice of a replacement medical staff member.
(b) Requirements for proctoring and monitoring, including but not limited to those in Section 5.3, shall be imposed on such terms as may be appropriate under the circumstances upon any member granted temporary privileges by the chief of staff after consultation with the departmental chair or the chair's designee.
(c) All persons requesting or receiving temporary privileges shall be bound by the bylaws and rules and regulations of the medical staff.

Disaster Privileges

(1) Conditions

Disaster privileges may be granted only when the hospital's Emergency Management Plan has been activated. Individuals with disaster privileges shall be identified and managed as described in the hospital's Emergency Management Plan. The Medical Staff Bylaws, rules, regulations and policies control in all matters relating to the exercise of disaster privileges.

(2) Circumstances

The Chairman of the Medical Staff or the CEO, or their designees, may, on a case by case basis, grant disaster privileges upon presentation of a valid photo identification issued by a state or federal agency and any of the following:

(a) A current Hospital picture identification
(b) A current license to practice
(c) Identification establishing that the individual is a member of a Disaster Medical Assistance Team (DMAT), MRC, ESAR-VHP, or other recognized state or federal organizations or groups
(d) Identification granted by a federal, state or municipal entity establishing that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances
(e) Identification by current hospital staff or medical staff member(s) with personal knowledge regarding the practitioner's identity and ability to act as a licensed independent practitioner during a disaster.

Verification of the credentials of individuals with disaster privileges is a high priority. Verification shall be initiated as soon as the immediate situation is under control and shall follow the procedures established in these Bylaws for granting temporary privileges to meet an important care need. Disaster privileges may be withdrawn at any time by the individuals listed above. Refusal or withdrawal of such privileges does not give the right to the Fair Hearing process unless the refusal or withdrawal results in a report to any state or national agency.

Medical Staff's Role in Exclusive Contracts Decision Making

Appropriateness of Exclusive Contracts

Privileges can be reduced or terminated as a result of a decision to close or continue closure of a department/service pursuant to an exclusive contract, or to transfer an existing exclusive contract, only following review by the medical staff of the related quality of care issues and a determination of appropriateness of the closure, continued closure or transfer as set forth below. The board of [trustees'/directors'] decision shall uphold the medical staff's determination unless the board of [trustees/directors] makes specific written findings that the medical staff's determination is arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law.

(a) The medical staff shall determine the need to close or continue closure of a department/service pursuant to an exclusive contract to be appropriate where:
    (1) a failure to provide full coverage of a needed service cannot be remedied by less extreme measures, such as mandated call schedules; or
    (2) irreconcilable differences within an existing department/service adversely affecting quality of care have not been resolved by less extreme measures; or
    (3) demonstrable efficiencies would result, producing significant improvement in the ability of the medi-

cal staff to dispense quality care, which have not been accomplished through less extreme measures.

A determination to close a department/service pursuant to an exclusive contract must be based upon the preponderance of the evidence, viewing the record as a whole, presented by any and all interested parties, following notice and opportunity for comment. A determination to continue closure of a department/service pursuant to an exclusive contract must be based upon the preponderance of the evidence presented by members of the medical staff, following notice and opportunity for comment.

(b) The medical staff shall determine the transfer of an existing exclusive contract to be appropriate only when:
  (1) continued closure of the department/service pursuant to an existing contract is found appropriate pursuant to:
    (a) above, and
  (2) quality of care is maintained or improved by the transfer.

(c) The medical staff member(s) whose privileges may be adversely affected by the medical staff's determination of appropriateness of the closure or continued closure of a department/service pursuant to an exclusive contract, or transfer of an exclusive contract, may request a hearing before the judicial review committee. Such a hearing will be governed by the provisions of Article VII except that:
  (1) the hearing shall be limited to the following issues:
    (i) whether the medical staff's determination of appropriateness is supported by a preponderance of the evidence;
    (ii) whether the medical staff followed its requirement for notice and comment on the issue of appropriateness;
    (iii) in cases of transfer, whether the medical staff's determination of effect on quality of care was appropriate.
  (2) All requests for such a hearing will be consolidated. Should an affected medical staff member request a hearing under this subsection, the medical staff's recommendation regarding the exclusive contract will be deferred, pending the outcome of the judicial review committee hearing.

(d) A medical staff member providing professional services under a contract with the hospital shall not have medical staff privileges terminated for reasons pertaining to the quality of care provided by the medical staff member without the same rights of hearing and appeal as are available to all members of the medical staff.

(e) Except as specified in this section, the termination of privileges following the decision determined to be appropriate by the medical staff to close a department/service pursuant to an exclusive contract or to transfer an exclusive contract shall not be subject to the procedural rights set forth in Article VII.

(f) Except in cases of contemporaneous transfer of an existing exclusive contract determined to be appropriate by the medical staff, a decision to terminate an exclusive contract shall not affect the privileges of medical staff members who were performing services pursuant to that contract, except that their privileges shall no longer be exclusive.

(g) Terms of this section will take precedence over any inconsistent terms in a contract between a member of the medical staff and the hospital, including, but not necessarily limited to, any contractual provisions purporting to waive all rights of hearing and appeal provided in these bylaws.

13.9 Medical Staff Role in Exclusive Contracting
The medical staff shall review and make recommendations to the board of [trustees/directors] regarding quality of care issues related to exclusive arrangements for physician and/or professional services, prior to any decision being made, in the following situations:

(a) the decision to execute an exclusive contract in a previously open department or service;
(b) the decision to renew or modify an exclusive contract in a particular department or service;
(c) the decision to terminate an exclusive contract in a particular department or service.

California Medical Association Model Medical Staff Bylaws §7.6, 14.9.

MEC Review of Proposed Contract Arrangements
The Medical Executive Committee shall collect information from the members of medical specialties that would be affected, from the hospital administration, and from other interested parties, in order to make an informed recommendation as to whether services should be closed or discontinued, or provided through a contract, and, should a contract arrangement be recommended, what contract sources should be utilized. However, the actual terms of any contract and any financial information related to the contract, including but not limited to the remuneration to be paid to medical staff members under contract, are not relevant and therefore shall neither be disclosed to the Medical Executive Committee nor discussed as part of this contracting evaluation process. Unless the recommenda-

tion is arbitrary or capricious, the Board's action regarding the contract shall be consistent with the recommendation of the Medical Executive Committee.

Hearing Rights for Contracting Physicians
Hearing rights granted under these bylaws are not subject to waiver by contract or otherwise between [hospital/health care entity] and other parties.

Core Privileges
Only privileges specifically requested by the applicant can be granted.

Histories and Physicals
Every patient receives a history and physical within twenty-four hours of admission, unless a previous history and physical performed within thirty days of admission is on record, in which case that history and physical will be updated within twenty-four hours of admission. Every patient admitted for surgery must have a history and physical within 24 hours prior to surgery, unless a previous history and physical performed within thirty days prior to the surgery is on record, in which case that history and physical will be updated within twenty-four hours of the surgery. Only those granted privileges to do so conduct history and physicals or update histories and physicals. Privileges to conduct a history and physical or an update to a history and physical are granted only to:

(a) Physicians
Privileges to conduct or update histories and physicals for patients admitted solely for oral/maxillofacial surgery, consistent with the time requirements stated in this section, may be granted to qualified physicians who are members of the medical staff or seeking temporary privileges.

(b) Oral/maxillofacial surgeons.
Privileges to conduct or update histories and physicals only for those patients admitted solely for oral/maxillofacial surgery, consistent with the time requirements stated in this section may be granted to qualified oral/maxillofacial surgeons who are members of the medical staff or seeking temporary privileges.

Medical Association of Georgia §V.B.6.

Proctoring
General Provisions
Except as otherwise determined by the medical executive committee, all initial appointees to the medical staff and all members granted new clinical privileges shall be subject to a period of proctoring. Each appointee or recipient of new clinical privileges shall be assigned to a department where performance on an appropriate number of cases as established by the medical executive committee, or the department as designee of the medical executive committee, shall be observed by the chair of the department, or the chair's designee, during the period of proctoring specified in the department's rules and regulations, to determine suitability to continue to exercise the clinical privileges granted in that department. The exercise of clinical privileges in any other department shall also be subject to direct observation by that department's chair or his or her designee. The member shall remain subject to such proctoring until the medical executive committee has been furnished with:

(a) a report signed by the chair of the department(s) to which the member is assigned describing the types and numbers of cases observed and the evaluation of the applicant's performance, a statement that the applicant appears to meet all of the qualifications for unsupervised practice in that department, has discharged all of the responsibilities of staff membership, and has not exceeded or abused the prerogatives of the category to which the appointment was made; and

(b) a report signed by the chair of the other department(s) in which the appointee may exercise clinical privileges, describing the types and number of cases observed and the evaluation of the applicant's performance and a statement that the member has satisfactorily demonstrated the ability to exercise the clinical privileges initially granted in those departments.

Failure to Obtain Certification
If an initial appointee fails within the time of provisional membership to furnish the certification required, or if a member exercising new clinical privileges fails to furnish such certification within the time allowed by the department, those specific clinical privileges shall automatically terminate, and the member shall be entitled to a hearing, upon request, pursuant to Article VII.
California Medical Association Model Medical Staff Bylaws §5.3.

External Peer Review
External peer review will take place in the context of focused review, investigation, application processing or at any other time only under the following circumstances, if and only if deemed appropriate by the medical staff department or the Medical Executive Committee or Board of Trustees; however, a practitioner subject to focused review or investigation can require the hospital or medical staff to obtain external peer review if it is not deemed appropriate by the medical staff department or the Medical Executive Committee or Board of Trustees.

(a) Ambiguity when dealing with vague or conflicting recommendations from committee review(s) where conclusions from this review could directly impact an individual's membership or privileges;
(b) Lack of internal expertise, when no one on the medical staff has adequate expertise in the clinical procedure or area under review;
(c) When the medical staff needs an expert witness for a fair hearing, for evaluation of a credential file or for assistance in developing a benchmark for quality monitoring;
(d) To promote impartiality in peer review;
(e) Upon the reasonable request of a practitioner.

The Medical Executive Committee or Board of Trustees may require external peer review in any circumstances deemed appropriate by either of these bodies.

Corrective Action
Procedures and Conduct

(1) Conduct Requiring

Activities or professional conduct of any practitioner detrimental to or behavior disruptive to patient safety or to the delivery of quality patient care, or conduct in violation of or contrary to these Bylaws, the Rules and Regulations of the Staff.

(2) Initiation

Corrective action may be initiated by any officer of the Staff, the Chair of any clinical department, the Chair of any standing committee, the Administrator, or the Board. Additionally, members of the nursing staff, allied health professionals and hospital employees, may request such action, by communicating a request to the Medical Executive Committee as described in this paragraph 2. All requests for corrective action shall be submitted to the Medical Executive Committee in writing and supported by reference to the activities or conduct constituting grounds for the request. A copy of the request and notice of the practitioner's right to appear pursuant to Paragraph (3) (b) below shall immediately be sent to the practitioner by the Medical Executive Committee by certified mail return receipt requested or by personal service. The Chair of the Medical Executive Committee shall promptly notify the Administrator in writing of all requests for corrective action received by the Medical Executive Committee and shall continue to keep the Administrator fully informed of all action taken in connection therewith.

(3) Medical Executive Committee Action

(a) Time
Within thirty (30) days following receipt of a request for corrective action, unless the affected practitioner agrees to an extension of time, the Medical Executive Committee shall take action upon the request or permit an appearance by the affected practitioner.

(b) Appearance by Member
If the corrective action could involve an adverse decision concerning clinical privileges, or a suspension or expulsion from the Staff, the affected practitioner shall be afforded an opportunity to make an appearance before the Medical Executive Committee prior to its taking action on such request. This appearance shall not constitute a hearing, but shall be preliminary and investigative in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply thereto.

(c) Recommendation
Within ten (10) business days following an appearance by the practitioner, the Medical Executive Committee shall take action with respect to the matter. A written record of action on the request for corrective action shall be made by the Medical Executive Committee and kept on file at the Hospital. The Medical Executive Committee shall promptly notify the Administrator of its action made in regard to a request for corrective action.

(d) Permitted Action
On a request for corrective action, the Medical Executive Committee of the Staff may take one of the following actions: a warning; letter of admonition; letter of reprimand; imposition of terms of probation or a requirement for consultation or continuing medical education; recommendation for reduction, suspension or revocation of clinical privileges; recommendation for alteration of already imposed restrictions; recommendation for suspension or revocation of Staff membership; absolution of the practitioner; or any alternative to the above-named deemed appropriate by the Medical Executive Committee. Action so taken may form the basis of future actions.

Illinois State Medical Society Model Medical Staff Bylaws §XI.A.

Harassment

Harassment by a medical staff member against any individual (e.g., against another medical staff member, house staff, hospital employee, or patient) on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex, or sexual orientation shall not be tolerated.

"Sexual harassment" is unwelcome verbal or physical conduct of a sexual nature which may include verbal harassment (such as epithets, derogatory comments, or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and visual harassment (such as the display of derogatory cartoons, drawings, or posters).

Sexual harassment includes unwelcome advances, requests for sexual favors, and any other verbal, visual, or physical conduct of a sexual nature when (1) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion, or other aspects of employment; or (2) this conduct substantially interferes with the individual's employment or creates an intimidating, hostile, or offensive work environment. Sexual harassment also includes conduct which indicates that employment and/or employment benefits are conditioned upon acquiescence in sexual activities.

All allegations of sexual harassment shall be immediately investigated by the medical staff and, if confirmed, will result in appropriate corrective action, from reprimands up to and including termination of medical staff privileges or membership, if warranted by the facts.
California Medical Association Model Medical Staff Bylaws §2.6.

Summary Suspension
Circumstances
The Chief of Staff, and Chair or Vice Chair of the respective department, or the Medical Executive Committee shall constitute an ad hoc committee for the limited purposes of this Section and shall have the right, whenever action must be taken immediately because continuation of practice of a practitioner constitutes an immediate danger to the public, including patients, visitors, and hospital employees and staff or for those administrative circumstances specified below, to summarily suspend all or any portion of the clinical privileges of a practitioner, effective immediately upon imposition. Where summary suspension is imposed by the Medical Executive Committee in the absence of the Chief of Staff, the Medical Executive Committee should immediately transmit notice of the suspension to the Chief of Staff.
Illinois State Medical Society Model Medical Staff Bylaws §XI. C.1.

Automatic Suspension
1) State Board Action
Action by the Texas State Board of Medical Examiners or other appropriate licensing board revoking or suspending a practitioner's license shall automatically suspend the practitioner's Staff membership and clinical privileges. Action by the appropriate state licensing board revoking or suspending the license of a limited license professional exercising clinical privileges shall automatically suspend the limited license professional's clinical privileges. Such suspension of Staff membership and clinical privileges shall continue throughout the period during which the practitioner's license is revoked or suspended. In the absence of any corrective action which has adversely affected the practitioner's Staff membership or clinical privileges, the suspension described in this paragraph shall automatically terminate upon the reinstatement of the practitioner's license by the Texas State Board of Medical Examiners or other appropriate state licensing board.

