Medical Staff
AHLA Fundamentals 2012

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Overview of the Medical Staff

• Medical Staff as defined by the Joint Commission:
  “The group of all licensed independent practitioners and other practitioners privileged through the organized medical staff process that is subject to the medical staff bylaws...”
Overview of the Medical Staff

• Medical Staff’s Role within the Institution:
  – The Medical Staff oversees the quality of care, treatment and services delivered by practitioners credentialed and privileged through the medical staff process.
  – The Governing Body has the ultimate authority and responsibility for the oversight and delivery of health care.

Laws Applicable to Medical Staff

• CMS Conditions of Participation - 42 CFR 482.12
  – The medical staff – The governing body must:
    • Determine which categories of practitioners are eligible for appointment to the medical staff;
    • Appoint members of the medical staff after considering the recommendations of the existing members of the medical staff;
    • Assure that the medical staff has bylaws and approve them;
    • Ensure that the medical staff is accountable to the governing body for the quality of care provided to patients
    • Ensure the criteria for selection are individual character, competence, training, experience, and judgment; and
    • Ensure staff membership or professional privileges in the hospital are not solely dependent upon certification or fellowship.
Laws Applicable to Medical Staff

• CMS Conditions of Participation - 42 CFR 482.22
  – The medical staff must adopt and enforce bylaws to carry out its responsibilities.
    • Have to be approved by the governing body
    • Include a statement of the duties and privileges of each category of medical staff
    • Describe the organization of the medical staff
    • Describe the qualifications to be met by a candidate
    • Requirement for H&P
    • Requirements for Telemedicine Practitioners
    • Autopsies

Laws Applicable to Medical Staff

• State Laws
  – The requirement to have bylaws as a requirement of state facility licensing requirements. Example – Va Code “12 VAC 5-410-210 – Medical Staff”
  – The requirement to accept all eligible applicants for medical staff membership.
  – The Medical Staff Bylaws constituting a contract between practitioner and the hospital.
  – Peer review protections and mandatory reporting requirements.
Medical Staff – Joint Commission

• The struggle between Independent Medical Staff and the Hospital Administration – MS.01.01.01
• The requirement to perform FPPE and OPPE – Joint Commission Requirement
• Primary Source Verification and use of Credentials Verification Organization (CVO)
• Temporary Privileges (Patient Care Need/Pending Approval)

Medical Staff Bylaws

• Medical Staff Bylaws as defined by the Joint Commission: “A document or group of documents adopted by the voting members of the organized medical staff and approved by the governing body that defines the rights, responsibilities, and accountabilities of the medical staff and various officers, persons, and groups within the structure of the organized medical staff; the self-governance functions of the organized medical staff; and the working relationship with and accountability to the governing body of the organized medical staff.”
Medical Staff Bylaws

• Required by Accreditation Entities (CMS, DNV, JC)
• Adopted by the voting Medical Staff members and approved by the Governing Body
• Cannot be unilaterally amended by Med Staff or Governing Body.
• Provide for the process but more substantive detail may be in Rules, Regulations and Policies.

Medical Staff Bylaws

• Typical Contents
  – Overview of eligibility requirements for Med Staff members.
  – Overview of application process.
  – Overview of corrective action process (and maybe fair hearing process).
  – Identifies medical staff categories
  – Identifies medical staff departments/sections
  – Identifies medical staff officers and standing committees.
Medical Staff Bylaws

• Eligibility requirements to consider.
  – Unrestricted medical license.
  – Board Certification.
  – Sufficient experience and training to perform the privileges requested.
  – Demonstrate a willingness to work with other providers and personnel at the hospital.
  – Agree to abide by rules, regulations and policies.
  – Maintain Professional Liability Insurance.
  – Practice medicine within the community.

Medical Staff Bylaws

• Application Process
  – The use of Pre-application Questionnaires.
  – Grounds for not providing an application.
  – Stating the effects of an application
  – Processing the application (MSO, Dept Chair, Credentials, MEC, Board of Directors).
Medical Staff Bylaws

• Corrective Action
  – The use of preliminary inquiries.
  – The initiation of a formal investigation.
  – Committee review (i.e. Credentials, Quality, MEC, etc.)
  – The Practitioners ability to submit information and participate in the process.
  – Summary Action (Suspension, Termination, etc.).
  – Medical Records or Automatic Suspensions.
  – Use of Attorneys in the process.

Medical Staff Bylaws

• Fair hearing process.
  – Identifies when a practitioner is entitled to a hearing.
  – The process for requesting a hearing.
  – The selection and use of a hearing panel and hearing office.
  – Notification of the Practitioner’s Rights and Obligations.
  – Hearing Procedures.
  – Appellate Review.
Medical Staff Bylaws

• Medical Staff Categories.
  – Active Staff.
  – Probationary/Provisional Staff
  – House Staff.
  – Courtesy/Consulting Staff.
  – Community Care/Referral Staff.
  – Honorary/Emeritus Staff.

Medical Staff Bylaws

• Medical Staff Department/Sections/Divisions.
  – Department v. Non-Department Medical Staff.
  – Purpose of Departments
  – Use of sub-divisions or sections within a department.
  – Chief or Chair of Departments
Medical Staff Bylaws

• Medical Staff Officers and Committees.
  – Types of Officers
    • President
    • President-Elect
    • Past-President
    • Secretary Treasurer.
  – Types of Committees
    • Medical Executive
    • Credentials
    • Bylaws
    • Nominating

Other Medical Staff Documents

• Medical Staff Rules and Regulations.
  – Admission and Discharge requirements
  – Requirements and contents for History and Physical Examinations
  – Requirements for Orders for treatment
  – Contents and Maintenance of the Medical Record
  – Rules for Patient Care
Other Medical Staff Documents

• Medical Staff Policies.
  – Credentials Policies or Manuals
  – Peer Review Policies
  – Disruptive Physician Policy
  – Physician Health Policy
  – Conflict of Interest Policy

Other Medical Staff Documents

• Hospital Policies
  – EMTALA
  – Medical Records
  – HIPAA
  – Restraint and Seclusion
  – Code of Conduct
Peer Review & Corrective Action

• Immunity & Confidentiality for Peer Review
  – Issues to verify with state laws
    • Does immunity apply for good faith proceedings?
      – Consider an absolute and unconditional release in your bylaws or application
    • Does immunity apply to individual providing information to the peer review committee?
      – If a witness provides information, are they immune?.

Peer Review & Corrective Action

• Immunity & Confidentiality for Peer Review
  – Issues to verify with state laws
    • Does confidentiality prohibit all disclosures?
      – You may be able to produce documentation to certain individuals/entities.
    • Does confidentiality apply only information generated by a committee?
      – Statements made by the practitioner to a peer review committee may not be protected.
Peer Review & Corrective Action

• Health Care Quality Improvement Act of 1986
  – HCQIA provides immunity for Professional Review Actions:
    “Action or recommendation of a professional review body . . . Which is based on the competence or professional conduct of an individual physician.” 42 U.S.C. 11151(9)

Peer Review & Corrective Action

• Health Care Quality Improvement Act of 1986
  – Standards for Immunity under HCQIA
    • Reasonable belief action in furtherance of quality healthcare
    • Reasonable effort to obtain the facts
    • Adequate notice and hearing procedures
    • Reasonable belief that action warranted by facts
  – Rebuttable presumption that immunity standards have been met
  – Must be overcome by preponderance of the evidence
Peer Review & Corrective Action

• Reporting Obligations for Certain Corrective Actions
  – Reporting to the NPDB
  – Reporting to State licensing Boards
  – Reporting to other facilities upon inquiry – Kadlec Medical Center v. Lakeview Anesthesia Associates, 527 F.3d 412, 2008 U.S. App. LEXIS 10267 (5th Cir. La. 2008)

Growing Trends in the Medical Staff

• Employed Physicians
  – Ensuring Medical Staff Credentialing & HR Vetting are consistent
  – Use of clean sweeps in contracts, i.e. Medical Staff Membership terminates with employment terminating.
  – Use of HR disciplinary process v. Medical Staff process
Growing Trends in the Medical Staff

- Accountable Care Organizations
  - Credentialing provides for the ACO through the Hospital Medical Staff process
  - If a hospital based ACO, do all participants of the ACO need clinical privileges.
  - Exchange of peer review information between independent entities participating in an ACO

Growing Trends in the Medical Staff

- On-call
  - Paying for call coverage when medical staff bylaws require active staff members to take call.
  - Providers giving up partial privileges to avoid call, i.e. OB/GYN giving up OB privileges.
Growing Trends in the Medical Staff

• Telemedicine Privileges

  – The provision of clinical services to patients by practitioners from a distance via electronic communications

  – Includes such services as teleradiology and teleICU services, and could presumably even include remotely performed robotic surgery.