2) Drug Enforcement Administration Action
Action by the Drug Enforcement Administration (including voluntary relinquishment by the practitioner) revoking or suspending a practitioner's controlled substances registration shall automatically suspend the Staff membership and clinical privileges to the extent necessary to be consistent with the action taken by the Drug Enforcement Administration. Action by the Drug Enforcement Administration revoking or suspending the controlled substances registration of a limited license professional exercising clinical privileges shall automatically suspend the limited license professional's clinical privileges to the extent consistent with the action taken by the Drug Enforcement Administration. In the absence of any corrective action which has adversely affected the practitioner's Staff membership or clinical privileges, the suspension described in this paragraph shall automatically terminate upon the reinstatement of the practitioner's registration by the Drug Enforcement Administration.

3) Medical Records—Staff Generally
A Staff member may have automatic suspension imposed for failure to complete medical records in accordance with Staff Rules and Regulations and these Bylaws, in the following manner:
(a) A temporary suspension in the form of withdrawal of admitting privileges (hereinafter called a "no bed status"), effective until medical records are completed, shall be imposed following the recommendation of such suspension to the Medical Executive Committee by the Medical Records Committee. Such suspension shall be imposed automatically beginning seven (7) business days after the mailing by registered mail, certified mail, or by personal service to the affected Staff member, at his or her current office address supplied by him or her to the Hospital, of a written notice from

the Chief of Staff of the Staff member's delinquency in completing his or her medical records, with the Chief of Staff also sending a copy of said notice to the Medical Records Committee. During this seven (7) day period, the affected Staff member may explain any extenuating circumstances to the Chief of Staff who, in his discretion, may extend the period before the temporary suspension shall begin.

(b) Remaining on no bed status in excess of thirty (30) days consecutively or forty-five (45) days total in any twelve-month period shall be grounds for immediate corrective action pursuant to Section A of this Article.

(4) Medical Records—Consulting Staff and Limited License Professionals Exercising Clinical Privileges

A Consulting Staff member or limited license professional may have automatic suspension imposed for failure to complete medical records in accordance with Staff Rules and Regulations and these Bylaws, in the following manner:

(a) A temporary suspension in the form of a withdrawal of all of a Consulting Staff member's consulting privileges and all of a limited license professional's clinical privileges (hereinafter referred to as "consulting status"), except as to those patients to which the affected practitioner is providing direct patient care services or is acting as a consultant at the time of the suspension, effective until medical records are completed, shall be imposed following the recommendation of such suspension to the Medical Executive Committee by the Medical Records Committee. Such suspension shall be imposed automatically beginning seven (7) business days after the mailing by registered mail, certified mail, or by personal service to the affected practitioner, at his or her current office address supplied by him or her to the Hospital, of a written notice from the Chief of Staff of the practitioner's delinquency in completing his or her medical records, with the Chief of Staff also sending a copy of said notice to the Medical Records Committee. During this seven (7) business day period, the affected practitioner may explain any extenuating circumstances to the Chief of Staff who, in his discretion, may extend the period before the temporary suspension shall begin.

(b) Remaining on no consulting status in excess of thirty (30) days consecutively or forty-five (45) days total in any twelve-month period shall be grounds for immediate corrective action pursuant to Section A above.

(5) Notice

The Chief of Staff shall promptly transmit notice of any suspension based on failure to complete medical records as described in Paragraphs (3) and (4) above to the Administrator, who shall promptly notify the affected practitioner in writing of the suspension and the grounds therefore and notice of his or her rights, if any, under Article XII in the form prescribed by Section A (4) above. This notice shall be delivered to the practitioner in person, if practical; if not, then by certified or registered mail. The Administrator shall likewise transmit notice of any suspension under Paragraphs (1) or (2) above.

(6) Enforcement

It shall be the duty of the Chief of Staff and the Medical Executive Committee to cooperate with the Administrator in enforcing all automatic suspensions.

Texas Medical Association Model Medical Staff Bylaws §XI.D.

Hearing Rights

When any practitioner receives notice of a recommendation of the Medical Executive Committee that if ratified by the Board will adversely affect the practitioner's appointment to or status as a member of the Staff or exercise of clinical privileges, the practitioner shall be entitled to a hearing before an ad hoc committee of the Staff.

Texas Medical Association Model Medical Staff Bylaws §XII.A.1.

Hearing Body for Small Medical Staffs

If a hearing is requested, the chief of staff shall make a recommendation to the administrator from among the following options:

(a) Hearing Committee: The chief of staff may recommend that the administrator, on behalf of the hospital, appoint a hearing committee to be composed of no fewer than three members of the medical staff selected by the chief of staff. The chief of staff shall also designate a committee chairman from among the committee members selected.

Committee members shall gain no direct financial benefit from the outcomes and (to the extent possible) shall not have acted as accuser, investigator, fact-finder, initial decision maker, or otherwise actively participated in the consideration of the matter leading up to the recommendation or action. However, knowledge of the matter involved shall not preclude a member of the medical staff from serving as a member of the hearing committee.

In the event that it is not feasible to appoint a hearing committee from the medical staff or the request of the

physician under review upon a showing of impartiality or bias, the chief of staff may select physicians or other practitioners who are not members of the medical staff and recommend them for temporary medical staff membership under these bylaws for the period of the hearing. The chief of staff may also recommend that the administrator appoint a hearing officer who meets the requirements of this article to conduct the hearing for the hearing committee. If requested by the hearing committee, the hearing officer may participate in the deliberations of such committee and be a legal advisor to it, but the hearing officer shall not be entitled to vote.

(b) Hearing Officer: The chief of staff may recommend that the administrator, on behalf of the hospital, appoint a hearing officer to conduct the hearing. The hearing officer may be an attorney at law qualified to preside over a quasi-judicial hearing, but an attorney regularly used by the hospital or medical staff for legal advice regarding its affairs and activities shall not be eligible to serve as hearing officer. The hearing officer shall gain no direct financial benefit from the outcome and must not act as a prosecuting officer or as an advocate.

(c) The chief of staff may recommend that the administrator, on behalf of the hospital, appoint an arbitrator who shall be mutually acceptable to the member under review and the medical staff and the hospital.

The hearing officer, hearing committee chairman, if no hearing officer is named, or arbitrator shall be the presiding officer. The administrator shall follow the chief of staff's recommendation unless it is inconsistent with these bylaws or with the law.

National Practitioner Data Bank Reporting

1. Adverse Action Reports

The medical center's authorized representative shall report an adverse action to the National Practitioner Data Bank only upon its adoption as a final action by the governing board and only using the description set forth in the final action as adopted by the governing board following completion of the hearing process in which the description has been included in the notice and has been subject to discussion by the parties. Where no hearing was requested or granted, the member shall be granted the opportunity to meet with the chief of staff and the medical center's authorized representative to review and discuss the proposed data bank report before it is filed. The medical center's authorized representative shall report any and all revisions of an adverse action, including but not limited to any expiration of the final action consistent with the terms of that final action.

2. Dispute Process

A member who was the subject of an adverse action report may request an informal meeting to dispute the report filed. The report dispute meeting shall not constitute a hearing and shall be limited to the issue of whether the report filed is consistent with the final action issued. The meeting shall be attended by the subject of the report, the chief of staff, and the medical center's authorized representative.

Disclosure of Interest

All nominees for election or appointment to medical staff offices, department chairships, or the medical executive committee shall, at least [20] days prior to the date of election or appointment, disclose in writing to the medical executive committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware, including contractual, employment or other relationships with the hospital, which could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the medical staff.
CMA Model Medical Staff Bylaws §14.6.

Duties

2.2-1 Chief of Staff

The chief of staff shall serve as the chief officer of the medical staff. The duties of the chief of staff shall include, but not be limited to:

(a) enforcing the medical staff bylaws and rules and regulations and policy, implementing sanctions where indicated, and promoting compliance with procedural safeguards where corrective action has been requested or initiated.
(b) calling, presiding at and being responsible for the agenda of all meetings of the medical staff.
(c) serving as chair of the medical executive committee, with vote.
(d) serving as a member of the joint conference committee.
(e) serving as an ex officio member of all other staff committees. As an ex officio member of such committees, the chief of staff will have no vote, unless his or her membership in a particular committee otherwise is required by these bylaws.
(f) interacting with the CEO and board of [trustees or directors] in all matters of mutual concern within the hospital. The chief of staff shall be a voting member of the board of [trustees or directors].
(g) appointing, in consultation with the medical executive committee, committee members for all standing

and special medical staff, liaison, or multidisciplinary committees, except where otherwise provided by these bylaws, and designating the chair of these committees except where otherwise indicated.

(h) representing the views and policies of the medical staff to the board of [trustees or directors] and to the CEO.
   (i) being a spokesperson for the medical staff in external professional and public relations.
   (j) performing such other functions as may be assigned to him or her by these bylaws, by the medical staff or by the medical executive committee.
   (k) serving on liaison committees with the board of [trustees or directors] and administration, as well as outside licensing or accreditation agencies.

2.2-2 Chief of Staff-elect

The chief of staff-elect shall assume all duties and authority of the chief of staff in the absence of the chief of staff. The chief of staff-elect shall be a member of the medical executive committee of the medical staff and of the joint conference committee, and shall perform such other duties as the chief of staff may assign or as may be delegated by these bylaws or by the medical executive committee.

2.2-3 Secretary-treasurer

The secretary-treasurer shall be a member of the executive committee. The duties shall include, but not be limited to:

(a) maintaining a roster of members.
(b) keeping accurate and complete minutes of all medical executive committee and medical staff meetings.
(c) calling meetings on the order of the chief of staff or medical executive committee.
(d) attending to all appropriate correspondence and notices on behalf of the medical staff.
(e) receiving and safeguarding all funds of the medical staff.
(f) excusing absences from meetings on behalf of the medical executive committee.
(g) performing such other duties as ordinarily pertain to the office or as may be assigned from time to time by the chief of staff or medical executive committee.

Ohio State Medical Association Model Medical Staff Bylaws §2.2.

Organized Medical Staff Representative and Alternate

The duties of the organized medical staff representative shall include, but not be limited to:

(a) representing the organized medical staff in the [Ohio State Medical Association (OSMA)] OMSS general assembly.
(b) reporting OSMA-OMSS activities to the chief of staff.
(c) such other duties as may be assigned from time to time by the chief of staff or the medical executive committee.

The duties of the organized medical staff representative alternate shall include, but not be limited to assuming all duties and authority of the organized medical staff representative in the absence of the representative.

Ohio State Medical Association Model Medical Staff Bylaws §2.2.

Hospital Board Of [Trustees Or Directors] Representative And Alternate

The duties of the medical staff's representative on the hospital board of [trustees or directors] shall include, but not be limited to:

(a) representing the medical staff on the hospital board and any board committees to which the representative is named, with vote.
(b) reporting board activities to the medical executive committee.
(c) such other duties as may be assigned from time to time by the chief of staff or the medical executive committee.

The duties of the medical staff representative and alternate shall include, but not be limited to assuming all duties and authority of the medical staff representative on the hospital board in the absence of the representative.

Ohio State Medical Association Model Medical Staff Bylaws §2.2.

Officer Removal

An officer of the Staff may be removed by two-thirds (2/3) vote of the regular Active Staff members eligible to vote for Staff officers. Removal may be based only upon failure to perform the duties of the office held as described in these Bylaws or upon failure to otherwise adhere to the requirements of these Bylaws. Illinois State Medical Society Model Medical Staff Bylaws §VII.F.

Formation, Merger, or Elimination of Departments or Services

A medical staff department or service can be formed, merged, or eliminated only after a determination by the medical executive committee of the appropriateness of the action.

(a) The medical executive committee shall determine the formation, merger, or elimination of a department or service to be appropriate based on consideration of its effects on the quality of care in the facility and/or community. A determination of the appropriateness must be based upon the preponderance of the evidence, viewing the record as a whole, presented at an open

forum before an ad hoc committee appointed by the chief of staff, by any and all interested parties, following notice and opportunity for comment.

(b) The medical staff member(s) whose privileges may be adversely affected by the medical staff's determination of the appropriateness of department or service elimination may request a hearing. Such a hearing will be governed by the hearing procedure under these bylaws, except that
  (1) The hearing shall be limited to the following issues:
    (A) whether the medical executive's determination of appropriateness is supported by the preponderance of the evidence; and
    (B) whether the medical staff followed by its requirements for notice and comment on the issue of appropriateness.
  (2) All requests for such a hearing will be consolidated. Should an affected medical staff member request a hearing under this subsection, the medical executive committee's action regarding the elimination of the department or service will be deferred, pending the outcome of the hearing.

(c) Except as specified in this section, the termination of privileges pursuant to the elimination of a department or service determined to be appropriate by the medical staff shall not be subject to the procedural rights otherwise set forth in these bylaws.

Budget Committee

Composition

The budget committee consists of [two] members of the medical staff and the medical staff treasurer [secretary-treasurer] who will serve as committee chair. Members shall serve three (3) year terms on a staggered basis, subject to re-appointment.

Duties

The budget committee:

- recommends the annual medical staff budget to the medical executive committee;
- recommends the amount of annual dues and, if appropriate, assessments to the medical executive committee;
- meets at the call of the chair but no less frequently than monthly; and
- fulfills other responsibilities as established in these bylaws or as are appropriately delegated by the medical executive committee or the medical staff.

Medical Association of Georgia §II.C.2.

Credentials Committee

(1) Composition

The Credentials Committee shall consist of one member from each department who are regular Active Staff members [or may be a committee of the whole if the Staff is nondepartmentalized].

(2) Duties

The Credentials Committee shall:

(a) Review and evaluate the qualifications of each practitioner applying for initial appointment, reappointment, or modification of and for clinical privileges, and, in connection therewith, obtain and consider the recommendations of the appropriate departments;

(b) Submit required reports and information on the qualifications of each practitioner applying for Staff membership or particular clinical privileges including recommendations with respect to appointment, membership, category, department affiliation, clinical privileges and special conditions;

(c) Investigate, review and report on matters referred by the Chief of Staff or the Medical Executive Committee regarding the qualifications, conduct, professional character or competence of any applicant or Staff member, in order to maintain and improve the quality of medical care rendered by the Staff; and

(d) Submit periodic reports to the Medical Executive Committee on its activities and the status of the pending applications.

(3) Meetings

The Credentials Committee shall meet as often as necessary, but at least once a month. The Committee shall maintain a record of its proceedings and actions and shall report to the Medical Executive Committee.

Texas Medical Association Model Medical Staff Bylaws §X.C.

Removal of MEC Authority

The Medical Staff may, at a regular or special meeting at which a quorum is achieved, remove and reassign any of the authority here delegated to the Executive Committee for a stated period of time, for a reason identified and supported by the meeting, by a vote of 2/3 of the voting members

Medical Executive Committee

(1) Composition

The Medical Executive Committee shall consist of the officers of the Staff and the department Chair. The Administrator or his or her designee shall not be members but may be invited to attend meetings.