Growing Trends in the Medical Staff

• Telemedicine Privileges – Options

  – Continue to credential/privilege telemedicine providers in traditional way by obtaining and reviewing all required information from original sources

  – Rely entirely on distant site and obtain from distant site only list of privileges granted

  – A “hybrid” approach involving a combination of the two options above
Growing Trends in the Medical Staff

• Telemedicine Privileges – “Hybrid” approach
  – Contract with Distant Site provides for Distant site to:
    • Obtain all information and documentation about practitioner
    • Education and training
    • Reference letters
    • Claims history
    • Adverse licensure or medical staff actions
    • Work history

Growing Trends in the Medical Staff

• Telemedicine Privileges – “Hybrid” approach
  – Contract with Distant Site provides for Distant site to:
    • Maintain credentialing files for each practitioner
    • Provide hospital copies of or access to credentialing files
Growing Trends in the Medical Staff

• Telemedicine Privileges – “Hybrid” approach
  – Contract with Distant Site provides for Distant site to:
    • Report any “adverse” information obtained
      – Medical malpractice claims within 10 years
      – Adverse action regarding hospital privileges
      – Any disciplinary action by licensing agency
      – Any FPPE or disciplinary action by distant site

Growing Trends in the Medical Staff

• Telemedicine Privileges – “Hybrid” approach
  – Contract with Distant Site provides for Distant site to:
    • Report any “adverse” information obtained
      – Any negative or adverse information
      – Questionable/negative letters of reference
      – Any adverse events resulting from services provided by telemedicine provider
      – Complaints about provider
Growing Trends in the Medical Staff

• Telemedicine Privileges – “Hybrid” approach
  – Contract with Distant Site provides for Distant site to:
    • Satisfy Medicare requirements
    • Ensure services are provided in a manner that allows hospital to comply with Medicare CoPs

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While Joint Commission Standards, Medicare Conditions of Participation, and State laws and regulations dictate certain things which must be addressed in medical staff bylaws or related documents, and in some cases place restrictions on what hospitals can do in connection with credentialing actions, hospitals and their medical staffs nevertheless have a great deal of flexibility concerning the procedures set forth in the bylaws relating to granting and terminating medical staff membership and clinical privileges, defining the rights and responsibilities of medical staff members, and setting forth available remedies when members of the medical staff fail to fulfill their obligations or meet the qualifications or requirements for membership on the medical staff. In addition, medical staff bylaws and related documents like fair hearing and appellate review plans can set forth procedures which can be very effective in managing the hearing process, making hearings less burdensome, and avoiding unnecessary hearings.

Following are some suggested medical staff bylaw provisions which are designed to avoid unnecessary hearings, permit prompt action to deal with various problems, protect the hospital and members of the medical staff when claims are filed by disgruntled medical staff applicants or members, and set forth a structure for the adoption of various administrative procedures which may be necessary to supplement the bylaws.

AVOIDING UNNECESSARY PROCESSING OF APPLICATIONS

Whenever possible, applications for medical staff membership or clinical privileges, including applications for reappointment, should not be provided to applicants or members of the medical staff who do not meet the basic qualifications or requirements for membership or privileges. Not providing applications to such individuals can avoid having to go through time consuming and cumbersome steps to administratively process applications, and obtain information about proposed applicants, when there is no chance that the application would ever be approved. For current staff members, withholding an application for reappointment can be an effective means of compelling current practitioners to provide information or respond to requests for comments that have been sent in connection with peer review and quality improvement matters. Examples of bylaws which accomplish these functions are as follows:

1. **Grounds for Not Providing Application Form.** No application for appointment shall be provided to a practitioner, nor shall an
application be accepted from a proposed applicant, if the Hospital President/CEO or Board of Directors determines based on information from a pre-application questionnaire or any other source that:

a. the Hospital does not have the ability to provide adequate facilities or services for the applicant or the patients to be treated by the prospective applicant,

b. The prospective applicant has interests or activities that are inconsistent with the needs, mission, operations and plans of the Hospital and the communities it serves, including any medical staff development plan.

c. the Hospital has contracted with an individual or group to provide the clinical services sought by the prospective applicant on an exclusive basis, and the prospective applicant will not be associated with the individual or group contracted with,

d. The prospective applicant has been excluded from participation in Medicare or Medicaid,

e. The prospective applicant does not meet the requirements relating to licensure and registration, professional liability insurance, board certification, or reapplication after adverse decision or resignation while under investigation or to avoid an investigation,

f. The prospective applicant is not a type of Allied Health Care Professional approved by the Board of Directors to provide patient care services in the Hospital,

g. The practitioner does not have a valid unrestricted state license, or is subject to any form of counseling, monitoring, supervision, educational requirement or any other ongoing review, condition, requirement or restriction of any kind.

h. The practitioner has been convicted of a felony or convicted of a misdemeanor related to the practitioner’s fitness to practice medicine.

i. The prospective applicant has provided materially false or misleading information on any pre-application
questionnaire or in connection with any pre-application review process.

No application for reappointment shall be provided to a practitioner who is currently a member of the medical staff or holds clinical privileges if the practitioner has not provided requested information or documents or not responded to requests for comments concerning peer review or quality improvement matters or the practitioner’s qualification for medical staff membership and privileges, provided the staff member has been notified in writing of the requested information and has had a reasonable opportunity to respond [has not responded within thirty (30) calendar days].

The applicant or prospective applicant shall be advised of the information relied on as grounds for not providing an application and the applicant or prospective applicant shall have a reasonable opportunity to submit information or evidence that the information relied on is not accurate.

No individual shall be entitled to a hearing or any other procedural rights as a result of a refusal by the Hospital to provide the individual an application form for initial appointment or reappointment.

2. **Restriction on Reapplication** An applicant who has received a final adverse decision concerning appointment, re-appointment, or clinical privileges, or who has resigned or failed to apply for reappointment while under investigation, in order to avoid investigation, or following an adverse recommendation by the Credentials Committee or Medical Executive Committee, shall not be eligible to reapply for appointment to the medical staff for a period of five (5) years unless the Board of Directors expressly provides otherwise. Upon any reapplication, the applicant shall submit, in addition to all of the other information required, specific information showing that the condition or basis for the earlier adverse decision, recommendation or resignation no longer exists.
DEALING WITH INCOMPLETE APPLICATIONS

The hospital is under no obligation to process applications which are incomplete. However, often it is unclear what constitutes an “incomplete” application. The definition of a complete application should not be limited to one where all of the initial documentation that is required is submitted. Once initial documentation is provided, and information is received from other sources, department chairs, the credentials committee, and the medical executive committee may have questions that require further documentation or information to resolve outstanding issues.

A bylaw provision that makes it clear that an application shall not be deemed to be complete until all of the information requested by department chairs, the credentials committee, and the medical executive committee has been provided can be very helpful in avoiding further processing of applications where the practitioner has not provided the requested information. In addition, having a bylaw provision which provides that incomplete applications shall be automatically deemed to be withdrawn after a specified period of time can be helpful in avoiding having to deny applications because information is missing, thereby, potentially requiring that a practitioner be afforded a hearing.

3. Incomplete Applications

No application for appointment or reappointment shall be accepted for processing until all information and documents required have been provided. The applicant shall be notified of any missing information or verifications and it shall be the responsibility of the applicant to have any missing information sent to the Medical Staff Office. If the applicant fails to provide or cause to be provided any information or verification within thirty (30) calendar days after being requested to do so, the application shall be automatically deemed to be withdrawn and the application, along with all fees, returned to the applicant, unless the time to obtain the information is extended by the Chief of Staff and the Hospital President/CEO or designee.

No application shall be considered to be complete until it has been reviewed by the appropriate department chair, Credentials Committee and Medical Executive Committee, and all have determined that no further documentation or information is required to permit consideration of the application. Additional information or documentation may be requested by any department chair, by the Credentials Committee or by the Medical Executive Committee. If

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the applicant fails to submit the requested information or documentation within thirty (30) calendar days after being requested to do so, the application shall be deemed to be incomplete and automatically withdrawn, unless the time to obtain the information is extended by the person or committee requesting the information.