The majority of the members of the Medical Executive Committee must be regular Active Staff members.

(2) Duties
The Duties of the Medical Executive Committee shall include, but not be limited to:
(a) Representing and acting on behalf of the Staff in the intervals between Staff meetings, subject to such limitations as may be imposed by these Bylaws;
(b) Coordinating and implementing the professional and organizational activities and policies of the Staff;
(c) Receiving and acting upon reports and recommendations from the Staff departments and committees;
(d) Recommending action to the Board on matters of a medical-administrative nature;
(e) Establishing the structure of the Staff, the mechanism to review credentials and delineate individual clinical privileges, the organization of quality assurance activities and mechanisms of the Staff, termination of Staff membership and fair hearing procedures, as well as other matters relevant to the operation of an organized Staff;
(f) Evaluating the medical care rendered to patients in the Hospital;
(g) Participating in the development of all Staff and Hospital policy, practice, and planning;
(h) Reviewing the qualifications, credentials, performance and professional competence and character of applicants and Staff members and making recommendations to the Board regarding Staff appointments and reappointments, assignments to departments, clinical privileges, and corrective action;
(i) Adopting such Staff Rules and Regulations as may be necessary for the proper conduct of the Staff consistent with these Bylaws;
(j) Taking reasonable steps to promote ethical conduct and competent clinical performance on the part of all Staff members including the initiation of and participation in corrective or review measures when warranted;
(k) Taking reasonable steps to develop continuing education activities and programs for the Staff;
(l) Designating such committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the Staff and approving or rejecting appointment to those committees by the Chief of Staff;
(m) Reporting to the Staff at each regular Staff meeting;
(n) Assisting in the obtaining and maintaining of accreditation;
(o) Appointing such special or ad hoc committees as may seem necessary or appropriate to assist the Medical Executive Committee in carrying out its functions and those of the Staff;
(p) Reviewing actions of the Board as such actions affect the Staff as a whole or individual members thereof;
(q) Reviewing actions of the Board as such actions affect the quality of patient care, including the right and duty to communicate to the Board the opinion, from a quality of care standpoint, of the Staff regarding any contract, whether proposed or in effect, between the Board or the Hospital on the one hand and one or more Staff members, other practitioners exercising clinical privileges, or any entity representing such Staff member(s) or other practitioner(s) on the other hand; and
(r) Reporting appropriate matters and making recommendations to the Board at each regular meeting.

(3) Meetings
The Medical Executive Committee shall meet as often as necessary as called by the Chief of Staff, but at least once a month, and shall maintain a record of its proceedings and actions.
Texas Medical Association Model Medical Staff Bylaws §X.B.

Duties of the Joint Conference Committee
The joint conference committee shall serve as the review body for all the health care entity's strategic planning. The committee shall review all strategic plans before the plans are sent to the board for approval in accordance with the committee's recommendations. The committee may request additional information from management before acting to approve or disapprove such plans. The committee shall serve as the conflict resolution forum for all conflicts arising between the medical staff and the hospital, which may be brought to the committee by the medical staff or medical executive committee, hospital management, or by the board. The committee shall also constitute a forum for the discussion of matters of hospital and medical staff policy, practice, and a forum for interaction between the board and the medical staff on such matters as may be referred by the executive committee or the board. To preserve the impartiality of the hearing process, however, individual peer review issues shall not be referred to the joint conference committee. The joint conference committee shall fulfill other responsibilities set forth in these bylaws.

Medical Staff Assistance Committee
(1) Composition
In order to improve the quality of care and promote the competence of the medical staff, there is hereby estab-

lished a Medical Staff Assistance Committee comprised of no less than [_____] Active Staff members appointed by the Chief of Staff, a majority of whom, including the chair, shall be physicians. Except for initial appointments, each member shall serve a term of [_____] years, and the terms shall be staggered as deemed appropriate by the Medical Executive Committee to achieve continuity. Insofar as possible, members of this committee shall not serve as active participants on the Executive Committee, any Disciplinary Committee, if any, or any other peer review or quality assurance committees while serving on this committee.

(2) Duties

The Medical Staff Assistance Committee shall have as its purpose the improvement of the quality of care and the promotion of competence among Staff members. The Committee may receive reports related to the health, well-being or impairment of medical staff members and, as it deems appropriate, may investigate such reports. The Committee's duties shall be:

(a) To recognize the responsibility of the staff for the provision of competent patient care and to provide assistance to those members who, because of a physical, emotional, or mental impairment, are in need of assistance and monitoring in order to restore of optimal functioning and competent patient care.
(b) To develop a written impaired Staff member policy that addresses appropriate intervention, denial, revocation, or limitation of clinical privileges, follow-up assessments, and the reinstatement of clinical privileges for impaired applicants or Staff members upon their re-entry; to obtain the approval of the Medical Staff for such policy; and to implement such policy;
(c) To receive any report relating to the mental or physical health, well-being, or impairment of any applicant or Staff member, as relevant to such person's ability to exercise the clinical privileges granted to, or requested by, such person;
(d) To investigate such reports to the extent necessary to protect the health, welfare, and safety of patients, other Staff members, and hospital personnel;
(e) To provide such advice, counseling, or referrals as it determines may be necessary;
(f) Upon the occurrence of any accident or incident in which a Staff member's performance cannot be discounted as a contributing factor, to request such chemical test or tests of blood, breath, urine, or other bodily substances as it may deem necessary for the purpose of determining alcoholic or other drug content of the Staff member's system, as relevant to such Staff member's ability to exercise the clinical privileges granted to, or requested by, such Staff member; and further to request such psychiatric or other medical evaluations as it shall deem necessary to determine the Staff member's ability to exercise the clinical privileges granted to, or requested by, such Staff member;
(g) Upon receipt of documentation of specific, contemporaneous physical, behavioral or performance indicators consistent with probable substance abuse, psychiatric or other medical conditions so as to create a reasonable suspicion that an applicant or a Staff member is using or is under the influence of alcohol or other drugs while rendering or participating in patient care or the exercise of clinical privileges or is suffering from some other psychiatric disorder, to request such tests or evaluations described in Paragraph (e) above as it deems necessary;
(h) To consider, in conjunction with the Credentials Committee and the Quality Assessment and Improvement Committee, the results of any such tests or evaluations or the refusal to consent to such testing or evaluation; to implement any intervention or other action in accordance with the impaired member policy as adopted by the Staff; and to request corrective action in accordance with the provisions of Article XI when appropriate; and
(i) To study matters relating to the general health and well-being of the Staff and to develop such educational programs as may be approved by the Medical Executive Committee.

The activities of the Medical Staff Assistance Committee shall be confidential. The refusal to consent to such testing or evaluation as is requested by the Medical Staff Assistance Committee shall constitute grounds for denial of an application for Staff membership or clinical privileges or for immediate suspension or revocation of all or any portion of a member's Staff membership or clinical privileges; however, any member against whom any action is taken with respect to Staff membership or clinical privileges as a result of the refusal to consent to testing or as a result of any test results shall have the right to a hearing and appellate review in accordance with Article XII.

(3) Meetings

The Medical Staff Assistance Committee shall meet as often as necessary as called by its Chair, but at least [six times per year]. The Medical Staff Assistance Committee shall maintain such records of its proceedings and actions as it deems advisable, but shall report its activities in their entirety to the Medical Executive Committee. Reports shall be as brief as possible relating to actions taken by

the Committee and protecting the confidentiality of all proceedings. Confidentiality is imperative: No identifying data shall be included in a report. Illinois State Medical Society Model Medical Staff Bylaws §X.N.

Bylaws Committee

11.11-1 Composition

The bylaws committee shall consist of at least [_____] members of the medical staff, including at least the vice chief of staff or chief of staff-elect and immediate past chief of staff.

11.11-2 Duties

The duties of the bylaws committee shall include:

(a) conducting an annual review of the medical staff bylaws, as well as the rules and regulations and forms promulgated by the medical staff, its departments and divisions;
(b) submitting recommendations to the medical executive committee for changes in these documents as necessary to reflect current medical staff practices; and
(c) receiving and evaluating for recommendation to the medical executive committee suggestions for modification of the items specified in subdivision (a).

11.11-3 Meetings

The bylaws committee shall meet as often as necessary at the call of its chair but at least [annually]. It shall maintain a record of its proceedings and shall report its activities and recommendations to the medical executive committee.
California Medical Association Model Medical Staff Bylaws §11.11.

CME Committee

11.17 Continuing Medical Education Committee

11.17-1 Composition

The continuing medical education committee shall be composed of physician members and other health professionals of the medical staff whose number shall be appropriate to the size of the hospital and amount of program activities produced annually. The composition shall be a chairperson, who shall serve for at least two years, and committee members who shall serve staggered terms in order to assure continuity. If the hospital has a Director of Medical Education, that individual should be at least an ex-officio member of the committee.

11.17-2 Duties

The continuing medical education committee shall perform the following duties:

(a) plan, implement, coordinate and promote ongoing special clinical and scientific programs for the medical staff. This includes:
    (1) identifying the educational needs of the medical staff;
    (2) formulating clear statements of objectives for each program;
    (3) assessing the effectiveness of each program;
    (4) choosing appropriate teaching methods and knowledgeable faculty for each program; and
    (5) documenting staff attendance at each program.
(b) assist in developing processes to assure optimal patient care and contribute to the continuing education of each practitioner.
(c) establish liaison with the quality assessment and improvement program of the hospital in order to be apprised of problem areas in patient care, which may be addressed by a specific continuing medical education activity.
(d) maintain close liaison with other hospital medical staff and department committees concerned with patient care.
(e) make recommendations to the medical executive committee regarding library needs of the medical staff.
(f) advise administration of the financial needs of the continuing medical education program.

11.17-3 Meetings

The continuing medical education committee shall meet as often as necessary, but at least quarterly. It shall maintain minutes of the program planning discussions and report to the medical executive committee.
California Medical Association Model Medical Staff Bylaws Section 11.17.

Electronic Participation

Notice, attendance, and actions including voting and participation may be accomplished by email or other electronic and/or telephonic means where permitted by the chair of the meeting on either an individual or group basis.

Attendance Requirements

Regular Active Staff members and all provisional Staff members shall be required to attend one-half (1/2) of the regular meetings within any fiscal year or fraction thereof, unless absences are excused. A list of acceptable excuses shall be set forth in the Rules and Regulations of the Staff, pursuant to Article XV. Failure to meet the attendance requirements shall be grounds for immediate corrective action pursuant to Article XI.
Texas Medical Association Model Medical Staff Bylaws §VIII.F.

Voting Rights
Only members of the medical staff may vote in departmental, sectional or general medical staff elections and at committee, department and medical staff meetings, unless otherwise specified in these bylaws.

Executive Session
At the call of the presiding officer, any medical staff committee, section or department, or the medical staff as whole, may meet in executive session with attendance restricted to medical staff members, a recording secretary and such advisors or other attendees as the presiding officer may specifically request to attend.

Indemnification
The hospital shall defend, or assume the costs incurred for defense and pay any settlements, judgments and damages on behalf of any member of the medical staff arising out of service on any hospital or medical staff committee or assisting in peer and professional review or quality management activities involving care provided at the hospital, so long as the member of the medical staff acted in good faith.

Confidentiality
Medical staff members and applicants and hospital representatives shall maintain the confidential nature of all medical staff records. No medical staff, department, section or committee minutes, files or records, including information contained in the credentials file of any member or applicant to this medical staff, shall be disseminated except as provided in this section. Dissemination of such information and records shall only be made where expressly required by law or pursuant to officially adopted policies of the medical staff.

Medical Staff Credentials Files
Insertion of Adverse Information
The following applies to actions relating to requests for insertion of adverse information into the medical staff member's credentials file:

(a) As stated previously, in Section _____, any person may provide information to the medical staff about the conduct, performance or competence of its members.
(b) When a request is made for insertion of adverse information into the medical staff member's credentials file, the respective department chair and chief of staff shall review such a request.
(c) After such a review a decision will be made by the respective department chair and chief of staff to:
    (1) not insert the information;
    (2) notify the member of the adverse information by a written summary and offer the opportunity to rebut this assertion before it is entered into the member's file; or
    (3) insert the information along with a notation that a request has been made to the medical executive committee for an investigation as outlined in Section _____ of these bylaws.
(d) This decision shall be reported to the medical executive committee. The medical executive committee, when so informed, may either ratify or initiate contrary actions to this decision by a majority vote.

Review of Adverse Information at the Time of Reappraisal and Reappointment
The following applies to the review of adverse information in the medical staff member's credentials file at the time of reappraisal and reappointment.

(a) Prior to recommendation on reappointment, the credentials committee, as part of its reappraisal function, shall review any adverse information in the credentials file pertaining to a member.
(b) Following this review, the credentials committee shall determine whether documentation in the file warrants further action.
(c) With respect to such adverse information, if it does not appear that an investigation and/or adverse action on reappointment is warranted, the credentials committee shall so inform the medical executive committee.
(d) However, if an investigation and/or adverse action on reappointment is warranted, the credentials committee shall so inform the medical executive committee.
(e) No later than 60 days following final action on reappointment, the medical executive committee shall, except as provided in (g):
    (1) initiate a request for corrective action, based on such adverse information and on the credentials committee's recommendation relating thereto, or
    (2) cause the substance of such adverse information to be summarized and disclosed to the member.
(f) The member shall have the right to respond thereto in writing, and the medical executive committee may elect to remove such adverse information on the basis of such response.
(g) In the event that adverse information is not utilized as the basis for a request for corrective action, or disclosed to the member as provided herein, it shall be removed from the file and discarded, unless the medical executive committee, by a majority vote, determines that such information is required for continuing evaluation of the member's:

(1) character;
(2) competence; or
(3) professional performance.

Confidentiality
The following applies to records of the medical staff and its departments and committees responsible for the evaluation and improvement of patient care:

(a) The records of the medical staff and its departments and committees responsible for the evaluation and improvement of the quality of patient care rendered in the hospital shall be maintained as confidential.
(b) Access to such records shall be limited to duly appointed officers and committees of the medical staff for the sole purpose of discharging medical staff responsibilities and subject to the requirement that confidentiality be maintained.
(c) Information which is disclosed to the governing body of the hospital or its appointed representatives—in order that the governing body may discharge its lawful obligations and responsibilities—shall be maintained by that body as confidential.
(d) Information contained in the credentials file of any member may be disclosed with the member's consent, to any medical staff or professional licensing board, or as required by law. However, any disclosure outside of the medical staff shall require the authorization of the chief of staff and the concerned department chair and notice to the member.
(e) A medical staff member shall be granted access to his/her credentials file, subject to the following provisions:
    (1) timely notice of such shall be made by the member to the chief of staff or the chief of staff's designee;
    (2) the member may review, and receive a copy of, only those documents provided by or addressed personally to the member. A summary of all other information—including peer review committee findings, letters of reference, proctoring reports, complaints, etc.— shall be provided to the member, in writing, by the designated officer of the medical staff (at the time the member reviews the credentials file)/(within a reasonable period of time, as determined by the medical staff). Such summary shall disclose the substance, but not the source, of the information summarized;
    (3) the review by the member shall take place in the medical staff office, during normal work hours, with an officer or designee of the medical staff present.
(f) In the event a notice of action or proposed action is filed against a member, access to that member's credentials file shall be governed by Section _____ .

Member's Opportunity to Request Correction/Deletion of and to Make Addition to Information in File

(a) After review of the file as provided under Section _____ the member may address to the chief of staff a written request for correction or deletion of information in the credentials file. Such request shall include a statement of the basis for the action requested.
(b) The chief of staff shall review such a request within a reasonable time and shall recommend to the medical executive committee, after such review, whether or not to make the correction or deletion requested. The medical executive committee, when so informed, shall either ratify or initiate action contrary to this recommendation, by a majority vote.
(c) The member shall be notified promptly, in writing, of the decision of the medical executive committee.
(d) In any case, a member shall have the right to add to the individual's credentials file, upon written request to the medical executive committee, a statement responding to any information contained in the file.

California Medical Association Model Medical Staff Bylaws §14.8.

Supervision of Allied Health Practitioners
All procedures performed in the hospital by [name of allied health professional] must be under the direct supervision of a licensed physician who is a member of the medical staff. *Illinois State Medical Society §V.G.3(m).*

Direct Amendment by Medical Staff
In addition to the amendment processes for medical staff bylaws, rules and regulations, and policies, the medical staff may adopt amendments to the medical staff bylaws, rules and regulations, or policies, for recommendation for adoption by the Board. To be adopted, such changes must receive a two-thirds (2/3) of the votes, with quorum present, cast by the voting members of the Medical Staff.

Adoption by Staff and Approval by Board
These bylaws shall be adopted after notice of proposed adoption has been given in writing at least thirty days prior to the meeting at which such adoption is proposed. Adoption shall require a two-thirds majority vote of the regular active staff members present and voting at any regular or special meeting of the staff at which a quorum is present, shall replace any previous bylaws, and shall become effective when approved by the board, which approval shall not be unreasonably withheld or delayed. These bylaws shall be deemed approved by the board if not disapproved within thirty-five days after being presented to the board. *Medical Association of Georgia Model Medical Staff Bylaws §XVI.A.*

Successor in Interest
These bylaws, and clinical privileges accorded under these bylaws, will be binding upon the hospital and medical staff of any successor in interest in this hospital.

Affiliation
The hospital's affiliation with other hospitals, health care systems or similar entities shall not in and of itself affect these medical staff bylaws.

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Appendix I

Conflict of Interest Guidelines for Organized Medical Staffs

October 2007

AMA Office of General Counsel
AMA Organized Medical Staff Section

Organized Medical Staff Conflict of Interest Guidelines[24]

Preamble
Conflicts of interests among the members of a hospital's[25] organized medical staff (OMS) are not completely avoidable. The presence of a conflict of interest is often indicative of the broad experience, accomplishments and diversity of institutional decision makers. It follows that the goal of any conflict of interest policy should be to identify potential conflicts of interest and manage those conflicts of interest which are actual and material. Nonetheless, the potential consequences of conflicts of interest shall be kept in mind by those charged with making decisions, and, in case of doubt, interests that may potentially lead to a conflict shall be disclosed.

A conflict of interest policy should be prepared with the objective of improving the internal decision-making processes of the OMS. The same conflict of interest policy should apply, and apply equally, to all falling under the policy.

Physician members of a hospital governing body (whether or not members of the OMS) should not be asked to adhere to a different conflict of interest policy than other members of the governing body. Only those OMS members who also serve on a hospital governing body owe a fiduciary duty to the hospital and can properly be required to adhere to the conflict of interest policy, if any, applicable to the members of its governing body. Governing body conflict of interest policies that expressly or in practice apply only to physician members of the body obscure the goal of physician participation in the governing body's deliberations. Conflict of interest disclosures of each member of a hospital governing body should be reviewed with the same level of scrutiny.

Basic Tenets for the Development of an OMS Conflict of Interest Policy
1. The OMS organizes itself for the purpose of overseeing and promoting delivery of quality health care in a hospital. Any conflict of interest shall be measured against this purpose. As a self-governing body, the OMS shall develop a conflict of interest policy applicable to members elected or appointed to various positions on behalf of the OMS. The OMS conflict of interest policy shall appropriately consider and reflect the OMS members' responsibilities in their elected or appointed positions. The OMS organizes itself in conformity with the OMS bylaws, which are contractually binding between the OMS and the hospital.

2. The objective of an OMS conflict of interest policy is to encourage unbiased, responsible OMS management and decision-making.

3. The OMS conflict of interest policy shall extend, and apply uniformly, to all similarly-situated elected or appointed members of the OMS.

4. Denial, dismissal from or restriction of OMS membership and/or privileges based on the existence of financial or personal interest that requires disclosure under the OMS's conflict of interest policy, or based on the existence of a conflict of interest, is never appropriate. Medical staff bylaws shall state that neither the existence of a conflict of interest, nor the disclosure thereof, shall affect OMS membership or privileges. Membership and privileges on the OMS shall be granted, revoked or otherwise restricted or modified based only on the professional training and experience criteria set forth in the OMS bylaws.

5. The OMS conflict of interest policy shall be adopted by the OMS. The OMS conflict of interest policy shall be adopted into the OMS bylaws and shall not be subject to unilateral amendment by either the OMS or hospital governing body.[26]

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24. Discussion of specific medical staff functions, such as peer review, is beyond the scope of this document. AMA Policy nonetheless holds paramount impartiality in the peer review process (see H-375.987; H-375.984; H-375.997; H-375.996; H-375.990).
25. While "hospital" is used throughout, these guidelines may be applied in various types of health care delivery institutions.
26. Employed physicians are entitled to all protections included in the OMS bylaws and policies. Physicians considering employment by a hospital should work with counsel to ensure that their employment contract adequately protects their interests. OMS members who are employed by a hospital shall independently observe common law loyalty and other legal duties owed their employer, without sacrifice of their professional autonomy in medical decision making; however, those duties are beyond the focus of these guidelines.

Rights and Duties of the OMS Regarding Conflicts of Interest

6. Disclosure obligations shall be limited to individuals elected or appointed to leadership positions serving the OMS (e.g., members of the medical executive committee, institutional review boards and all peer review panels), as determined by the OMS[27]. These individuals have a special responsibility for achieving the OMS's goals.

7. Candidates for election or appointment to leadership positions serving the OMS shall be afforded an opportunity, and have a duty, to disclose any actual or potential interest that a reasonable person would believe may have the potential to create a conflict in representing, advocating for or otherwise serving the OMS. Initial disclosures shall be in writing and signed at the time of candidacy. Subsequent written disclosures shall be required from each leader at the time of re-election or re-appointment, at any change in appointed or elected position or at any material change in the member's interests. Written disclosures of interests, other than those submitted at time of reappointment which show no changes from the prior written disclosure form, shall be submitted to the medical executive committee, and shall be available to any OMS member. All personal proprietary information shall be kept confidential and only used for OMS conflict of interest purposes in connection with their OMS leadership position.

OMS members in leadership positions shall verbally disclose all interests that could potentially constitute a conflict of interest in the course of each OMS meeting or other OMS event where such a disclosure may be relevant to the immediate proceeding. Disclosures of such interests shall be made to the entire OMS body or OMS committee, as appropriate, on which the elected or appointed OMS member sits. Verbal disclosures shall be recorded in the minutes of proceedings, as shall abstentions and recusals based on conflicts of interest.

8. Each disclosed interest shall be assessed by the pertinent OMS body or committee on a case-by-case basis in conformity with the OMS conflict of interest policy.

9. Conflicts of interest are financial and/or personal.

The following "material" *financial interests* should be disclosed under the OMS conflict of interest policy. Depending upon the circumstances and the role of the involved individual, they may give rise to a conflict of interest with the OMS and/or the hospital.

A material financial interest exists when the OMS leader or candidate 1) has an employment, consulting or other financial arrangement with the hospital of the OMS or another hospital or 2) holds an ownership interest of at least 5 percent in the hospital of the OMS or another hospital, excluding a physician's individual or group practice or 3) any size ownership interest in an organization providing products or services to the hospital of the OMS or another hospital (including a financial interest in an entity which is engaged in an existing or proposed business relationship with the hospital) or 4) receives more than 5 percent of his/her annual income from the conflicted financial interest or 5) holds the position of director, trustee, officer or key employee in the hospital of the OMS or another hospital, excluding a physician's individual or group practice; or an organization providing products or services to the hospital of the OMS or another hospital (including an entity which is engaged in an existing or proposed business relationship with the hospital). *All material financial interests must be disclosed by OMS leaders and candidates*.

Individually held material financial interests of a spouse, or domestic partner, if known by the leader or candidate, must be disclosed, if material when aggregated. In addition, material financial interests held by the leader or candidate and a parent or child, must also be disclosed.

Personal interests which must be disclosed arise out of the relevant personal activities of an OMS leader or candidate or his/her immediate family members (e.g., pursuit by the affected individual of a claim or litigation against the hospital)[28]. Personal interests shall be disclosed.

In the event a financial or personal conflict of interest is determined to exist, the OMS conflict of interest policy shall specify the appropriate and least disruptive remedial action available in order to preserve, to the maximum

27. While certain OMS leaders have clear disclosure obligations due to their position in service of the entire OMS, the OMS must decide to which other leaders disclosure obligations extend. For example, the OMS may determine that those elected or appointed to medical staff office, department or section chair, committee leader or membership, hospital board membership, AMA Organized Medical Staff Section representative or other OMS leadership position must also disclose.
28. Additional examples of potential personal conflicts of interest include the following: religious (e.g., a Catholic hospital's requirement that all physicians be Catholic), environmental (e.g., a hospital's expansion plans which conflict with a neighborhood preservation group of which a physician leader is a member) or political (e.g., the agenda of a physician-public office holder that may conflict with a hospital's business or other goals).

extent feasible, the ability of a involved individual to carry out the responsibilities of the leadership role to which his/her has been elected or appointed, as follows:

I. Remedial Measures for Conflicts of Interest

(1) In order of increasing severity, a conflict of interest shall result in one or more of the following. The leader's:

(a) Disclosure of the conflict of interest;

(b) Abstention from voting on the matter to which the conflict relates; and

(c) Recusal from the decision-making process and participation in, including the receipt of information related to, the matter to which the conflict relates;

(2) If information is not to be disclosed on a "going forward" basis to the recused member based on the existence of a conflict of interest, the member shall be informed of the fact he/she is not receiving information related to the matter to which the conflict relates.

II. Involuntary Recusal for Conflicts of Interest

(a) Where a involved individual has failed to voluntarily disclose a potential conflict of interest, to abstain from voting, or recuse himself/herself, from the decision-making process and/or participation, and two-thirds of the OMS committee or body of which the involved individual is a member determines that the involved individual should not participate in the matter at hand, the involved member shall thereupon be disqualified from any further participation in a specific matter, so long as the matter remains under consideration.

(b) Votes to involuntarily recuse an involved individual may be based upon information obtained through disclosure by the involved individual or credible information provided by others.

(c) Before a vote is taken on whether involuntary recusal is appropriate, the involved individual shall be notified of this possibility and permitted an opportunity to explain to the OMS committee or body why he/she should be allowed to participate in the matter at hand.

(2) Where an involuntary recused individual holds his/her position as a representative of a specific department (i.e., an "ex-officio" or a "slotted seat") and the medical staff bylaws or policies do not provide a process for replacement, the department electing or appointing that member shall be permitted to elect or appoint, in a time-expedient fashion, an alternate free of a conflict for the duration of the consideration of the matter to which the conflict relates.

10. Under no circumstances shall the existence of a conflict of interest or a recusal (whether or not voluntary) result in dismissal from or forfeiture of an elected or appointed OMS leadership position without action to this effect provided for in the medical staff bylaws by the person or group electing or appointing that member.

In developing a conflict of interest policy with the assistance of competent counsel, an OMS should adapt these guidelines to fit its needs and comply with all governing law.

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Sample OMS Leaders' Interest Disclosure Form
OMS Leadership Candidates' Disclosure of Interests and Statement of Compliance with the [INSERT ENTITY] OMS Conflict of Interest Policy

The attached [INSERT NAME OF ORGANIZED MEDICAL STAFF] (OMS) Conflict of Interest Policy requires each [INCLUDE ALL ELECTED AND APPOINTED POSITIONS SERVING THE OMS THAT THE OMS DETERMINES MUST DISCLOSE] to disclose in writing upon candidacy/election or appointment his or her material financial and personal interests, and to execute a statement confirming, to his or her knowledge, compliance with the OMS Conflict of Interest Policy.

Conflicts of interest are not completely avoidable. The presence of outside interests, even a conflict of interest, is often indicative of the broad experience, accomplishments and diversity of institutional decision-makers. It follows that the goal of an OMS conflict of interest policy is to identify potential conflicts of interest and manage those conflicts of interest which are actual and material. Nonetheless, the potential consequences of conflicts of interest shall be kept in mind by those charged with making decisions, and, in case of doubt, interests that may potentially lead to a conflict shall be disclosed.

Written disclosure of potential conflict of interest shall be made at the earliest appropriate time, and, specifically, prior to each election or appointment to a leadership position serving the OMS. OMS leaders have an obligation to verbally disclose potential and actual conflicts of interest as appropriate for the remainder of their term thereafter.

* * * * *

"Material financial interest" means:

- an employment, consulting or other financial arrangement, or
- an ownership interest of more than 5 percent, or
- an interest which contributes more than 5 percent to your annual income, or
- a position as director, trustee, managing partner, officer or key employee.

Individually held financial interests of a spouse, or domestic partner, if known by the leader or candidate, must be disclosed, if material when aggregated. In addition, material financial interests held by the leader or candidate and a parent or child, must also be disclosed.

"Personal interest" means those interests that arise out of your relevant personal activities, or the personal activities of your immediate family.

* * * * *

1. Do you/your spouse/domestic partner individually, or do you and your child/parent, have a material financial interest in (i) the [INSERT NAME OF THE HOSPITAL OF THE OMS], including its subsidiaries and affiliates (collectively, "Entity") (ii) another hospital, but excluding your individual or group practice or (iii) any organization providing products or services to or which is engaged in an existing or proposed business relationship with the Entity or another hospital?

No _____

Yes _____

If yes, please specify in detail.

_____

_____

2. Do you or an immediate family member have a personal interest related to the Entity?

No _____

Yes _____

If yes, please specify in detail.

_____

_____

_____

3. Are you involved in any other relationship, activity or interest which may raise a conflict of interest or impair your objectivity to fairly consider or implement the OMS's bylaws or policies or otherwise fulfill your elected/appointed role on behalf of the OMS?