**AVOIDING UNNECESSARY HEARINGS**

Although it is necessary to afford medical staff members the right to a hearing in certain circumstances in order to qualify for the immunity provisions of the Healthcare Quality Improvement Act, there are many actions that may be taken with regard to a practitioner’s medical staff membership or clinical privileges which may be considered “adverse,” but which should not entitle the practitioner to a hearing. Hearings should be limited to those circumstances where action is being taken based on the professional qualifications and competence of the practitioner. Examples of bylaw provisions which allow various actions to be taken without entitling a practitioner to a hearing are as follows:

4. **Appointments for less than two years** Appointments and reappointments may be for a period of less than two (2) years if the Board of Directors determines it is necessary to establish or maintain an orderly system for renewal of appointments. In addition, the Board of Directors may, after considering the recommendations of the Medical Executive Committee, appoint or reappoint a practitioner for less than two (2) years in order to provide for more frequent evaluations of the practitioner if it is determined to be necessary to assure that the practitioner’s care and/or conduct are appropriate. **Appointment or reappointment for a period of less than two (2) years shall not entitle a practitioner to a hearing or other rights as set forth in the Fair Hearing and Appellate Review Plan.**

5. **Rights associated with temporary, locum tenens, emergency and disaster privileges** The granting of temporary, locum tenens, emergency or disaster privileges shall not confer Medical Staff membership on any practitioner, nor shall practitioners holding such privileges be considered to be members of the medical staff or have any of the rights provided to Medical Staff members by these Bylaws or otherwise except as expressly stated herein. **The refusal to grant, or termination or withdrawal of, temporary, locum tenens, emergency or disaster privileges shall not entitle the practitioner involved to a hearing or any other procedural rights or review unless the action is reportable to the National Practitioner Data Bank.**
6. **Procedures Not Permitted to be Performed** The Board of Directors may at any time after considering the recommendation of the Medical Executive Committee direct that specific procedures or clinical practices not be performed at the Hospital if the Board of Directors determines that such practices or procedures are not medically acceptable, cannot be properly performed at the Hospital, are inconsistent with the mission, operations or principles of the Hospital, or for any other reason determines that the procedures or services should not be performed in the Hospital. *There shall be no appeal or hearing with regard to any decision by the Board of Directors that any practices or procedures are not permitted to be performed in the Hospital.*

7. **Actions For Which No Hearing Is Required.**

In the event any practitioner is summarily suspended for

(i) failure to maintain appropriate malpractice insurance,
(ii) failure to maintain a current, active, unrestricted appropriate State license,
(iii) exclusion from participation in Medicare or Medicaid, or
(iv) failure to maintain a current, active DEA certification (if required for the practitioner’s specialty),

the practitioner shall be notified of the suspension and the basis of the suspension by regular and certified mail, and given ten (10) calendar days to produce clear and convincing evidence that the facts relied on in taking summary action are not correct. If the Hospital does not receive such evidence from the member within ten (10) calendar days, the individual shall be deemed to be no longer be qualified for Medical Staff membership and/or clinical privileges and the practitioner’s Medical Staff membership and clinical privileges shall automatically terminate, *in which event the practitioner shall not be entitled to a hearing as set forth elsewhere in these Bylaws or the Fair Hearing and Appellate Review Plan.*

No practitioner shall be entitled to a hearing as a result of any action which is recommended or taken which is not reportable to the state or the National Practitioner Data Bank, including, but not limited to, the following:

a. Letters of warning, reprimand, or admonition;
b. Imposition of monitoring, proctoring, review or consultation requirements;

c. Requiring provision of information or documents, such as office records, or notice of events or actions;

d. Imposition of educational or training requirements;

e. Placement on probationary or other conditional status;

f. Appointment or reappointment for less than two (2) years;

g. Failure to place a practitioner on any on-call or interpretation roster, or removal of any practitioner from any such roster; or,

h. Continuation of provisional appointment.

i. The refusal of the Board of Directors to grant a request for a waiver or extension of time regarding the Board certification requirements set forth in Section xxx.

j. Termination of medical staff membership and/or clinical privileges as a result of matters which are not related to the practitioner’s professional qualifications, competence or conduct such as

i. failure to pay dues or assessments,

ii. failure to meet any objective requirement imposed on all staff members that specific numbers of procedures be performed to maintain or demonstrate clinical competence, or

iii. the Hospital elects to enter into an exclusive contract for the provision of certain services.

If any action is taken which does not entitle the practitioner to a hearing, the practitioner shall be offered the opportunity to submit a written statement or any information which the practitioner wishes to be included in the practitioner’s peer review records along with the documentation regarding the action taken.
SERVICE ON-CALL ROSTERS

No attempt will be made here to suggest bylaw provisions or other policies which set forth the specific circumstances under which practitioners are required to serve on, or may be exempted from, on-call rosters. Service on on-call rosters is an increasingly difficult subject and how the problem is solved in a particular institution is going to be entirely dependant upon the composition and culture of the medical staff and the hospital concerned. However, one concept that is strongly recommended is that no attempt be made to specify in the medical staff bylaws precisely what the on-call requirements will be. Rather, the bylaws should set forth a procedure for the establishment of specific call requirements so that the call requirements can be easily modified without having to go through the cumbersome, time consuming, and often politically volatile, process of amending the medical staff bylaws. The bylaws should simply provide for call requirements to be established by the departments and medical executive committee subject to approval by the hospital President/CEO and/or governing body.

It is recommended that any call requirements be subject to ultimate approval by the hospital president/CEO and/or governing body so that the hospital can assure that inappropriate call provisions are not being adopted by individual departments and the medical executive committee, which unreasonably reward or punish specific staff members, or jeopardize the interests of the hospital or its ability to comply with its community and legal obligations. In addition, either putting a practitioner on or removing them from a call or interpretation roster should not require giving the practitioner the right to a hearing since such action does not adversely affect their medical staff membership or clinical privileges.

8. Service on Call and Interpretation Rosters   The appropriate department and section chairs shall make recommendations to the Medical Executive Committee and the President/CEO concerning what on-call rosters, and rosters for the interpretation of tests, are required to meet the needs of the Hospital and patients and any criteria for service on such rosters. The final decision concerning what call and interpretation rosters will be utilized by the hospital, and the criteria for serving on call or interpretation rosters. The appropriate department and section chairs, or their designees, shall establish the schedule for service on all call and interpretation rosters. Any disputes or disagreements concerning on-call or interpretation rosters shall be submitted to the Medical Executive Committee which shall make a recommendation to the President/CEO, or designee, who shall make the final decision on such matters.

The Board of Directors of the Hospital may, after considering the recommendations of the Medical Executive Committee and
appropriate departments, require that the members of the Medical Staff, including the Provisional Staff, serve on on-call or interpretations rosters as a condition of Medical Staff membership if the Board of Directors determines that such action is necessary to meet the needs of the Hospital and the community it serves.

The Board of Directors may, after considering the recommendations of the Medical Executive Committee and appropriate departments or sections, approve criteria for Members of the Medical Staff to be exempt from required service on call and interpretation rosters.

Any practitioner providing services on an on-call roster or for the interpretation of tests or special procedures may be removed from such roster at any time by the Hospital President/CEO, after considering the recommendations of the Chair of the Medical Staff and the chair of the appropriate department, if it is determined that it is in the best interests of the Hospital, the Medical Staff, or patient care to do so. Requiring service on, or removal from, an on-call roster or from any roster for the interpretation of tests or special procedures shall not be considered to be a reduction in privileges nor an adverse action concerning the practitioner’s clinical privileges or medical staff membership. No practitioner shall be entitled to a hearing or any peer review procedures as a result of the failure of the practitioner to be appointed to or the removal of the physician from any roster for on-call services or interpretation of tests or special procedures.

WAIVER OF BYLAW AND OTHER REQUIREMENTS

While it is advisable to delineate specific requirements or exceptions to requirements related to medical staff membership, clinical privileges, and practitioner’s rights and responsibilities, it is impossible to anticipate every set of circumstances. With the passage of time, situations change and issues arise that were never anticipated when a specific bylaw was adopted. Accordingly, an omnibus waiver provision which permits the governing body, after considering the recommendations of the medical executive committee and appropriate departments, to waive any requirement set forth in the bylaws is advisable.

9. Waiver The Hospital Board of Directors may, after considering the recommendations of the Medical Executive Committee and any appropriate department chairs, waive any of the requirements for Medical Staff membership and clinical privileges established pursuant to these Bylaws or the rules and regulations of the Medical Staff or any department or division for good cause shown if the
Board determines that such waiver is necessary to meet the needs of the Hospital and the community it serves. The refusal of the Board of Directors to waive any requirement shall not entitle any practitioner to a hearing or any other rights of review.

RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

It is important that the bylaws spell out exactly what the responsibilities are of those practitioners who apply for and ultimately obtain medical staff membership and/or clinical privileges. Following are examples of bylaw provisions that address the responsibilities of new applicants and current practitioners with privileges, including the duty to provide specific information and documents, maintain professional liability insurance, submit to drug testing and absolutely release the hospital and members of the medical staff from liability for peer review and credentialing actions and reporting of information to others.