No _____

Yes _____

If yes, please describe each relationship, activity or interest in detail.

_____

_____

_____

Statement of Compliance with the Conflict of Interest Policy

I understand that I am expected to comply with the Conflict of Interest Policy of the [INSERT NAME OF ORGANIZED MEDICAL STAFF]. To my knowledge and belief, I am in compliance with the Conflict of Interest Policy and have disclosed my material financial and any personal interests. I understand that I have a continuing responsibility to comply with the Conflict of Interest Policy, and I will promptly disclose any changes required to be disclosed under the Policy.

Signature_____

Print Name_____

Position_____

Date_____

Appendix J

AMA Board of Trustees Report on Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations

The following Board of Trustees report was referred for decision at the 2005 Annual meeting of the AMA House of Delegates.

Report of the Board of Trustees 23-A-05 Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations (Reference Committee G)

Executive Summary
At the 2004 Interim Meeting, the House of Delegates referred Board of Trustees Report 17, "Principles for Incident-Based Peer Review and Disciplining at Health Care Facilities," to revisit the recommendations. Board Report 17 responded to Resolution 835 that was adopted as amended at the 2003 Interim Meeting. Resolution 835 asked our American Medical Association (AMA) Board of Trustees to study and report back on the advisability of adopting the Massachusetts Medical Society Model Principles for Incident-Based Peer Review and Disciplining at Health Care Facilities. It also asked the AMA to send the Model Principles to all state medical societies and all medical staffs in the United States and be prominently posted on the AMA's Web site should they be adopted by our AMA.

The Model Principles consist of 27 statements, many of which are current AMA policy. Rather than considering the Model Principles as a whole, the report addresses each principle separately. In those cases where a model principle would ensure that fairness and due process are afforded to any physician whose medical care and professional conduct is being reviewed, the Board recommends that either adoption as new policy or incorporation into existing policy. In the process of comparing the Model Principles with AMA policy, the Board identified some inconsistencies and ambiguities. This report addresses those problems and also recommends consolidation of AMA policies where appropriate.

Report of the Board of Trustees 23-A-05

Subject: Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations
(Board of Trustees Report 17, I-04)

Presented by: J. James Rohack, MD, Chair

Referred to: Reference Committee G
(Virginia Latham, MD, Chair)

Introduction
At the 2004 Interim Meeting, the House of Delegates referred Board of Trustees Report 17, "Principles for Incident-Based Peer Review and Disciplining at Health Care Facilities," to revisit the recommendations. Board Report 17 responded to Resolution 835 that was adopted at the 2003 Interim Meeting. Resolution 835, introduced by the Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont Delegations, asked our American Medical Association Board of Trustees to study and report back at the 2004 Annual Meeting the advisability of adopting the Massachusetts Medical Society (MMS) Model Principles for Incident-Based Peer Review and Disciplining at Health Care Facilities (Model Principles). It also asked the AMA to send the Model Principles to all state medical societies and all medical staffs in the United States and be prominently posted on the AMA's web site should they be adopted by our AMA.

Many of the Model Principles are existing AMA policy, but some of them should be incorporated, sometimes with modifications, into AMA policy. In the process of comparing the Model Principles with AMA policy, the Board identified ambiguities and some inconsistencies in AMA policy. This report compares the Model Principles with AMA policies related to physician peer review, corrective action, and due process in hospitals and other institutions and recommends consolidation and amendments to AMA policies where it is appropriate.

Background
The demands for greater accountability in health care by governmental, business, and consumer groups, and the continued advancement in technology and patient safety, require objective and systematic evaluation of the care provided by physicians and hospital employees. Peer review is an ongoing process of clinical departments and standing committees to assess and evaluate the medical care delivered to patients and improve the quality and safety of medical care provided in hospitals and other

facilities. It should also be an educational process for physicians to assure quality medical services. Intensified peer review may be initiated in response to the circumstances of a single case or a pattern or trend in performance. The AMA has developed several policies to ensure that the principles of fairness and due process are afforded any physician whose medical care and professional conduct is being reviewed.

The MMS is concerned "that the systems to identify and improve poor quality have little teeth due to the paucity of adequate remedial resources," and "the lack of objectivity and due process may make peer review, as it is currently practiced, ineffective and may create innocent victims out of competent physicians, deprive patients of their services, and expose physician reviews to legal liability." More specifically, the MMS is concerned that current peer evaluations are often based on a single untoward event or quality review screens, (e.g., unplanned return to the operating room) rather than a pattern of care based on statistical approaches. The demarcation between quality improvement and the corrective action process is not always clear when the peer review process is triggered by an adverse or sentinel event. To ensure that peer review, as required under federal and state law, is effective in achieving the goal of quality improvement, while being fair, transparent, and credible, the MMS developed model principles to guide peer review activities for health care facilities.

Health Care Quality Improvement Act
The Health Care Quality Improvement Act (HCQIA) of 1986 was enacted to encourage physicians to participate in peer review committees by granting limited immunity from civil liability (claims from monetary damages). HCQIA is codified in Section 11101 et.seq. of Title 42 of the United States Code. HCQIA also established a national reporting system (National Practitioner Data Bank) intended to restrict the ability of incompetent physicians to move from state to state by requiring disclosure of the physicians' previous disciplinary or peer review action.

To qualify for immunity under HCQIA, the professional review action must meet certain minimal standards. It must be taken in the reasonable belief that it will further the quality of health care. The physician under review must have received appropriate notice of the proposed action and of the hearing itself. The hearing must be held before a mutually agreed upon arbitrator or before a hearing officer or hearing panel not in direct economic competition with the physician involved. In the hearing, the accused physician is entitled to representation by an attorney, to a record of the proceedings, to call, examine, and cross-examine witnesses, to present relevant evidence, regardless of its admissibility in a court of law, and to submit a written statement at the close of the hearing. Upon completion of the hearing, the physician has the right to receive the written recommendation of the arbitrator, hearing officer, or hearing panel and the right to receive a written decision of the health care entity. The recommendation and the decision are to include the basis for the conclusions reached.

Certain of the procedural protections can be relaxed in the event of a threatened health care emergency. A hearing is not required in the case of a suspension or restriction of clinical privileges for a period not longer than fourteen days, during which an investigation is conducted to determine the need for a professional review action. Clinical privileges can be immediately suspended or restricted where the failure to take such an action may result in an imminent danger to the health of an individual, provided that the physician receives a subsequent notice and the right to a hearing or other adequate procedures.

MMS Model Principles
The Model Principles consist of 27 statements, each of which is separately discussed below.

1. Model Principle 1 states that patient safety and quality of care is the goal of peer review. Principle 1 is indirectly addressed in AMA Ethical Opinion E-4.07 and Policy H-230.989[1] (Policy Database), but the Board believes it should be explicitly stated in AMA policies related to peer review.

2. Model Principle 2 states, in effect, that all relevant facts and circumstances should be considered before invoking a disciplinary procedure. While this point is not specifically included in Policy H-265.998, it is self evident and therefore unnecessary for inclusion in AMA policy.

3. Model Principle 3 states that all relevant information should be obtained promptly and then made available to the subject physician. After the information has been obtained, the issues should be discussed with the subject physician, and alternative courses of action should be considered before proceeding to the formal peer review process. Policy H-225.992 addresses the first part of Principle 3 and it should be amended to incorporate the second part of this principle.

4. Model Principle 4 states that the process must be mindful and attuned to the prevention of medical errors and recommend appropriate system changes to minimize them. The Principles of Medical Ethics II, III, and VII address a physician's ethical responsibility to participate in performance improvement. Since the Principles of Medical Ethics are general, Principle 4 should be included in the amendments to Policy H-375.984.

5. Model Principle 5 states that the "triggers that initiate a peer review within a health care facility should be valid, transparent and available to all member physicians and should be uniformly applied to all cases and physicians." AMA Ethical Opinion E-9.05 and Policies H-225.992, H-230.989, H-375.983, and H-375.997 provide that peer review must have established principles and procedures that provide a fair and objective hearing to any physician whose care or professional conduct is being reviewed. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right of a hearing, the opportunity to be present and to rebut the evidence, and the opportunity to present a defense. The composition of a hearing panel sitting in judgment of a physician should include a significant number of persons at a similar level of training. They have an ethical responsibility to be guided primarily by concern for the welfare and best interests of patients. The intent of Principle 5 is addressed by current policy so no action is needed on this model principle.

6. Model Principle 6 states that physicians' health and impairment issues should be identified and managed by a medical review committee, separate from the disciplinary process. Policies H-235.977 and H-275.940 address Principle 6 so no action is needed on this model principle.

7. Model Principle 7 states that peer review actions should, at minimum, meet HCQIA standards for federal immunity. AMA Policy H-375.983 addresses Principle 7; however, since Principle 7 is articulated more clearly, Policy H-375.983 should be amended.

8. Model Principle 8 states that summary suspension or restriction of clinical privileges may only be used to prevent imminent danger to health. Such summary actions must be followed by adequate notice and hearing procedures prior to becoming final. Principle 8 is taken from the HCQIA and should be included in AMA policy. A charge of "imminent danger to health of any individual" should be adequate for the chief of staff, medical executive committee or clinical department chair to summarily suspend clinical privileges, but the medical executive committee should meet within fourteen days to review and consider the summary suspension. The medical executive committee should be able to modify, continue or terminate the summary suspension. Upon request, the affected physician may attend and make a statement concerning the issues under investigation, but the meeting with the medical executive committee shall not constitute the physician's fair hearing.

9. Model Principle 9 states that all parties involved in the peer review process must preserve its confidentiality, but all facts obtained for and in the peer review process should be made available to the subject physician. Policies H-375.992, H-375.993, and H-375.997 address Principle 9 so no action is needed on this model principle.

10. Model Principle 10 states that direct economic competitors of the subject physician are to be barred from serving on the peer review panel. It also states that the panel should include a fair representation of specialists or sub-specialists from the subject physician's specialty or subspecialty, whenever feasible. The restriction against direct economic competitors is already addressed by Policy H-375.983[2][f], but the policy provides that physicians serving on the panel need not be in the same specialty as the physician involved. The Board believes that current policy should be amended to include a fair representation of the same specialist/sub-specialist as the physician involved, whenever feasible.

11. Model Principle 11 states that physicians should rotate service on the peer review committee. A peer review panel is usually appointed for each hearing so it is not feasible to rotate service on them. Policy H-375.983 recommends that the members of the hearing panel be physicians who have the respect of the medical community. The medical staff bylaws should include language on how physicians are elected or selected to serve on the medical executive committee and other committees. Each member of the medical staff should be appointed to a clinical department that reviews the quality and safety of patient care and establishes professional standards. No action is needed on Principle 11.

12. Model Principle 12 states that membership on the peer review committee should be open to all physicians on the medical staff and should not be restricted to those physicians who have an exclusive contract with the hospital, salaried physicians, or those on the faculty. Principle 12 is consistent with Policy H-375.990 that states that peer review of the performance of hospital medical staff physicians should be objective and supervised by physicians.

The addition of Principle 12 would strengthen and clarify Policy H-375.990.

13. Model Principle 13 states that only physicians should be voting members of formal peer review committees convened for disciplinary matters. Currently Policy H-375.983[2][f] states that a peer review panel should consist of physicians. The addition of "only" to the current policy would make it consistent with Principle 13.

14. Model Principle 14 states that whenever a peer review committee adequately representing the specialty or subspecialty of the subject physician cannot be adequately constituted with physicians from within the institution, while excluding direct economic competitors, qualified external consultants or an external peer review panel through another appropriate institution should be appointed to conduct the peer review. Ethical Opinion E-4.07 states that physicians involved in the granting, denying, or termination of hospital privileges have an ethical responsibility to be guided primarily by concern for the welfare and best interests of patients in discharging this responsibility. Although, D-375.996 provides that medical staffs include bylaw provisions that provide for an external and impartial review when there is an allegation by a reviewed physician that he or she has not received an objective, impartial peer review, the Board believes a policy should be added to provide guidance on external peer review.

15. Model Principle 15 states that physicians serving on the peer review committee should receive information and training in the elements and essentials of peer review. The Board believes that the physicians serving on a hearing panel should be instructed by the hearing officer or attorney advising the panel on the requirements of the HCQIA, state peer review statutes, and their ethical obligations (i.e., E-9.05). Principle 15 should be included in AMA policy.

16. Model Principle 16 states that the hospital or other organization on whose behalf the peer review is done must ensure that the physicians serving on any peer review committee are provided with appropriate indemnification and insurance for peer review acts taken in good faith. The organization must also provide assistance to the committee in abiding by the HCQIA requirements for federal immunity. Policies H-225.976 and H-225.977 address Principle 16, so no action is needed on this model principle.

17. The first sentence of Model Principle 17 states that the peer review committee should be guided by generally accepted clinical guidelines and established standards and practices This sentence should be included in AMA policy, but "hearing panel" should be substituted for "peer review committee". The second sentence of Principle 17 states that those guidelines, standards, and practices must be made available to the subject physician before a hearing. This sentence should not be included in AMA policy. Medical practice cannot be readily codified. It is too complicated to be set forth in the manner contemplated by the second sentence of Principle 17. However, Section 11112 of the HCQIA requires that the physician subject to peer review must be given the reasons for the proposed professional review action, a right to call, examine, and cross-examine witnesses, the opportunity to present evidence determined to be relevant by the hearing officer, and submit a written statement at the close of the hearing, among other rights.

18. Model Principle 18 states that clinical guidelines, standards and practices used for evaluation of quality of care should be transparent and available to the extent feasible. To the extent possible, clinical guidelines, standards, and practices used for evaluation of quality of care should be made available to members of the clinical department, but it is too complicated to be a general requirement, as set forth by Principle 18.

19. Model Principle 19 states that, wherever feasible, structured assessment instruments and multiple reviewers should be used to increase reliability. Principle 19 is unclear and should not be included in AMA policy.

20. Model Principle 20 states that, where feasible, statistical analysis to compare with peers' performance must be used with appropriate case mix adjustments. The Board believes that information management systems and statistical analysis with de-identified information and appropriate case mix adjustment can be useful tools that medical staff committees can utilize to assess the quality and safety of medical care provided in the institution, but it does not believe Principle 20 should be included in AMA policy. The peer review panel or hearing officer should determine whether it is appropriate to utilize case mix adjustments.

21. Model Principle 21 states that not less than 30 days notice should be given to the subject physician for any formal hearing or appeal. Since Principle 21 is consistent with the HCQIA it will be addressed to the proposed amendment to Policy H-375.983.

22. Model Principle 22 states that all pertinent information obtained by the peer review committee should be

made available to the subject physician in a timely manner before the hearing. In response to some physicians not being able to obtain copies of medical records and other information necessary to prepare for the peer review hearing, the House of Delegates adopted Policy H-230.957 at the 2004 Annual Meeting. It asks our AMA to support legislation guaranteeing that physicians engaged in staff privileges disputes have free and full access to all medical records related to those disputes so they can adequately defend themselves. In addition, Policy H-225.992 provides that physicians accused of an infraction of medical staff bylaws, rules, regulations, policies or procedures should be promptly notified that an investigation is being conducted and given an opportunity to respond. As a result, no action is needed on Principle 22.