10. Effect of Application. By applying for appointment or reappointment to the Medical Staff or clinical privileges, and as long as the practitioner is a member of the Medical Staff or has clinical privileges, the applicant/practitioner automatically:

   a. Agrees that if at any time, an adverse ruling is made with respect to the applicant’s membership, staff status, and/or clinical privileges, the applicant will exhaust all remedies afforded by these Bylaws and the Fair Hearing and Appellate Review Plan, as well as any administrative or other remedies provided by commonwealth law, before resorting to formal legal action.

   b. Agrees to notify the Chief of Staff and the Hospital President/CEO immediately in writing upon learning that the applicant or practitioner:

      i. is the subject of a complaint or investigation by, or has been charged with misconduct by, any licensing or disciplinary authority of any state or federal agency or professional organization,

      ii. has been charged with a misdemeanor, excluding traffic offenses, or a felony,

      iii. has been notified that their professional liability insurance carrier intends to cancel, not renew, restrict or impose any conditions or deductibles on their professional
liability insurance for any reason related to the practitioner’s clinical practices or claims history,

iv. has been notified of the loss of their DEA number or exclusion from the Medicaid or Medicare program, is under investigation by Medicaid or Medicare, or has been subjected to any fine, penalty or sanction by Medicare or Medicaid,

v. is or has been the subject of any actual or proposed disciplinary action, including any modification of clinical privileges, restriction of clinical privileges, or placing of conditions on clinical privileges (including any form of monitoring or review), by any other hospital or health care facility or organization,

vi. is or has been the subject of any actual or proposed disciplinary action by any regulator, licensing or disciplinary authority or professional organization, including any form of reprimand or sanction,

vii. has voluntarily relinquished, agreed not to exercise, or involuntarily lost any licensure, certification, registration, medical staff membership or clinical privileges at any healthcare facility,

viii. has entered into a contract or agreement with any impaired physicians committee or similar entity as a result of any substance abuse or other disease or disorder, or

ix. has developed any mental or physical illness or sustained any injury which could have an effect on the exercise of the individual’s clinical privileges.

c. Agrees to provide any information or documentation, including appropriate medical records, which may be requested to answer any questions or resolve any issues concerning the practitioner’s clinical competence or conduct, or to provide information concerning any matters or actions set forth in section [b.] above.

d. Agrees that the failure of an applicant or practitioner to provide the notification as required by section [b.] above shall be grounds for summary suspension or other action
related to the practitioner’s medical staff membership and/or privileges.

e. Agrees to maintain professional liability insurance providing coverage for the entire time the member has privileges at the Hospital with an insurer approved by the Hospital Board of Directors in no less than the minimum amount and in such form as may be required from time to time by the Board of Directors, or provide such other evidence of financial responsibility as the Board of Directors may approve.

f. Acknowledges that any material misstatement or omission on any application, or made at any time during the appointment or reappointment process, or after medical staff membership and/or clinical privileges have been granted, shall be grounds for immediate denial of the application for appointment or reappointment, or summary suspension and termination of Medical Staff membership and clinical privileges if the misstatement or omission is discovered after the practitioner is appointed or reappointed.

g. Acknowledges that the failure to provide complete and accurate information in connection with any investigation concerning the practitioner’s Medical Staff membership, or clinical privileges, shall be grounds for immediate suspension and termination of Medical Staff membership and clinical privileges.

h. Absolutely and unconditionally releases from any and all liability the Hospital and all Hospital representatives for all actions performed in connection with providing, obtaining or reviewing information and evaluating or making recommendations or decisions concerning the applicant and the applicant’s credentials. The term “Hospital representative” includes the members of the Board of Directors, all officers, employees, and agents of the Hospital, and all members and officers of the Medical Staff, its departments and committees, and any outside reviewers, who have responsibility for collecting, providing or evaluating information concerning the applicant’s credentials or making recommendations or acting on any application for Medical Staff membership or clinical privileges.

i. Absolutely and unconditionally releases from any liability all individuals and organizations who provide information to the
Hospital and its representatives, including otherwise privileged or confidential information, relating to the applicant’s ability, background, conduct, professional ethics, character, physical and mental health, emotional stability, and other matters relating to the applicant’s qualifications for staff appointment and clinical privileges.

j. Authorizes and consents to the Hospital, its officers, agents employees Medical Staff members and its representatives providing other hospitals, medical associations, licensing boards, the National Practitioner Data Bank and other health care organizations concerned with provider performance, conduct, and the quality, appropriateness, and efficiency of patient care, with any information or opinions related to such matters which the Hospital or any of its officers, agents, employees Medical Staff members or representatives may have concerning the practitioner, and absolutely and unconditionally releases the Hospital and its officers, agents employees, Medical Staff members and representatives from any and all liability for providing such information.

k. Agrees to provide, upon request by the department chair, credentials committee, medical executive committee or Chief of Staff, access to and copies of the practitioner’s office charts and records relating to the treatment of patients who have been treated by the practitioner in the Hospital or any related facility if deemed necessary for the review of the practitioner’s professional activities and current clinical competence.

l. Agrees to immediately notify the Medical Staff Office in writing of any change in the practitioner's home or office addresses or telephone numbers so that the Medical Staff Office has current addresses and telephone numbers at all times. The practitioner further agrees that any notice delivered to the home or office address of the practitioner which is on file in the Medical Staff Office shall be conclusively deemed to have been received by the practitioner. Any notice sent by regular mail shall be conclusively deemed to have been received on the second business day after the date the notice was mailed.

m. Agrees to submit any reasonable evidence of current health status which may be reasonably requested by the chair of any department, the Chair of the Medical Staff, the
Credentials Committee or its Chair, or the Medical Staff Executive Committee, and to submit to such mental or physical examination, including providing blood, urine, or other samples, as the Section Chair, Department Chair, Chair of the Medical Staff, Chair of the Credentials Committee, Senior Vice President for Medical Affairs or Medical Staff Executive Committee might require at any time and for any reason, including random, unannounced drug screens without cause.

n. Acknowledges that a practitioner who fails or refuses to provide any requested evidence of current health status, including providing blood, urine or other samples for testing for drug or alcohol use, shall be deemed to be no longer qualified for medical staff membership and clinical privilege, in which event the medical staff membership and clinical privileges shall be automatically terminated for administrative reasons and the practitioner shall not be entitled to a hearing.

o. Agrees that if at any time, an adverse ruling is made or action taken with respect to the practitioner’s membership, staff status, and/or clinical privileges, the applicant shall be required to exhaust all remedies afforded by these Bylaws and the Fair Hearing and Appellate Review Plan, before resorting to formal legal action.

**SUMMARY ACTION**

Medical staff bylaws traditionally provide for summary suspension in the event of an immediate threat to patient care. Some states restrict when summary suspension can be employed to cases involving immediate threats to patients or others. At the same time some courts have held that private hospitals may have very broad authority to impose summary suspension. There are often occasions when

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2 Some jurisdictions by statute permit summary suspension only when there is egregious misconduct or when action must be taken promptly to address an immediate threat to patients or others. See CAL. BUS. & PROF. CODE § 809.5(a) (authorizing summary suspension “...where the failure to take that action may result in an imminent danger to the health of any individual...”); 210 ILL. COMP. STAT. 85/10.4(2)(C)(i) (authorizing a hospital or a medical staff “... to summarily suspend, without a prior hearing, a person’s medical staff membership or clinical privileges if the continuation of practice of a medical staff member constitutes an immediate danger to the public, including patients, visitors, and hospital employees and staff....”)

3 See, e.g., Veldhuis v. Central Mich. Community Hosp., 369 N.W.2d 478 (Mich. 1985) where the court held that a private hospital has the power to appoint and remove members at will, without
summary suspension or other action may be desirable and appropriate even though it is not clear that there is an “immediate” threat to “patient care.” Accordingly, unless it would be contrary to state law, it can be helpful to specify the kinds of conduct which may justify summary action beyond the traditional immediate threat to patients, employees or others in the hospital. Failure to enumerate clearly the grounds for summary action may cause a court to interpret the hospital’s bylaws in a very restrictive manner thereby limiting the circumstances when summary action can be taken.4

Although “summary suspension” is commonly the action that is taken to address an immediate threat, there are times when something other than a complete suspension might be appropriate. Accordingly, a bylaw which provides for “summary action” rather than “summary suspension” can provide more flexibility. Summary action might include not only a suspension of all of a practitioner’s privileges, but also suspension of some portion of the privileges or some other restriction or conditions being placed on the exercise of privileges such as mandatory second opinions, supervision, monitoring, reporting or recordkeeping.