23. Model Principle 23 states that, to the extent feasible, the reviewers should evaluate the process of care given while blinded to the outcome. Principle 23 should be added to Policy H-265.998.

24. Model Principle 24 states that any conclusion reached or action recommended or taken should be based upon the information presented to the peer review committee and make available to the subject physician. Indefensible and vague accusations, personal bias and rumor should be given no credence and should be carefully excluded from consideration. Any conclusion reached should be defensible under a 'reasonably prudent person' standard." The first sentence of Model Principle 24 is very similar to Principle 22. The essence of peer review is that physicians should assess their peers based on all available evidence, and based on their personal discretion and professional experience. As written, the second and third sentences may be inconsistent with HCQIA §11112(b)(3)(C)(iv), which allows the presentation of any relevant evidence, regardless of its admissibility in a court of law. As a result, the second and third sentences of Principle 24, as modified, should be added to Policy H-375.983.

25. Model Principle 25 states that the conclusion reached and action recommended by a health care facility should include, as an important focus, steps for remediation, as needed, for the subject physician and for the system. Model Principle 25, as phrased, gives undue weight to the remedial aspects of peer review. The Board believes that if the language is modified to indicate that the conclusion reached and action recommended "may" include steps for remediation and if the phrase "as an important focus" is eliminated, Principle 25 should be included in AMA policy.

26. Model Principle 26 states that the findings, recommendations, and actions of the peer review committee should not be vague or stated in general terms but should clearly and specifically state in writing the nature of the physician's act or omission, how it deviated from the standard of care, what the standard is and its source, and what specific step the physician could have taken or not taken to meet the standard of care. The Board supports inclusion of Principle 26 in AMA policy as modified: "The peer review panel should endeavor to state its findings, recommendations, and findings as concretely as possible." While the general proposition of Principle 26, which seeks clarity of language, is desirable, this objective must be weighed against the danger of making the peer review process too legalistic. If Model 26, as presently phrased, were to be incorporated verbatim into medical staff bylaws, physicians' attorneys would have a wide avenue for attacking the final judgments of peer review panels.

27. Model Principle 27 states that a process should be available to appeal any disciplinary finding of a health care facility, but it does not state to whom the appeal should be taken or the scope of the issues that can be reviewed. Principle 27 is consistent with Policy H-225.997[2], which vests final authority for termination of medical staff privileges in the hospital governing body. The hospital governing body is responsible for the conduct of the hospital, including oversight of patient safety, quality of care, and clinical performance. It exercises its fiduciary responsibilities, in part, through oversight, review, approval, and/or implementation of the medical staff's actions. As long as peer review is conducted fairly, it should be the responsibility of the medical staff, not subject to second-guessing by the governing body, to evaluate the professional competence, education, experience, and qualifications of the physicians within the health care facility. Since Principle 27 is addressed by Policy H-225.997[2], it is unnecessary and no action is needed.

Recommendations

The Board of Trustees recommends that the following recommendations be adopted in lieu of Board of Trustees Report 17 (I-04) and that the remainder of this report be filed:

1. That the AMA amend Policy H-375.984, "Peer Review," to add Model Principle 1 to read as follows:

   <u>Quality of care and patient safety is the goal of peer review. Peer review should also address the prevention of medical errors and appropriate system changes to minimize them.</u> The AMA affirms that it is the ethical duty of a physician to share truthfully quality care in-

formation regarding a colleague when requested by an authorized credentialing body, so long as the information that is shared is not a proceeding or a document protected by statute or regulation as confidential peer review information. (Sub. Res. 93, A-88; Reaffirmed: Sunset Report, I-98) (Modify Current HOD Policy)

2. That the AMA amend Policy H-225.992 to incorporate Model Principles 3 and 22, and change the title to "Right to Relevant Information," to read as follows:

(1) The AMA advocates "timely notice" and "opportunity to rebut" any adverse entry in the medical staff ~~physician~~ member's ~~personal~~ credential file, believes that any ~~hospital~~ health care organization file on a physician should be opened to him or her for inspection, and supports inclusion of these provisions in the hospital medical staff bylaws. (2) All relevant information pertaining to a potential peer review action should be obtained promptly from the subject physician. Relevant information includes, but is not limited to, pre-event factors, names of other health professionals involved in the care of the patient, and the contributing environmental factors of the health care facility/system. (3) A physician accused of an infraction of medical staff bylaws, rules, regulations, policies or procedures and faced with potential peer review action shall be promptly notified that an investigation is being conducted and shall be given an opportunity to respond. (4) All material information obtained by the peer review committee regarding the subject of the peer review should be made available to the physician under review in a timely manner prior to the hearing. (5) The investigating individual or body shall interview the practitioner, unless the practitioner waives his/her right to be heard, to evaluate the potential charges and explore alternative courses of action before proceeding to the formal peer review process. (Res. 121, I-83; Reaffirmed: CLRPD Rep. I-93-1; Modified by Sub. Res. 801, A-94) (Modify Current HOD Policy)

3. That the AMA amend Policy H-375.983(2), "Peer Review after Patrick v. Burget," to read as follows and change the title to "Appropriate Peer Review Procedures."

(2) ~~Our AMA urges hospitals, medical staffs, and peer reviewers to review the guidelines for peer review conduct in Health Care Quality Improvement Act of 1986 and to observe the following guidelines~~ Peer review procedures and actions should, at a minimum, meet the Health Care Quality Improvement Act of 1986 standards for federal immunity:

(a) In any situation where it appears that a disciplinary proceeding may be instigated against a physician that could result in the substantial loss or termination of the physician's medical staff membership and/or clinical privileges, the advice and guidance of legal counsel should be sought ~~by those persons who are involved in this phase of the peer review process~~. The accused physician should have legal counsel separate from the health care organization or medical staff. The health care organization/medical staff attorney should undertake the procedures needed to prepare ~~attorney's participation should continue in preparation~~ for the hearing including the written notice of charges, the marshaling of evidence and ~~the~~ facts, and the selection of witnesses. The health care organization/medical staff attorney should be instructed that his or her role ~~is not that of a prosecutor, but as an~~ includes ~~advisor in~~ assuring that the proceedings are conducted fairly, bearing in mind the objectives of protecting consumers of health care and the physician involved against false or exaggerated charges. The role of the attorney for the accused physician is solely to defend his or her client.

(b) The medical executive committee may recommend to the governing body that a hearing officer be appointed to conduct the hearing. The medical executive committee shall recommend a hearing officer to the governing body. The governing body shall be deemed to approve the selection unless it provides written notice to the medical executive committee stating the reasons for its objections within five days. If an attorney is sought to be the hearing officer, those solo attorneys or attorneys from a firm regularly used by the hospital, medical staff, or the involved medical staff member or applicant for membership for legal advice regarding their affairs and activities should not be eligible to serve as a hearing officer. The hearing officer shall gain no direct financial benefit from the outcome.

(c) The attorney advising the ~~hearing panel~~ medical staff/health care organization and the attorney representing the physician involved should be accorded reasonable latitude in cross-examination, but acrimony should not be allowed by the hearing body/panel or hearing officer.

(d) Substantial latitude should be permitted in the presentation of evidence, medical reference works and testimony, within reasonable time constraints and the discretion of the hearing body/panel or hearing officer.

(e) A court reporter should be present to make a verbatim transcript of the hearing which should be available to the parties and the costs borne by the ~~hospital or~~ health care ~~entity~~ organization.

(f) Within the discretion of the hearing body/panel or hearing officer, witnesses may be requested to testify under oath.
(g) The hearing body/panel should only consist of physicians, none of whom are direct economic competitors with the physician involved or who stand to gain through a recommendation or decision adverse to the physician. It is desirable that members of the hearing body/panel be physicians who have the respect of the medical community, and should include a fair representation of the same specialists/sub-specialist physicians as the physician involved, whenever feasible.
(h) Physicians who are direct economic competitors of the physician involved may testify as witnesses, whether they are called by the physician or the hearing panel or the ~~hospital~~ health care organization, but a physician should not be deprived of his or her privileges solely on the basis of medical testimony by economic competitors. In any proceZedings that result in the termination of privileges, there should be testimony from one or more physicians who are not economic competitors or who do not stand to gain economically by an adverse action, but who are knowledgeable in the treatment, patient care management and areas of medical practice or judgment upon which the adverse action is based.
(i) The hearing body/panel should lend credence to evidence brought before it in a manner reflective of the specificity of the evidence, and personal or economic biases of witnesses. Hearing bodies/panels should apply the "reasonable prudent person" standard.
(j) When investigation indicates that a disciplinary proceeding is warranted for the purpose of reducing, restricting, or terminating a physician's hospital privileges, he or she should not be permitted to resign without a finding that his or her termination occurred without cause. The disciplinary proceedings should be conducted by the hearing body/panel or hearing officer with the presentation of testimony and evidence, irrespective of whether the physician involved chooses not to be present. (BoT Rep. MMM, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: BoT Rep. 8, I-01) (Modify Current HOD Policy)

4. That the AMA amend Policy H-265.998, "Guidelines for Due Process," to incorporate Model Principles 25 and 26 to read as follows:

While it is not possible to develop universal guidelines for due process, voluntary utilization of the following general guidelines for due process, adapted in each instance to suit the circumstances and conditions of the institution or health care organization and within the requirements of the applicable laws of the jurisdiction, should assist in providing the type of hearing which the law in each jurisdiction requires:

(1) The physician should be provided with a statement, or a specific listing, of the charges made against him or her.
(2) The physician is entitled to adequate notice of the right to a hearing and a reasonable opportunity to prepare for the hearing.
(3) It is the duty and responsibility of the hearing body/panel or hearing officer to conduct a fair, objective and independent hearing pursuant to established rules.
(4) The rules of procedure should clearly define the extent to which attorneys may participate in the hearing.
(5) The physician against whom the charges are made should have the opportunity to be present at the hearing and hear all of the evidence against him or her.
(6) The physician is entitled to the opportunity to present a defense to the charges against him or her.
(7) To the extent feasible, the hearing body/panel or hearing officer should evaluate the process of care given while blinded to the outcome.
(8) The hearing body/panel or hearing officer should render a decision based on the evidence produced at the hearing.
(9) The conclusions reached and actions recommended by the hearing body/panel or hearing officer should include, as appropriate, remedial steps for the physician and for the health care facility itself.
(10) The hearing body/panel or hearing officer should endeavor to state its findings, recommendations, and actions as concretely as possible. When feasible, the hearing body/panel or hearing officer should include terms that permit measurement and validation of the completed remediation process.
(11) Within 10 days of the receipt of the hearing body/panel or hearing officer decision, the physician or medical executive committee has the right to request an appellate review. The written request for an appellate review shall include an identification of the grounds for appeal and a clear and concise statement of the facts in support of the appeal. The grounds for an appeal of the decision shall be: (a) substantial non-compliance with the procedures required in the medical staff bylaws, applicable law, or application of law which has created demonstrable prejudice; (b) insufficient evidence

in the hearing record to support the decision. If an appellate review is to be conducted, the appeal board shall schedule the appellate review and provide notice to the physician and medical executive committee. The governing body may sit as the appeal board or it may appoint an appeal board composed of not less than three members of the governing body. The appeal board shall consider the record of the hearing before the hearing body/panel or hearing officer, but may accept additional oral or written evidence, subject to a foundation that information could not have been made available during the hearing. The appeal board shall present its recommendation to the governing body as to whether the governing body should affirm, modify or reverse the hearing body/panel or hearing officer decision. If the appeal board determines that a fair procedure has not been afforded, the matter can be remanded to the hearing body/panel or hearing officer for further review and recommendation.

(12) In any hearing, the interest of patients and the public must be protected. (BoT Rep. II, A-80; Reaffirmed: Sunset Report, I-98) (Modify Current HOD Policy)

5. That the AMA amend Policy H-375.990, "Peer Review of the Performance of Hospital Medical Staff Physicians," to incorporate Model Principle 12 to read as follows:

Our AMA encourages peer review of the performance of hospital medical staff physicians, which is objective and supervised by physicians. Membership on peer review committees and hearing bodies/panels should be open to all physicians on the medical staff and should not be restricted to those physicians who have an exclusive contract with the hospital, salaried physicians, or those on the faculty.

6. That the AMA adopt the following new policy, based on Model Principle 8:

Summary suspension of clinical privileges is an extraordinary remedy which should be used only when the physician's continued practice presents an "imminent danger to the health of any individual." The decision to summarily suspend a member's medical staff membership or clinical privileges should be made by the chief of staff, chair or vice-chair of the member's clinical department, or medical executive committee. The medical executive committee (MEC) must meet as soon as possible, but in no event more than 14 days after the summary suspension is imposed, to review and consider the summary suspension. The MEC should be able to modify, continue or terminate the summary suspension. The suspended physician must be invited to attend and make a statement concerning the issues under investigation, but the meeting with the MEC shall not constitute the physician's fair hearing. (New HOD Policy)

7. That the AMA adopt the following new policy, based on Model Principle 14:

At the request of a medical staff department or of a member under review, or at its own initiative to promote adequate and unbiased review, the medical executive committee shall arrange for an external peer review through the state or local medical society, the relevant specialty society or other source appropriate to obtain professional and impartial clinical assessment. (New HOD Policy)

8. That the AMA adopt the following new policy, based on Model Principle 15:

Physicians serving on the hearing body/panel should receive information and training in the elements and essentials of peer review. (New HOD Policy)

9. That the AMA adopt the following new policy, based on the first sentence of Model Principle 17:

The hearing body/panel of a health care organization should be guided by generally accepted clinical guidelines and established standards in making its determination. (New HOD Policy)

10. That the AMA rescind Policy H-225.976 because it is a duplication of Policy H-225.977. (Rescind HOD Policy)

11. That our AMA make available in the next revision of its *Physicians' Guide to Medical Staff Organization Bylaws*, as a separate and distinct appendix, the new and amended policies relating to peer review. (Directive to Take Action)

After the recommendations of this Board Report are finalized, a separate document entitled, "Principles for Incident-Based Peer Review," should be developed and made available to all state medical societies and all hospital medical staffs in the United States. (Directive to Take Action)

Fiscal Note: No Significant Fiscal Impact

Peer Review/Corrective Action/Due Process

(American Medical Association Policy, Ethical Opinions, and Directives—AMA Policy Database)

E-4.07 Staff Privileges
The mutual objective of both the governing board and the medical staff is to improve the quality and efficiency of patient care in the hospital. Decisions regarding hospital privileges should be based upon the training, experience, and demonstrated competence of candidates, taking into consideration the availability of facilities and the overall medical needs of the community, the hospital, and especially patients. Privileges should not be based on numbers of patients admitted to the facility or the economic or insurance status of the patient. Personal friendships, antagonisms, jurisdictional disputes, or fear of competition should not play a role in making these decisions. Physicians who are involved in the granting, denying, or termination of hospital privileges have an ethical responsibility to be guided primarily by concern for the welfare and best interests of patients in discharging this responsibility. (IV, VI, VII) Issued July 1983; Updated June 1994.