11. Summary Action

The Medical Executive Committee, the Chief of Staff, the chair of the staff member’s department, the Vice President for Medical Affairs or the Hospital President/CEO may summarily suspend, restrict or place conditions or requirements on all or any portion of the clinical privileges of any practitioner in accordance with this section. Any such suspension, restrictions, conditions or requirements shall be effective immediately and shall remain in effect until terminated by the Hospital President/CEO or the Board of Directors after considering the recommendations of the Medical Executive Committee. Grounds for imposition of summary suspension, restriction or conditions shall include, but not be limited to, the following:

4 See McMillan v. Anchorage Community Hosp., 646 P.2d 857 (Alaska 1982); see also Ritter v. Board of Comm’rs of Adams County Pub. Hosp. Dist. No. 1, 637 P.2d 940 (Wash. 1981) (summary suspension held to be inappropriate to deal with physician’s behavior problems where bylaws provided for summary action if “action must be taken immediately in the best interests of patient care.”)
(i) the conduct of a practitioner creates a reasonable possibility of injury or damage to any patient, employee or person present in the Hospital or to the Hospital,

(ii) a practitioner is charged with the commission of a felony$^5$,

(iii) a practitioner is charged with the commission of a misdemeanor which may relate to the practitioner’s suitability for Medical Staff membership,

(iv) a practitioner engages in or is charged with unlawful or unethical activity related to the practice of medicine,

(v) a practitioner engages in any dishonest, unprofessional, abusive or inappropriate conduct which is or may be disruptive of Hospital operations and procedures,$^6$

(vi) the practitioner has had any medical staff membership, clinical privileges, certification, licensure or registration terminated, suspended, restricted, limited, reduced or modified in any way, has resigned from any other medical staff in order to avoid an investigation or proposed action concerning medical staff membership or clinical privileges, or has voluntarily surrendered or agreed not to exercise any clinical privileges while under investigation or to avoid an investigation,

(vii) it is determined that the practitioner made a material misstatement or omission on any pre-application or application for appointment or reappointment, or at any time provided incorrect information or otherwise deceived or attempted to deceive or mislead the Medical Staff and/or the Hospital,$^7$

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$^5$ In Bouquett v. St. Elizabeth Corp., the summary suspension was based on a concern that retaining a physician on the staff who had been convicted of a felony would “not be perceived well by the community.” The action was held sufficiently within the bylaws standard authorizing summary suspension when such action “must be taken immediately in the best interest of patient care in the hospital.” 538 N.E.2d 113, 114-15 (Ohio 1989).

$^6$ In Landefeld v. Marion General Hospital, 994 F.2d 1178 (6th Cir. 1993) a board-certified internist was suspended and refused reinstatement as the result of his stealing from other doctors’ mailboxes. The court determined that the hospital had properly suspended the doctor because of his “intolerable conduct,” and had properly refused to reinstate him because of reasonable and continuing concerns about his behavior and lack of honesty.

$^7$ A summary suspension imposed for false answers on an application has been found to meet the bylaws standard that such action “… must be taken immediately in the best interest of patient care in the hospital….“ Pariser v. Christian Health Care Systems, Inc. 627 F. Supp. 39, 42-43 (E.D. Mo. 1984).
(viii) a practitioner has falsified or inappropriately destroyed or altered any medical record,

(ix) a practitioner refuses to submit to evaluation or testing relating to the practitioner’s mental or physical status, including refusal to submit to any testing related to drug or alcohol use.

(x) a practitioner abandons a patient or wrongfully fails or refuses to provide care to a patient,

(xi) a practitioner fails to maintain appropriate malpractice insurance or a current, unrestricted active state license to practice medicine, or

(xii) a practitioner engages in clinical activities outside the scope of the practitioner’s approved clinical privileges.

ATTORNEY REPRESENTATION

It is helpful for bylaws to specify when a staff member is entitled to be accompanied by legal counsel and when they are not. Frequently a practitioner will attempt to bring their attorney to meetings of the credentials committee or meetings with medical staff leaders when the practitioner’s conduct or clinical activities are being discussed. Just as employees are not permitted to bring their attorneys with them to counseling sessions or interviews, the bylaws should make it clear that a practitioner is not entitled to be accompanied by counsel at that time or in connection with any investigation.

12. Attorney Representation. No practitioner shall be entitled to be accompanied by an attorney in connection with any investigation or interview prior to the time that the practitioner is entitled to a hearing in accordance with these Bylaws. However, the practitioner may be accompanied by an attorney at any hearing or in connection with any appearance before the Medical Executive Committee or the Board of Directors, provided that the practitioner shall be required to respond personally to any questions directed to the practitioner. If the practitioner will be represented by counsel or another representative at any hearing or appearance, the practitioner shall notify the Medical Staff of the name of the attorney or other representative at least ten calendar (10) days prior to the hearing or appearance. Failure to do so shall result in the practitioner’s not being permitted to be accompanied by counsel.
HEARING PROVISIONS

Medical Staff Peer Review hearings can be cumbersome, time consuming and costly endeavors. Moreover, inadequate bylaw or fair hearing provisions may make the process confusing and create uncertainty concerning what are the proper procedures to be followed and what are the rights and responsibilities of the practitioner requesting the hearing, the medical staff members and leaders participating in the hearing, the hearing panel members, the hearing officers, and the attorneys representing the parties. There are a number of bylaw provisions which can address some of these issues.

The concepts employed in these provisions are that while hearings should not take on all the trappings of trials in civil proceedings, there are many aspects of civil procedure which can be effectively adapted to peer review hearings and can make the entire process much more manageable. Following are examples of such hearing provisions.


a. Appointment of Hearing Panel and Alternates The Medical Staff President, subject to the approval of the Hospital Chief Executive Officer, shall appoint three (3) members of the Medical Staff to serve on a hearing panel. There also may be appointed one or more alternate members of the hearing panel. Any member of the hearing panel, including any alternate, who participates in the entire hearing, or reviews the transcript of any portions of the hearing for which the panel member is not in personal attendance, may be permitted to participate in the deliberations and to vote on the recommendations of the hearing panel.

The practitioner shall be notified of the prospective members of the hearing panel and if the practitioner has any objection to any proposed panel member, the practitioner shall, within ten calendar (10) days after notification, state the objection in writing and the reasons for the objection. The Medical Staff President and the Hospital Chief Executive Officer shall, after considering such objections, decide in their discretion whether to replace any person objected to and the practitioner shall be notified of the final members of the hearing panel.

The hearing panel may make a recommendation to the Medical Executive Committee as long as a majority of the panel members, including any alternates, have attended all the hearings or read the transcript of any hearings for which a panel member was not in
personal attendance.8 A majority of the members of the hearing panel, including any alternates shall constitute a quorum for purposes of conducting a hearing.

b. **Burden of Proof** Whenever a hearing relates to the denial of a practitioner's request for appointment, reappointment or modification of privileges, the practitioner need only be advised of the nature and source of the information upon which the adverse recommendation is based and the practitioner shall have the burden of proving by clear and convincing evidence that the adverse recommendation lacks any factual basis or that the conclusions drawn therefrom are arbitrary, unreasonable, or capricious. It shall not be a defense to any action proposed by the Medical Executive Committee or the Board of Trustees that different action may have been taken in the past with regard to any other staff member.

c. **Disclosure of Experts and Opinions**

   i. **By Medical Staff** If any expert witness is to be called as a witness in support of the recommendations of the Medical Staff at the hearing, the practitioner shall be told at least fifteen (15) calendar days before the hearing the identity of the experts to be called, and provided (i) a copy of the witnesses curriculum vitae, (ii) a written reports from the experts setting forth the substance of the expert's testimony, the opinions of the experts and the grounds for the opinions, and (iii) copies of all documents or materials provided by the practitioner for review by the expert. No witness may be called on behalf of the Medical Staff, no testimony or opinions may be elicited from any expert, nor any documents submitted for consideration by the panel, which have not been disclosed in accordance with this section, unless the hearing officer determines that any failure to disclose was unavoidable.

   ii. **By Practitioner** At least seven (7) calendar days prior to the hearing the practitioner shall provide to the Medical Staff and any attorney representing the Medical Staff a list of any witnesses the practitioner will call to testify, a summary of the subject matter of the witnesses' testimony and a copy of all documents the practitioner intends to introduce at the hearing.

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8 “As long as the transcripts of the proceedings missed were available to the absent members, enabling them ultimately to make an informed decision, there is no deprivation of due process.” *Laverne v. Sobol*, 539 N.Y.S. 2d 556 (N.Y. App. Div. 1989), appeal denied, 545 N.E.2d 868 (N.Y. 1989).
hearing. If the practitioner intends to call any expert witnesses at the hearing, the member shall identify the experts to be called, and provide (i) a copy of the witnesses' curriculum vitae, (ii) a written report from the experts setting forth the substance of the expert's testimony, the opinions of the experts and the grounds for the opinions, and (iii) copies of all documents or materials provided by the practitioner for review by the expert. No witness may be called on behalf of the practitioner, no testimony or opinions may be elicited from any expert, nor any documents submitted for consideration by the panel, which have not been disclosed in accordance with this section, unless the hearing officer determines that any failure to disclose was unavoidable.

d. **Hearing Officer** The Medical Staff President and the Chief Executive Officer of the Hospital shall select a hearing officer to preside at the hearing. The hearing officer shall be an attorney or other individual familiar with procedures relating to peer review hearings.

The hearing officer shall have the authority to rule on all procedural matters related to the hearing including the scheduling of hearings, and shall have the authority to recess and reconvene the hearing, to rule on requests for postponements or extensions of time, to impose time limits for examination and cross-examination of witnesses, to limit the number of witnesses to be called by the Medical Staff or the practitioner, to generally regulate the proceedings and to advise the members of the hearing panel concerning legal and procedural issues. All time periods may be modified by the hearing officer or chair of the committee or body before which the case is currently pending for good cause.

The hearing officer shall rule on any objections to testimony or evidence that is offered at the hearing, decide whether evidence has sufficient relevance and reliability to be submitted to the hearing panel for consideration.

The hearing officer shall be available to the members of the hearing panel after the conclusion of the hearing to advise them on any procedural or legal matters and to assist the panel with the drafting of their report and recommendations, but shall not vote on any recommendations.

e. **Timely Objections:** In the event any applicant or practitioner has any objection to any action taken or procedures followed by the Hospital, the Medical Staff, or any individual, hearing panel or
committee with regard to the consideration of any application for appointment or reappointment, any investigation, any corrective action, any hearing, or other action, the applicant or practitioner shall immediately state such objection and the reasons for the objection to the individual or body concerned in writing, or verbally if the objection arises during any recorded proceedings, in order to permit the body before whom the matter is pending to address the objection and take any corrective action deemed appropriate. The failure to give such notice of any objection shall be deemed to be a waiver of any such objection and consent to the procedures being followed or action being taken.

f. Disclosure of Witnesses and Evidence:

At least fifteen (15) calendar days prior to the hearing, the practitioner involved shall be sent by certified and regular mail a copy of all medical records or documents expected to be submitted to the panel for consideration.9 If any expert witness is to be called as a witness in support of the recommendations of the Medical Staff at the hearing, the practitioner shall be notified at least fifteen (15) calendar days before the hearing the identity of the experts to be called, and provided (i) a copy of the witnesses curriculum vitae, (ii) a written reports from the experts setting forth the substance of the expert's testimony, the opinions of the experts and the grounds for the opinions, and (iii) copies of all documents or materials provided by the practitioner for review by the expert. No witness may be called on behalf of the Medical Staff, no testimony or opinions may be elicited from any expert, nor any documents submitted for consideration by the panel, which have not been disclosed in accordance with this section.

At least seven (7) calendar days prior to the hearing the practitioner shall provide to the Medical Staff and any attorney representing the Medical Staff the following:

a. a statement setting forth the reasons why the practitioner contends that the adverse recommendation is unreasonable, inappropriate or lacks any factual basis,

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9 Courts in some states have concluded that physicians have a right to access at the hearing to documents relied on by the hospital or its medical-staff committees in reaching its decision. E.g., Rosenbilt v. Superior Court of Orange County, 282 Cal. Rptr. 819 (Cal. App. 1991); Applebaum v. Bd. of Directors, 104 Cal. App. 3d 648 (1980); Garrow v. Elizabeth Gen. Hosp., 401 A.2d 533 (N.J. 1979).
b. a list of any witnesses the practitioner will call to testify and a summary of the subject matter of the witnesses' testimony,

c. a copy of all documents the practitioner intends to introduce at the hearing, and

d. if the practitioner intends to call any expert witnesses at the hearing, the member shall identify the experts to be called, and provide (i) a copy of the witnesses curriculum vitae, (ii) a written reports from the experts setting forth the substance of the expert's testimony, the opinions of the experts and the grounds for the opinions, and (iii) copies of all documents or materials provided by the practitioner for review by the expert.

No witness may be called on behalf of the practitioner, no testimony or opinions may be elicited from any expert, nor any documents submitted for consideration by the panel, which have not been disclosed in accordance with this section.

Except as specifically provided in this Fair Hearing Plan, there shall be no right to conduct discovery in connection with any hearing, and no practitioner shall be permitted access to or to introduce any evidence of any peer review records, minutes or other documents or information relating to any other practitioner, or any actions taken or not take with regard to any other practitioner(s). The practitioner requesting a hearing shall, however, be entitled to any documents relied on by the Medical Executive Committee or Governing Body in making any recommendation or decision, any documents to be introduced at the hearing, and any medical records relied on or to be introduced at the hearing, so long as the individual and their counsel agree in writing to keep all such documents and their contents confidential. The production of such documents shall not constitute a waiver of any peer review protection for those documents or any other documents.

10 It has also been held that, while access to documents relied upon by the hospital might be appropriate, the physician is not entitled to propound interrogatories or to take depositions prior to the hearing. Huntsville Mem'l Hosp. v. Ernst, 763 S.W.2d 856 (Tex. App. 1988) Further, a number of courts have ruled that a physician was not denied a fair hearing because the hospital refused to allow access to the files of other physicians. Cooper v. Delaware Valley Med. Ctr., 630 A.2d 1 (Pa. Super. 1993), aff'd, 654 A.2d 547 (Pa. 1994); Smith v. Ricks 31 F.3d 1428 (9th Cir. Ariz. 1994), cert. denied, 514 U.S. 1035 (1995). Jackson v. Fulton-DeKalb Hosp. Auth., 423 F. Supp. 1000 (N.D. Ga. 1976), aff'd, 559 F.2d 1214 (5th Cir. 1977); and Woodbury v. McMinnon, 447 F.2d 839 (5th Cir. 1971).
f. **Right of Hearing Panel to request information or evidence.** The hearing panel may call and examine witnesses and receive and examine such exhibits as it deems appropriate on its own initiative, provided all parties involved shall be given reasonable notice of all witnesses or exhibits to be examined by the panel and provided adequate opportunity to challenge or rebut such evidence. The hearing panel may recess any hearing to obtain further information or evidence.

g. **Rules of Evidence** The hearing need not be conducted according to technical rules of evidence relating to admissibility or presentation of evidence and all evidence determined by the hearing officer to be fair, relevant and reliable shall be considered. All testimony shall be presented under oath or affirmation.

**CONSIDERATION OF HEARING PANEL REPORT AND RECOMMENDATIONS BY MEDICAL EXECUTIVE COMMITTEE**

After a hearing is concluded, the hearing panel makes its recommendations which can go to the Medical Executive Committee or directly to the governing body, depending on what the bylaws and fair hearing plan provide. It is recommended that in every case where the hearing is held regarding an adverse recommendation of the Medical Executive Committee, that the report and recommendations of the hearing panel go back to the Medical Executive Committee for review and comment before the matter is considered by the governing body. The reason for this process is that if the hearing panel reaches a different conclusion from the Medical Executive Committee, the Medical Executive Committee should have the opportunity to respond and set forth any reasons why it disagrees with the recommendations of the hearing panel. Having such additional recommendations of the Medical Executive Committee available to the governing body may well provide a basis for the board to act in the “reasonable belief” that the action is justified and is in the furtherance of quality health care. Without further recommendations from the Medical Executive Committee, the governing body would only have the recommendations of the hearing panel for consideration and there may be a concern that there is not an adequate basis to act contrary to the hearing panel recommendations.

In addition, the practitioner should be required to identify in writing recommendations of the hearing panel, or any procedures, with which the practitioner disagrees so that the Medical Executive Committee has the opportunity to consider those complaints and address them. The failure of a practitioner to raise any issue before the Medical Executive Committee may be grounds for a court to hold that the practitioner has waived those issues.

*14. After final adjournment of the hearing, the hearing panel shall make a written report setting forth the findings, conclusions and*
recommendations of the hearing panel, and the basis for the recommendations. A copy of the report shall be sent to the practitioner. The Medical Executive Committee shall consider the report and recommendations of the hearing panel and the Medical Staff President may, in his/her sole discretion, permit or require the practitioner or his/her representative to appear before the Medical Executive Committee to present oral argument or respond to inquiries.

Within fifteen (15) calendar days after receipt of the report and recommendations of the hearing panel, the practitioner shall submit a written statement to the Medical Executive Committee specifying the findings of fact, conclusions and procedural matters with which the practitioner disagrees and the reasons for such disagreement. The practitioner may not submit new information, nor evidence not previously considered by the hearing panel, except as may be requested by the Executive Committee.

**REMAND OF PEER REVIEW RECOMMENDATIONS FOR FURTHER PROCEEDINGS**

There should also be provisions which permit the Medical Executive Committee and the governing body to each remand the matter for further investigation, hearings or recommendations. This could give the governing body a means of remedying any defect or deficiency in the prior proceedings which the practitioner complains of.

15. If additional information or clarification is needed by the Medical Executive Committee, the Committee may remand the case to the hearing panel for any further proceedings. If the Medical Executive Committee refers the matter back to the hearing panel for further consideration, the Medical Executive Committee shall state the reasons for such referral.