E-9.031 Reporting Impaired, Incompetent, or Unethical Colleagues
Physicians have an ethical obligation to report impaired, incompetent, and unethical colleagues in accordance with the legal requirements in each state and assisted by the following guidelines:

Impairment. Impairment should be reported to the hospital's in-house impairment program, if available. Otherwise, either the chief of an appropriate clinical service or the chief of the hospital staff should be alerted. Reports may also be made directly to an external impaired physician program. Practicing physicians who do not have hospital privileges should be reported directly to an impaired physician program. If none of these steps would facilitate the entrance of the impaired physician into an impairment program, then the impaired physician should be reported directly to the state licensing board.

Incompetence. Initial reports of incompetence should be made to the appropriate clinical authority who would be empowered to assess the potential impact on patient welfare and to facilitate remedial action. The hospital peer review body should be notified where appropriate. Incompetence which poses an immediate threat to the health of patients should be reported directly to the state licensing board. Incompetence by physicians without a hospital affiliation should be reported to the local or state medical society and/or the state licensing or disciplinary board.

Unethical conduct. With the exception of incompetence or impairment, unethical behavior should be reported in accordance with the following guidelines:

Unethical conduct that threatens patient care or welfare should be reported to the appropriate authority for a particular clinical service.

Unethical behavior which violates state licensing provisions should be reported to the state licensing board. Unethical conduct which violates criminal statutes must be reported to the appropriate law enforcement authorities. All other unethical conduct should be reported to the local or state medical society.

Where the inappropriate behavior of a physician continues despite the initial report(s), the reporting physician should report to a higher or additional authority. The person or body receiving the initial report should notify the reporting physician when appropriate action has been taken. Physicians who receive reports of inappropriate behavior have an ethical duty to critically and objectively evaluate the reported information and to assure that identified deficiencies are either remedied or further reported to a higher or additional authority. Anonymous reports should receive appropriate review and confidential investigation. Physicians who are under scrutiny or charge should be protected by the rules of confidentiality until such charges are proven or until the physician is exonerated. Issued March 1992 based on the report "Reporting Impaired, Incompetent, or Unethical Colleagues," Issued January 1992; Updated June 1994. (II)

E-9.05 Due Process
The basic principles of a fair and objective hearing should always be accorded to the physician or medical student whose professional conduct is being reviewed. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right of a hearing, the opportunity to be present and to rebut the evidence, and the opportunity to present a defense. These principles apply when the hearing body is a medical society tribunal, medical staff committee, or other similar body composed of peers. The composition of committees sitting in judgment of medical students, residents, or fellows should include a significant number of persons at a similar level of training.

These principles of fair play apply in all disciplinary hearings and in any other type of hearing in which the reputa-

tion, professional status, or livelihood of the physician or medical student may be negatively impacted.

All physicians and medical students are urged to observe diligently these fundamental safeguards of due process whenever they are called upon to serve on a committee which will pass judgment on a peer. All medical societies and institutions are urged to review their constitutions and bylaws and/or policies to make sure that these instruments provide for such procedural safeguards. (II, III, VII) Issued prior to April 1977; Updated June 1994.

E-9.10 Peer Review
Medical society ethics committees, hospital credentials and utilization committees, and other forms of peer review have been long established by organized medicine to scrutinize physicians' professional conduct. At least to some extent, each of these types of peer review can be said to impinge upon the absolute professional freedom of physicians. They are, nonetheless, recognized and accepted. They are necessary and committees performing such work act ethically as long as principles of due process (Opinion E-9.05) are observed. They balance the physician's right to exercise medical judgment freely with the obligation to do so wisely and temperately. Issued prior to April 1977; Updated June 1994. (II, III, VII)

H-225.976 Risks for Hospital Medical Staff Physicians
The AMA reaffirms Resolution 183 (I-89), which states that the AMA (a) adopt as policy that every physician who serves as medical staff president, head of a medical staff department, a member of a medical staff peer review or quality review committee or acts in any hospital and/or medical staff administrative capacity, absent malice, should be fully indemnified and held harmless by the hospital; and (b) notify the American Hospital Association of this policy. (Sub. Res. 12, I-90; Amended by CLRPD Rep. 1, I-95)

H-225.977 Liability Coverage for Physician Members of Hospital Committees
Our AMA believes that every physician who serves as medical staff president, head of a medical staff department, a member of a medical staff peer review or quality review committee or acts in any hospital and/or medical staff administrative capacity, absent malice, should be fully indemnified and held harmless by the hospital. (Res. 183, I-89; Reaffirmed: Sunset Report, A-00)

H-225.992 Right to a Hearing
(1) The AMA advocates "timely notice" and "opportunity to rebut" any adverse entry in the medical staff physician's personal file, believes that any hospital file on a physician should be opened to him for inspection, and supports inclusion of these provisions in the hospital medical staff bylaws.
(2) A physician accused of an infraction of medical staff bylaws, rules, regulations, policies or procedures shall be promptly notified that an investigation is being conducted and shall be given an opportunity to respond. The investigating individual or body shall interview the practitioner unless the practitioner waives his/her right to be heard. (Res. 121, I-83; Reaffirmed: CLRPD Rep. I-93-1; Modified by Sub. Res. 801, A-94)

H-230.984 Peer Review of the Performance of Hospital Medical Staff Physicians
The AMA (1) encourages state and local medical associations to establish procedures and committees for monitoring, upon the request of the medical staff, the effectiveness of hospital medical staff peer review; and (2) supports working with the AHA and other appropriate organizations to devise methods to encourage the development of such programs. (CMS Rep. E, I-86; Reaffirmed: Sunset Report, I-96)

H-230.989 Patient Protection and Clinical Privileges
Concerning the granting of staff and clinical privileges in hospitals and other health care facilities, the AMA believes:
(1) the best interests of patients should be the predominant consideration;
(2) the accordance and delineation of privileges should be determined on an individual basis, commensurate with an applicant's education, training, experience, and demonstrated current competence. In implementing these criteria, each facility should formulate and apply reasonable, nondiscriminatory standards for the evaluation of an applicant's credentials, free of anti-competitive intent or purpose;
(3) differences among health care practitioners in their clinical privileges are acceptable to the extent that each has a scientific basis. …

H-235.968 Physician Review of Medical Staff Activities
The AMA recommends that hospital medical staffs have a policy that would allow minutes of medical staff committees, except minutes concerning peer review or corrective action information, be made available for review by medical staff members in the medical staff office; and recommends that the medical executive committee approve all reports, policies and recommendations from medical staff clinical departments and committees and have a process to distribute significant changes to the members of the medical staff. (BoT Rep. 10, A-96)

H-235.977 Medical Staff Committees to Assist Impaired or Distressed Physicians
Our AMA recognizes the importance of early recognition of impaired or distressed physicians, and encourages hospital medical staffs to have provisions in their bylaws for a mechanism to address the physical and mental health of their medical staff and housestaff members. (Sub. Res. 67, A-89; Reaffirmed: BoT Rep. 17 and Sunset Report, A-00)

H-235.987 Right of Committees of Medical Staffs to Meet in Executive Sessions
The AMA (1) supports the right of any hospital medical staff committee to meet in executive session, with only voting members of the medical staff present, in order to permit open and free discussion of issues such as peer review and to maintain confidentiality; and (2) encourages individual medical staffs to incorporate provisions in their bylaws to affirm this right. (Res. 182, A-84; Reaffirmed by CLRPD Rep. 3 - I-94)

H-265.998 Guidelines for Due Process
While it is not possible to develop universal guidelines for due process, voluntary utilization of the following general guidelines for due process, adapted in each instance to suit the circumstances and conditions of the institution or organization and within the requirements of the applicable laws of the jurisdiction, should assist in providing the type of hearing which the law in each jurisdiction requires:
(1) The physician should be provided with a statement, or a specific listing, of the charges made against him.
(2) The physician is entitled to adequate notice of the right to a hearing and a reasonable opportunity to prepare for the hearing.
(3) It is the duty and responsibility of the hearing body to conduct a fair, objective and independent hearing pursuant to established rules.
(4) The rules of procedure should clearly define the extent to which attorneys may participate in the hearing.
(5) The physician against whom the charges are made should have the opportunity to be present at the hearing and hear all of the evidence against him.
(6) The physician is entitled to the opportunity to present a defense to the charges against him.
(7) The hearing body should render a decision based on the evidence produced at the hearing.
(8) In any hearing, the interest of patients and the public must be protected. (BoT Rep. II, A-80; Reaffirmed: Sunset Report, I-98)

H-275.940 Physician Impairment
The AMA adopts the policy that, except in the case of summary suspension necessary to protect patients from imminent harm, no adverse action be taken against the privileges of a physician by a hospital, managed care organization or insurer based on a claim of physician impairment without a suitable due process hearing in accordance with medical staff bylaws to determine the facts related to the allegations of impairment and, where appropriate, a careful clinical evaluation of the physician. (Res. 701, I-97)

H-275.965 Health Care Quality Improvement Act of 1986 Amendments
The AMA supports modification of the federal Health Care Quality Improvement Act in order to provide immunity from federal antitrust liability to those medical staffs credentialing and conducting good faith peer review for allied health professionals to the same extent that immunity applies to credentialing of physicians and dentists. (Res. 203 (A-88)

H-285.998 Managed Care
… (5) Utilization Review The medical protocols and review criteria used in any utilization review or utilization management program must be developed by physicians. Public and private payors should be required to disclose to physicians on request the screening and review criteria, weighting elements, and computer algorithms utilized in the review process, and how they were developed. …

H-300.973 Promoting Quality Assurance, Peer Review, and Continuing Medical Education
The AMA
(1) reaffirms that it is the professional responsibility of every physician to participate in voluntary quality assurance, peer review, and continuing medical education activities; (2) to encourage hospitals and other organizations in which quality assurance, peer review, and continuing medical education activities are conducted to provide recognition to physicians who participate voluntarily; (3) to increase its efforts to make physicians aware that participation in the voluntary quality assurance and peer review functions of their hospital medical staffs and other organizations provides credit toward the AMA's Physicians' Recognition Award; and (4) to continue to study additional incentives for physicians to participate in voluntary quality assurance, peer review, and continuing medical education activities. (BoT Rep. SS, I-91)

H-315.983 Patient Privacy and Confidentiality
… (4) Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review. … (BoT Rep. 9, A-98; Reaffirmation I-98; Appended: Res. 4, and Reaffirmed: BoT Rep. 36, A-99; Appended: BoT Rep. 16 and Reaffirmed: CSA Rep. 13, I-99; Reaffirmation A-00; Reaffirmed: Res. 246 and 504 and Appended Res. 504 and 509, A-01; Reaffirmed: BoT Rep. 19, I-01)

H-320.968 Approaches to Increase Payor Accountability
… (2) Conduct of Review. Our AMA supports the development of additional draft state and federal legislation to: (a) require private review entities and payors to disclose to physicians on request the screening criteria, weighting elements and computer algorithms utilized in the review process, and how they were developed; …

H-375.966 Peer Review Protection Under Federal Law
Our AMA supports: (1) federal legislation that will enhance protection of peer review information even if such information is shared with governmental agencies in an effort to better and more comprehensively analyze the patient safety measures and quality of healthcare measures being utilized in clinical settings; and (2) federal legislation to afford peer-review protection to information sharing and reporting in the context of patient safety and quality improvement. (Res. 239, A-01; Appended: BoT Rep. 14, I-02)

H-375.967 Supervision and Proctoring by Facility Medical Staff
Our AMA advocates that the conduct of medical staff supervision be included in medical staff bylaws and be guided by the following principles:
(1) Physicians serving as medical staff supervisors should be indemnified at the facility's expense from malpractice claims and other litigation arising out of the supervision function.
(2) Physicians being supervised should be indemnified at the facility's expense for any damages that might occur as a result of implementing interventions recommended by medical staff supervisors.
(3) AMA principles of peer review as found in Policies H-320.968 [2,d], H-285.998 [5], and H-320.982 [2c,d] should be adhered to in the conduct of medical staff supervision.
(4) The medical staff member serving as supervisor should be determined through a formal process by the department chair or medical staff executive committee.
(5) The scope of the medical staff supervision should be limited to the provision of services that have been restricted, are clearly questionable, or are under question, as determined by the department chair or medical staff executive committee.
(6) The duration of the medical staff supervision should be limited to the amount of time necessary to adequately assess the degree of clinical competence in the area of skill being assessed.
(7) Medical staff supervision should include a sufficient volume of procedures or admissions for meaningful assessment.
(8) Medical staff supervisors should provide periodic performance reports on each patient to the appropriate designated medical staff committee. The reports should be transcribed or transcripted by the medical staff office to assure confidentiality. The confidentiality of medical staff supervision reports must be strictly maintained.
(9) Physicians whose performance is supervised should have access to the performance reports submitted by medical staff supervisors and should be given the opportunity to comment on the contents of the reports. (CMS Rep. 3, A-99)

H-375.968 Supervision and Proctoring by Facility Medical Staff
Our AMA policy states that medical staff supervision refers to the imposition, usually involuntary and usually subsequent to an adverse event, of significant consultation, oversight, or close monitoring of a physician who has privileges and whose clinical competence, cognitive skills, procedural skills, or outcomes have been questioned. Supervision usually is limited to particular competencies under question and may apply to any site of service (CMS Rep. 3, A-99)

H-375.969 Physician Access to Performance Profile Data
AMA policy is that every physician should be given a copy of his/her practice performance profile information at least annually by each organization retaining such physician information. (Res. 827, A-98)

H-375.972 Lack of Federal Peer Review Confidentiality Protection
Our AMA will seek to vigorously pursue enactment of federal legislation to prohibit discovery of records, information, and documents obtained during the course of professional review proceedings. (Res. 221, I-96; Reaffirmed: BoT Rep. 13, I-00; Reaffirmation A-01; Reaffirmed: BoT Rep. 8, I-01; Reaffirmed: CMS Rep. 6, I-02)

H-375.977 Peer Review—Caused Litigation
The AMA urges medical staffs to review their hospital's policies for directors and officers liability and general liability coverage to determine if the policy provides defense, indemnity, or loss of income coverage for those members of

the medical staff who are involved in a lawsuit as a result of the activities they have performed in good faith, conducting official peer review responsibilities or other official administrative duties of the medical staff. (Res. 707, I-92)