Within sixty (60) calendar days after the practitioner’s appearance before the Board, or sixty (60) days after date of the report of the Medical Executive Committee if the practitioner does not appear before the Board, the Governing Body shall act to accept, reject, or accept with modification, the recommendations of the Medical Executive Committee, or refer the matter back to the Medical Executive Committee or the hearing panel for further consideration or investigation. If the Governing Body refers the matter back to the Medical Executive Committee or hearing panel for further consideration, the Governing Body shall state the reasons for such referral.
OBLIGATION TO PAY ATTORNEY FEES

The principal that practitioners who file suit because of unfavorable peer review actions may have to pay attorney fees for the defendants who “substantially prevail” in such actions has been established by HCQIA.\(^{11}\) However, HCQIA permits and awards attorney fees only in the event the action by the physician, or conduct during the litigation, is determined to be “frivolous, unreasonable, without foundation, or in bad faith.”

Since many states treat medical staff bylaws as a contract,\(^{12}\) consideration should be given to a bylaw provision which obligates a practitioner to pay the legal expenses of the hospital, and any individual defendants, in any lawsuit relating to credentialing and peer review if the defendants substantially prevail, regardless of whether there is a determination that the action was frivolous, unreasonable, without foundation or in bad faith. Such provisions are common in contracts. That is a much different standard than awarding attorney fees only when the action is deemed to be frivolous. The presence of such provisions could well deter such unsubstantiated challenges to actions taken by hospitals with regard to medical staff credentialing and peer review. Moreover, it could deter the filing of claims against individuals who participated in the peer review process since the plaintiff would have to substantially prevail against every individual defendant. Such a provision could provide as follows:

16. Payment of Attorney Fees: If any practitioner who is the subject of an adverse recommendation or action in connection with the practitioner’s medical staff membership or clinical privileges initiates a suit against any entity or person who is in any way involved in any peer review, credentialing, recredentialing, corrective action, or other action, recommendation or decision, the practitioner filing the suit shall be required to pay all costs and expenses incurred by each individual defendant in defending the suit, including reasonable attorney fees, unless the practitioner substantially prevails against the individual defendant.

CHIEF OF STAFF DUTIES

In order to provide maximum flexibility, the bylaws should provide that the chief of staff can perform the duties of any other medical staff leader including

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\(^{11}\) 42 U.S.C. §11113
department chairs, section chairs, or committee chairs if the individual is unavailable or otherwise fails to perform their duties.

17. **Chief of Staff Duties** The Chief of Staff, or the Vice Chief of Staff if the Chief of Staff is unavailable, may perform any of the duties of any department chair, section chair, or chair of any Medical Staff committee, if such individual is unavailable or otherwise fails to perform their necessary duties.

**MEDICAL STAFF COMMITTEES**

To provide maximum flexibility, rather than specifying in the medical staff bylaws all of the medical staff committees, the bylaws can simply provide that committees may be established by the medical executive committee with approval of the hospital president and chief executive officer. That permits committees to be created and abolished without amending the bylaws. It also permits the scope, membership, and duties of committees to be revised by the medical executive committee with the approval of the hospital president and CEO without having to go through the entire cumbersome bylaw amendment process.

18. **Medical Staff Committees** The committees of the Medical Staff shall consist of those committees established by these Bylaws and such other committees as may be established by the Medical Executive Committee with the approval of the Hospital President/CEO. The committees established by these Bylaws shall consist of the Medical Executive, Nominating, and Credentials Committees.

There shall be established such joint Hospital/Medical Staff committees as the Medical Executive Committee and the Hospital the Hospital President/CEO shall agree upon to address such issues as infection control, performance improvement, utilization review, pharmacy and therapeutics, and other administrative and clinical issues as may be required by JCAHO or otherwise. The specific membership and duties of joint Hospital/Medical Staff committees shall be established by the Medical Executive Committee subject to the approval of the Hospital President/CEO. The scope, membership and duties of Committees may be revised, and committees may be merged or terminated, by the Medical Executive Committee with the approval of the Hospital President/CEO.

Members of joint committees shall be those practitioners appointed by the Chief of Staff, subject to the approval of the Hospital President/CEO, and those representatives or employees of the
Hospital appointed by the Hospital President/CEO with the approval of the Chief of Staff.

CONFIDENTIALITY

While it is generally understood that members of the medical staff are expected to maintain the confidentiality of the peer review, quality improvement, risk management, utilization review, and other information related to the provision of healthcare services, most bylaws do not provide a sanction for the inappropriate release or disclosure of confidential information. It can be helpful to have a bylaw provision which specifically provides that a medical staff member may be suspended or terminated for improperly releasing confidential information.

19. Confidentiality of Information Each member of the Medical Staff agrees to maintain as confidential all information and documents related to patients’ condition or treatment, peer review, performance improvement and evaluation, risk management, utilization review, and other information related to the evaluation of the provision of health care, or actions or conduct of health care providers. Failure to maintain the confidentiality of confidential information shall be grounds for immediate suspension and/or termination of Medical Staff membership and clinical privileges.

AMENDMENT OF BYLAWS

Bylaws traditionally provide for amendments to be approved by the medical executive committee, then by the full medical staff, and finally by the governing body. Recently, the Joint Commission issued a revised standard MS.01.01.01 that addressed specific issues relating to the amendment of bylaws. In particular, the Joint Commission wanted to provide for a process by which the medical staff could propose bylaw amendment directly to the board of directors without having to first have approval by the medical executive committee. Apparently, the fear of the Joint Commission is that as more members of the medical executive committee become employees or contractors of the hospital, their interest may no longer be aligned to the medical staff. The following provisions provide an amendment process that complies with MS.01.01.01.

It is also advisable to have a provision in the bylaws for amendments to be approved by mail ballots. Often it is difficult to get a quorum which can delay the adoption of important amendments. In addition, calling a special meeting of the medical staff can be cumbersome and waiting until the next regular meeting of the full medical staff can also delay adoption of important bylaw amendments.
Finally, there should be a clear provision specifying when amendments take effect. Such a provision is particularly important with regard to credentialing and peer review matters which may be underway at the time a bylaw is adopted.

20. Proposed bylaw amendments may be sent to the Medical Staff Bylaws Committee for review and comment. All proposed bylaw amendments shall be presented to the Medical Executive Committee which may approve, disapprove or approve with modifications any proposed Bylaw amendment.

2. Bylaw amendments approved by the Medical Executive Committee shall be forwarded to the Board of Directors which shall approve, disapprove or approve with modifications the proposed amendments. If the Board of Directors approves with modifications any bylaw amendments approved by the Medical Executive Committee, such amendments as modified shall be returned to the Medical Executive Committee which may accept or reject the modifications adopted by the Board of Directors. If the Medical Executive Committee rejects the modifications, the amendment shall again be submitted to the Board of Directors which then may either approve or disapprove the amendment as adopted by the Medical Executive Committee. The Medical Executive Committee or the Board of Directors may require that any disputes regarding proposed bylaw amendments be referred to a Joint Conference Committee for discussion and further recommendation to the Medical Executive Committee and the Board of Directors.

3. All proposed amendments approved by the Medical Executive Committee and the Board of Directors shall be subject to approval by majority vote of the members of the Active Staff. Amendments may be presented for approval at the next meeting of the Medical Staff or may be submitted to members of the Active Staff for approval by written or electronic ballot. The Medical Executive Committee shall determine whether to submit the proposed amendments for approval by mail, electronically or at a meeting of the Medical Staff. Bylaw amendments submitted for approval by mail or electronically shall be subject to approval by a majority of the members of the Active Staff submitting written or electronic ballots. Written or electronic ballots shall be prepared and validated in such manner as the Medical Executive Committee shall approve and only ballots received in the Medical Staff Office within twenty one (21) calendar days after the ballots are mailed or electronically sent shall be counted.

4. The Medical Executive Committee shall have the authority to adopt amendments to the Medical Staff Bylaws without approval of the full Medical Staff if such amendments are solely for technical modifications or clarifications, reorganization or renumbering, or to correct grammatical,
spelling, or punctuation errors. Such amendments shall be effective when approved by the Board of Directors. In addition, the Medical Executive Committee may adopt any amendments required for legal reasons or to comply with any regulatory or accreditation requirements. Such technical amendments shall be effective when approved and shall remain in effect unless disapproved by the Board of Directors within sixty (60) days or by the Medical Staff at its next general meeting.

5. Bylaw amendments may also be proposed to the Board by the Medical Staff by majority vote of the members of the Active Staff entitled to vote. Proposed Bylaws may be brought before the Active Medical Staff by petition signed by twenty percent (20%) of the members of the Active Staff. Any such proposed bylaw amendment or rule, regulation policy or procedure approved by a majority of the Active Medical Staff shall be submitted to the Medical Executive Committee for review and comment before such proposed bylaw amendment is presented to the Board.