H-375.979 Litigation Over Hospital Peer Review Decisions

Our AMA believes that it is important to minimize expensive and time-consuming litigation over hospital peer review decisions if hospital peer review is to be a successful and effective mechanism for assuring the quality and appropriateness of hospital services. The AMA, therefore, recommends that state medical societies pursue one of the following alternatives to help minimize litigation over peer review decisions: (1) seek state legislation to create a forum that would qualify hospital peer review in the state for the state action exemption; (2) create a privately organized forum that would not qualify for the state exemption but would minimize the possibility of litigation by allowing for an objective evaluation of the decision outside of the hospital; and (3) pursue legislation that would create procedural protections designed to ensure fairness in the hospital peer review process that are the equivalent of or more substantial than those set forth in the Health Care Quality Improvement Act of 1986, or encourage hospital medical staffs to adopt bylaws with the requisite protections. (BoT Rep. DD, A-91; Reaffirmation A-00)

H-375.982 Peer Review Defined as the Practice of Medicine

Our AMA defines the act of peer review as the practice of medicine and encourages state medical associations to consider similar action. (Res. 104, A-89; Reaffirmed: Sunset Report, A-00)

H-375.983 Peer Review after Patrick v. Burget

(1) Our AMA urges state medical associations to investigate applicable state law to determine if additional state agency supervision of peer review is needed to meet the active state supervision requirement set forth by the Supreme Court.
(2) Our AMA urges hospitals, medical staffs, and peer reviewers to review the guidelines for peer review conduct in Health Care Quality Improvement Act of 1986 and to observe the following guidelines:

(a) In any situation where it appears that a disciplinary proceeding may be instigated against a physician that could result in the substantial loss or termination of the physician's clinical privileges, the advice and guidance of legal counsel should be sought by those persons who are involved in this phase of the peer review process. The attorney's participation should continue in preparation for the hearing including the written notice of charges, the marshaling of evidence and the facts, and the selection of witnesses. The attorney should be instructed that his role is not that of a prosecutor, but as an advisor in assuring that the proceedings are conducted fairly, bearing in mind the objectives of protecting consumers of health care and the physician involved against false or exaggerated charges.
(b) The attorney advising the hearing panel and the attorney representing the physician involved should be accorded reasonable latitude in cross-examination, but acrimony should not be allowed by the hearing panel.
(c) Substantial latitude should be permitted in the presentation of evidence, medical reference works and testimony, within reasonable time constraints and the discretion of the hearing panel.
(d) A court reporter should be present to make a verbatim transcript of the hearing which should be available to the parties and the costs borne by the hospital or health care entity.
(e) Within the discretion of the hearing panel, witnesses may be requested to testify under oath.
(f) The hearing panel should consist of physicians, none of whom are direct economic competitors with the physician involved or who stand to gain through a recommendation or decision adverse to the physician. It is desirable that members of the hearing panel be physicians who have the respect of the medical community, but they need not be in the same specialty as the physician involved.
(g) Physicians who are direct economic competitors of the physician involved may testify as witnesses, whether they are called by the physician or the hearing panel or the hospital, but a physician should not be deprived of his privileges solely on the basis of medical testimony by economic competitors. In any proceedings that result in the termination of privileges, there should be testimony from one or more physicians who are not economic competitors or who do not stand to gain economically by an adverse action, but who are knowledgeable in the treatment, patient care management and areas of medical practice or judgment upon which the adverse action is based.
(h) When investigation indicates that a disciplinary proceeding is warranted for the purpose of terminating a physician's hospital privileges, he should not be permitted to resign without a finding that his termination occurred without cause. The disciplinary proceedings should be conducted by the hearing panel with the presentation of testimony and evidence, irrespective of whether the physician involved chooses not to be

present. (BoT Rep. MMM, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: BoT Rep. 8, I-01)

H-375.984 Peer Review
The AMA affirms that it is the ethical duty of a physician to share truthfully quality care information regarding a colleague when requested by an authorized credentialing body, so long as the information that is shared is not a proceeding or a document protected by statute or regulation as confidential peer review information. (Sub. Res. 93, A-88; Reaffirmed: Sunset Report, I-98)

H-375.987 Bias in Peer Review Proceedings
Our AMA reaffirms its encouragement of state and local medical associations to establish procedures and committees to monitor, upon the request of the medical staff, the effectiveness of hospital medical staff review. (CMS Rep. E, I-86; Reaffirmed: I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: BoT Rep. 8, I-01)

H-375.989 Protection of Peer Review Records in Litigation.
Our AMA believes that for peer review to be effective, peer review data must be kept confidential. (Sub. Res. 68, I-85; Reaffirmed CLRPD Rep. 2, I-95; Reaffirmed: BoT Rep. 8, I-01)

H-375.990 Peer Review of the Performance of Hospital Medical Staff Physicians
Our AMA encourages peer review of the performance of hospital medical staff physicians, which is objective and supervised by physicians. (Res. 57, I-85; Reaffirmed CLRPD Rep. 2, I-95; Reaffirmed: BoT Rep. 8, I-01)

H-375.992 Confidentiality of Staff Activity
Our AMA (1) supports efforts to ensure the preservation of quality care activities as a primary function of the medical staff, through affirmation of the need for confidentiality codes relevant to medical staff peer review activities; and (2) encourages state medical societies to seek the strengthening of existing laws and the promulgation of laws in those states where confidentiality codes do not exist. (Sub. Res. 116, I-83; Reaffirmed: CLRPD Rep. I-93-1; Reaffirmed: BoT Rep. 8, I-01)

H-375.993 Confidentiality in Medical Staff Peer Review
Our AMA encourages medical staff peer review committees to consider excluding non-physicians when evaluating the professional practices of fully licensed physicians. (Sub. Res. 147, A-83; Reaffirmed: CLRPD Rep. I-93-1; Reaffirmed: BoT Rep. 8, I-01)

H-375.997 Voluntary Medical Peer Review
The AMA advocates the following principles for voluntary medical peer review:
(1) Medical peer review is an organized effort to evaluate and analyze medical care services delivered to patients and to assure the quality and appropriateness of these services. Peer review should exist to maintain and improve the quality of medical care.
(2) Medical peer review should be a local process.
(3) Physicians should be ultimately responsible for all peer review of medical care.
(4) Physicians involved in peer review should be representatives of the medical community; participation should be structured to maximize the involvement of the medical community. Any peer review process should provide for consideration of the views of individual physicians or groups of physicians or institutions under review.
(5) Peer review evaluations should be based on appropriateness, medical necessity and efficiency of services to assure quality medical care.
(6) Any system of medical peer review should have established procedures.
(7) Peer review of medical practice and the patterns of medical practice of individual physicians, groups of physicians, and physicians within institutions should be an ongoing process of assessment and evaluation.
(8) Peer review should be an educational process for physicians to assure quality medical services.
(9) Any peer review process should protect the confidentiality of medical information obtained and used in conducting peer review. (CMS Rep. A, I-81; Reaffirmed: CLRPD Rep. F, I-91)

H-450.965 Medical Staff Leadership in Continuous Quality Improvement
The AMA will work with the AHA to assure that hospitals, in their continuous quality improvement/total quality management (CQI/TQM) programs, include practicing physicians in the development and implementation of such programs, especially the development of criteria sets and clinical indicators; provide feedback on CQI/TQM findings to physicians on a confidential basis; and inform all members of the medical staff on the CQI/TQM programs developed. (Sub. Res. 701, A-94)

H-450.997 Quality Assurance and Peer Review for Hospital Sponsored Programs
The AMA urges hospital medical staffs to make certain that all hospital sponsored, initiated, or affiliated medical services have appropriate peer review and quality assurance programs. (Sub. Res. 92, I-84; Reaffirmed by CLRPD Rep. 3 - I-94)

D-375.996 Peer Review Immunity
Our AMA: (1) recommends that medical staffs adopt bylaws that provide for a peer review process that is consistent with HCQIA criteria and AMA policy;
(2) recommends medical staffs include bylaw provisions that provide an option or alternative for external and impartial review when there is an allegation by a reviewed physician;
(3) recommends that if physicians believe that negligent or misdirected peer review is a problem, legislative action be considered at the state level to assure a fair due process proceeding for physicians subject to review;
(4) shall request that the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) require medical staff bylaws to include due process protections for peer review, including the option for external and impartial review; and
(5) shall continue to monitor the legal and regulatory challenges to peer review immunity and non-discoverability of peer review records and proceedings, as well as consider legislative remedies, including the feasibility and impact of amending HCQIA to provide the option for external peer review for hospital medical staff physicians.
(BoT Rep. 25, A-02)

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Appendix K

AMA Principles for Strengthening the Physician-Hospital Relationship

In November 2007, the AMA Organized Medical Staff Section (OMSS) developed, adopted and recommended to the House of Delegates twelve detailed principles on strengthening the physician-hospital relationship that were adopted as AMA policy. The principles are aimed at protecting medical staff self-governance and improving health care quality and patient safety.

1. The organized medical staff and the hospital governing body are responsible for the provision of quality care, providing a safe environment for patients, staff and visitors, and working continuously to improve patient care and outcomes, with the primary responsibility for the quality of care rendered and for patient safety vested with the organized medical staff. These activities depend on mutual accountability, interdependence, and responsibility of the organized medical staff and the hospital governing body for the proper performance of their respective obligations.

2. The organized medical staff, a self-governing organization of professionals, possessing special expertise, knowledge and training, discharges certain inherent professional responsibilities by virtue of its authority to regulate the professional practice and standards of its members, and assumes primary responsibility for many functions, including but not limited to: the determination of organized medical staff membership; performance of credentialing, privileging and other peer review; and timely oversight of clinical quality and patient safety.

3. The leaders of the organized medical staff, with input from the hospital governing body and senior hospital mangers, develop goals to address the healthcare needs of the community and are involved in hospital strategic planning as described in the medical staff bylaws.

4. Ongoing, timely and effective communication, by and between the hospital governing body and the organized medical staff, is critical to a constructive working relationship between the organized medical staff and the hospital governing body.

5. The organized medical staff bylaws are a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body. The organized medical staff and hospital bylaws, rules and regulations should be aligned, current with all applicable law and accreditation body requirements and not conflict with one another. The hospital bylaws, policies and other governing documents do not conflict with the organized medical staff bylaws, rules, regulations and policies, nor with the organized medical staff's autonomy and authority to self govern, as that authority is set forth in the governing documents of the organized medical staff. The organized medical staff, and the hospital governing body/administration, shall, respectively, comply with the bylaws, rules, regulations, policies and procedures of one another. Neither party is authorized to, nor shall unilaterally amend the bylaws, rules, regulations, policies or procedures of the other.

6. The organized medical staff has inherent rights of self governance, which includes but are not limited to:

a. Initiating, developing and adopting organized medical staff bylaws, rules and regulations, and amendments thereto, subject to the approval of the hospital governing body, which approval shall not be unreasonably withheld. The organized medical staff bylaws shall be adopted or amended only by a vote of the voting membership of the organized medical staff.

b. Identifying in the medical staff bylaws those categories of medical staff members that have voting rights.

c. Identifying the indications for automatic or summary suspension, or termination or reduction of privileges or membership in the organized medical staff bylaws, restricting the use of summary suspension strictly for patient safety and never for purposes of punishment, retaliation or strategic advantage in a peer review matter. No summary suspension, termination or reduction of privileges can be imposed without organized medical staff action as authorized in the medical staff bylaws and under the law.

d. Identifying a fair hearing and appeals process, including that hearing committees shall be composed of peers, and identifying the composition of an impartial appeals committee. These processes, contained within the organized medical staff bylaws, are adopted by the organized medical staff and approved by the hospital governing board, which approval cannot be unreasonably withheld nor unilaterally amended or altered by the hospital governing board or administration. The voting members of the organized medical staff decide any proposed changes.

e. Establishing within the medical staff bylaws: 1) the qualifications for holding office, 2) the procedures for electing and removing its organized medical staff officers and all organized medical staff members elected to serve as voting members of the Medical Executive Committee, and 3) the qualifications for election and/or appointment to committees, department and other leadership positions.

f. Assessing and maintaining sole control over the access and use of organized medical staff dues and assessments, and utilizing organized medical staff funds as appropriate for the purposes of the organized medical staff.

g. Retaining and being represented by legal counsel at the option and expense of the organized medical staff.

h. Establishing in the organized medical staff bylaws, the structure of the organized medical staff, the duties and prerogatives of organized medical staff categories, and criteria and standards for organized medical staff membership application, reapplication credentialing and criteria and processing for privileging. The standards and criteria for membership, credentialing and privileging shall be based only on quality of care criteria related to clinical qualifications and professional responsibilities, and not on economic credentialing, conflicts of interest or other non-clinical credentialing factors.

i. Establishing in the organized medical staff bylaws, rules and regulations, clinical criteria and standards to oversee and manage quality assurance, utilization review and other organized medical staff activities, and engaging in all activities necessary and proper to implement those bylaw provisions including, but not limited to, periodic meetings of the organized medical staff and its committees and departments and review and analysis of patient medical records.

j. The right to define and delegate clearly specific authority to an elected, Medical Executive Committee to act on behalf of the organized medical staff. In addition, the organized medical staff defines indications and mechanisms for delegation of authority to the Medical Executive Committee and the removal of this authority. These matters are specified in the organized medical staff bylaws.

k. Identifying within the organized medical staff bylaws a process for election and removal of elected Medical Executive Committee members.

l. Defining within the organized medical staff bylaws the election process and the qualifications, roles and responsibilities of clinical department chairs. The Medical Executive Committee must appoint any clinical chair that is not otherwise elected by the vote of the general medical staff.

m. Enforcing the organized medical staff bylaws, regulations and policies and procedures.

n. Establishing in medical staff bylaws, medical staff involvement in contracting relationships, including exclusive contracting, medical directorships and all hospital-based physician contracts, that affect the functioning of the medical staff.

7. Organized medical staff bylaws are a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body, as well as between those two entities and the individual members of the organized medical staff.

8. The self-governing organized medical staff determines the resources and financial support it requires to effectively discharge its responsibilities. The organized medical staff works with the hospital governing board to develop a budget to satisfy those requirements and related administrative activities, which the hospital shall fund, based upon the financial resources available to the hospital.

9. The organized medical staff has elected appropriate medical staff member representation to attend hospital governing board meetings, with rights of voice and vote, to ensure appropriate organized medical staff input into hospital governance. These members should be elected only after full disclosure to the medical staff of any personal and financial interests that may have a bearing on their representation of the medical staff at such meetings. The members of the organized medical staff define the process of election and removal of these representatives.

10. Individual members of the organized medical staff, if they meet the established criteria that are applicable to hospital governing body members, are eligible for full membership on the hospital governing body. Conflict of interest policies developed for members of the organized medical staff who serve on the hospital's governing body are to apply equally to all individuals serving on the hospital governing body.

11. Well-defined disclosure and conflict of interest policies are developed by the organized medical staff which relate exclusively to their functions as officers of the organized medical staff, as members and chairs of any medical staff committee, as chairs of departments and services, and as members who participate in conducting peer review or who serve in any other positions of leadership of the medical staff.

12. Areas of dispute and concern, arising between the organized medical staff and the hospital governing body, are addressed by well-defined processes in which the organized medical staff and hospital governing body are equally represented. These processes are determined by agreement between the organized medical staff and the hospital governing body.

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