6. Except as otherwise provided herein, these bylaws, and all amendments to these bylaws, shall be effective at such time as is specified by the Medical Executive Committee and approved by the Board of Directors. Any amendment shall be effective immediately upon approval and shall apply to all pending matters to the extent practical, unless the Board of Directors directs otherwise, regardless of whether any particular Medical Staff member received notice of the amendment. If the Medical Executive Committee and the Board of Directors do not otherwise specify when any bylaw amendments shall be effective, such amendments shall be effective at such time as they are finally approved by the Medical Staff and shall apply to all matters currently pending to the extent practical.

OTHER PROVISIONS

- Provide for approval and removal of Department and Service Chairs by the Governing Body.

- Statement in Bylaws that members of the Medical Staff are part of an Organized Health Care Arrangement (OHCA) as defined by HIPAA.

- No nominations for medical staff or department officers from the floor

- Prohibit Medical Staff leaders (MEC members, Medical Staff officers, Department leaders) from
1. serving as department chair, MEC member or member of governing body of any other health care facility, or

2. having an ownership interest in any competing healthcare facility

- Provisions establishing a process for review by medical staff and approval by CEO or Board of new services or procedures which medical staff members want to perform.
OUTLINE OF MODEL MEDICAL STAFF BYLAWS

ARTICLE I

NAME, PURPOSES, STANDARDS AND APPLICABILITY

1.1. Name.
1.2. Purposes.
1.3. Standards.
1.4. Applicability of these Bylaws
1.5. Organized Health Care Arrangement

ARTICLE II

MEMBERSHIP AND CLINICAL PRIVILEGES

2.1. Medical Staff Membership.
2.2. General Requirements and Criteria.
2.3. Board Certification.
2.4. Non-Discrimination.
2.5. Term of Appointment.
2.6. Provisional Appointment.
2.7. Temporary, Pending, Locum Tenens, Emergency, Disaster and Telemedicine Privileges.
   2.7.1. Temporary Privileges.
   2.7.2. Locum Tenens Privileges.
   2.7.3. Emergency and Disaster Privileges.
      2.7.3.1. Emergency Privileges.
      2.7.3.2. Disaster Privileges.
   2.7.4. Telemedicine Privileges.
   2.7.5. General.
2.9. Leave.
   2.9.1. Voluntary Leave of Absence.
   2.9.2. Medical Leave.
2.10. Allied Healthcare Providers.
2.11. Delineation of Clinical Privileges.
2.12. On-Call and Interpretation Rosters.
2.13. Residents, Fellows and Medical Students.

ARTICLE III

PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

3.1. Pre-Application Questionnaire.
3.2. Grounds for Not Providing Application Form.
3.3. Form of Application.
3.4. Failure to Timely Apply for Reappointment.
3.5. Effect of Application.
3.6. References.
3.7. Processing the Application.
   3.7.1. Applicant’s Burden.
   3.7.2. Medical Staff Comments.
   3.7.3. Completeness and Verification.
   3.7.4. Department and Section Action.
   3.7.5. Credentials Committee Action.
   3.7.6. Medical Executive Committee Action.
   3.7.7. Board of Directors Action.
   3.7.8. Time for Action.
3.8. Reapprication after Adverse Decision or Recommendation.
3.9. Request for Modification of Appointment.

ARTICLE IV
CORRECTIVE ACTION

4.1. Preliminary Investigation.
4.2. Credentials Committee Action.
4.3. Medical Staff Executive Committee Action.
4.4. Board of Directors Action.
4.5. General.
4.7. Medical Records Suspension.
4.8. Automatic Suspension and Termination.
4.9. Attorney Representation.

ARTICLE V
HEARINGS

5.1. Fair Hearing and Appellate Review Plan.
5.2. Adoption and Amendment.
5.3. Action for which no hearing is required.

ARTICLE VI
MEDICAL STAFF CATEGORIES

6.1. Staff Categories.
6.2. Active Staff.
6.3. Courtesy Staff.
6.4. Consulting Staff.
6.5. House Staff.
6.6. Community Care Staff.
6.7. Honorary Staff.
6.8. Outside Consultants
ARTICLE VII
DEPARTMENTS AND SECTIONS

7.1. Departments.
7.2 Sections.
7.3. Assignment to Departments and Sections.
7.4. Functions of Departments and Sections.
7.5. Department Officers.
    7.5.2. Duties of Department Officers.
        7.5.2.1. Chairs.
        7.5.2.2. Vice Chair.
        7.5.2.3. Unavailability of Chair or Vice-Chair.
    7.5.3. Vacancies.
7.6. Nomination and Election of Department and Section Officers.
7.8. Removal of Department or Section Officers.

ARTICLE VIII
MEDICAL STAFF OFFICERS

8.1. Officers and Qualifications.
8.2. Elections.
8.3. Nominations.
8.4. Vacancies.
8.5. Removal of Officers.
8.6. Duties.
    8.6.1. President.
    8.6.2. President-elect.
    8.6.3. Secretary-Treasurer.
    8.6.4. Past-President.

ARTICLE IX
COMMITTEES

9.1. Medical Staff Committees.
    9.1.4.1. Bylaws Committee.
        9.1.4.1.1. Membership.
        9.1.4.1.2. Duties.
        9.1.4.1.3. Meetings.
    9.1.4.2. Credentials Committee.
        9.1.4.2.1. Membership.
        9.1.4.2.2. Duties.
        9.1.4.2.3. Meetings.
    9.1.4.3. Medical Executive Committee.
        9.1.4.3.1. Membership.
        9.1.4.3.2. Duties.
        9.1.4.3.3. Meetings.
    9.1.4.4. Nominating Committee.
        9.1.4.4.1. Membership.
9.1.4.4.2. Duties.
9.1.4.4.3. Meetings.

9.2. Joint Conference Committee:
9.3. Joint Medical Staff-Hospital Committees.
9.4. Vacancies on Committees.
9.5. Ex-Officio, Non-Voting Members.

ARTICLE X
MEDICAL STAFF MEETINGS

10.1. General Staff Meetings.
    10.1.1. Annual Meeting.
    10.1.2. Regular Meetings.
    10.1.3. Special Meetings.
    10.1.4. Order of Business and Agenda.
10.2. Department and Committee Meetings.
    10.2.1. Regular Meetings.
    10.2.2. Special Meetings.
10.3. Notice of Meetings.
    10.3.1. General Medical Staff Meetings.
    10.3.2. Other Regular Meetings.
    10.3.3. Special Meetings.
    10.3.4. Form of Notice.
10.4. Emergency Meetings.
10.5. Quorum.
    10.5.1. General Staff Meetings.
    10.5.2. Department, Section, and Committee Meetings.
10.7. Minutes.
10.8. Attendance.
10.9. Meeting Attendance Requirements.
10.10. Procedure.

ARTICLE XI
GENERAL

11.2. Review of Rules, Regulations and Bylaws.
11.3. Confidentiality of Information.
11.4. Dues and Assessments.
11.5. Status of Bylaws.
11.6. Conflicts with Other Documents.
11.7. Privilege and Immunity.

ARTICLE XII
AMENDMENT OF BYLAWS
ARTICLE I

1.1. Purposes
1.2. Right to Hearing
1.3. Request for Hearing

ARTICLE II

HEARING PROCEDURES

2.1. Appointment of Panel Members
2.2. Notice to Practitioner of Hearing Date
2.3. Notification of Prospective Panel Members
2.4. Notification of Reasons for Proposed Action, Witnesses and Summary of Hearing Rights
2.5. Hearing Officer
2.6. Burden of Proof
2.7. Report and Recommendations of Hearing Panel
2.8. Practitioner Response to Report and Recommendations
2.9. Appearance Before Medical Executive Committee
2.10. Medical Executive Committee Action
2.11. Board of Directors Action

ARTICLE III

APPELLATE REVIEW

3.1. Request for Appellate Review
3.2. Written Statement of Practitioner
3.3. Notice of Appearance Before Board
3.4. Oral Argument before Board of Directors
3.5. Action by Board of Directors
3.6. Reconsideration by Medical Executive Committee
3.7. Final Action by Board of Directors
3.8. Notification of Board Action
3.9. Written Statement from Board
3.10. Effective Date

ARTICLE IV

GENERAL PROVISIONS

4.1. Timely Objections to Actions
4.2. Attorney Representation
4.3. Medical Staff Representative
4.4. Hearing Date and Notice
4.5. Presence of Practitioner
4.6. Examination and Cross Examination of Witnesses
4.7. Testimony of Practitioner
4.8. Evidence and Testimony Requested by Hearing Panel
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<tr>
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