



Medical Staff Boot Camp: Rights and Responsibilities of Medical Staff

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Medical Staff Boot Camp: Rights and Responsibilities of the Medical Staff

I. Introduction

The organized medical staff at a North Carolina hospital is a legally recognized entity, a body with its own existence, powers, privileges, and responsibilities. Whether it exercises its prerogatives effectively and fulfills its duties depends on two things: (1) the extent of its legal powers, and (2) the degree to which it chooses to use them.

The organized medical staff shares responsibility for the hospital's operations with two other groups, the hospital's governing body (its board of trustees) and its administration. The relationship among these three is a checks-and-balances system that works best when each appreciates and fulfills its role, while respecting the roles of the other two.

As in any such system, with the classic American example being the balance among the legislature, the executive and the judiciary, each group in the system will compete with the others and fill the others' roles if they cede their places. Just as in the American political system, it is easiest for the executive – here the hospital administration – to fill roles better allotted to the others, but each group can, in fact, overstep and hurt the hospital.

This paper and the accompanying presentation will identify the legal powers and responsibilities of the medical staff and discuss practical ways in which the staff can use them in concert or in healthy competition with the administration and the governing body.

The authors conclude the organized medical staff has the right to be well informed about the hospital's operations and the right to guide (but not dictate) these operations to the benefit of the patients, the hospital, and the medical staff. In a well-run hospital, the staff will use its powers, but if the staff neglects its powers, the hospital, patients, and staff will suffer.

II. Executive Summary

A. The medical staff is a legal entity. We know this because it is recognized in state law, federal conditions of participation and The Joint Commission Standards. Each of these sources expresses the idea differently, but in combination, they are compelling proof that the staff has an existence and rights of its own.



B. As a legal entity, the medical staff can make a contract. North Carolina law recognizes this. There is a N.C. case – *Virmani v. Presbyterian Health Services Corp.* -- which says so.

C. The medical staff bylaws are a contract between the staff and the hospital. We know this because the *Virmani* case says so. Rights and responsibilities granted in the bylaws are legally enforceable.

D. What rights and responsibilities should be in the staff bylaws? Some rights and responsibilities are required by state law, federal conditions of participation or The Joint Commission standards. Some are explicitly given to the hospital administration or its governing body. Others are negotiable. The staff should seek all the rights and responsibilities it needs to ensure quality care, patient safety, and a sound medical staff.

E. How can the staff get, keep, and enforce the rights and responsibilities it needs?
A well run and effective staff will do the following:

1. Engage and represent its members.
2. Understand its rights and prerogatives.
3. Advocate for its members and their patients.
4. Be seen to engage the administration and the governing body.
5. Politick for its members and their patients.
6. Insist on its rights and prerogatives.
7. Take a long view.
8. Prepare and present bylaws that reflect its rights and prerogatives.
9. Hold its officers and leaders accountable.

F. What are some of the issues or problems which the medical staff must address from time to time, in light of the staff's legal and contractual rights and obligations?

1. Limitations on qualified right of medical staff to self-governance
2. Eligibility criteria for medical staff membership and privileges
3. Right of individual physician to fair hearing
4. Effects of hospital exclusive contracts on medical staff membership and privileges
5. Effects of economic credentialing on medical staff membership and privileges
6. Discoverability of peer review information
7. Physician responsibility for on call coverage
8. Topics to be addressed in drafting medical staff bylaws

III. Sources of Medical Staff Authority and Responsibility

These are basic sources of the organized medical staff's rights and duties.



1. North Carolina State Statutes, Regulations & Case Law
2. Federal Law & Regulations
 - Medicare Conditions of Participation
 - Health Care Quality Improvement Act
3. The Joint Commission Standards
4. Medical Staff Bylaws, Rules & Regulations
5. Professional Education & Clinical Expertise

Most of these sources are formal and written, but the last is a very practical one. The staff's professional education and clinical expertise give it the preeminent ability to make recommendations and decisions about patient care, peer review, credentialing, and membership.

IV. Constraints on Medical Staff Authority & Responsibility

The first constraint on the medical staff's authority and responsibility is, of course, the power granted by law, policy or agreement to the other parties, namely, the governing body and the administration. To the extent the government, the Joint Commission, and the bylaws grant power to the hospital administration or its governing body, such grants limit what the medical staff can or even should do.

The second constraint is, however, entirely practical. The medical staff lacks three things the administration has plenty of: time, operational expertise, and continuity. Whereas the medical staff operates on a volunteer basis, and its leadership must split its time between medical practice, on one hand, and staff work, on the other, the administration works full time, for salary, on hospital operations. Further, the administration has more business and management training than most physicians. Finally, administrators expect to serve continuously for years in a system with lines of responsibility and authority leading to a chief executive. All of this gives the administration a practical power that the staff does not naturally have.

It is worth noting that the governing body also has practical constraints on it similar to those on the staff. Its members are largely volunteers. They generally have other daily responsibilities. They often do not have business backgrounds or, at least, healthcare business backgrounds. The governing body's membership probably turns over more often than the administration. All these make it harder for the governing body to operate as it might want to.



Still, the governing body has ultimate legal power and responsibility in several key respects (see below). So, in the authors' experience, unhealthy competition between the administration and the organized medical staff often turns into competition for the governing body's attention, trust, and deference.

IV. State Law & Regulations

In North Carolina, by legal definition, a hospital must have an "organized medical staff." N.C. Gen. Stat. § 131E-76(3). Quite simply, no organized staff means no hospital. See also, 10A NCAC 13B.3201(3). This medical staff consists of all the individuals who have sought and obtained clinical privileges at the facility. 10A NCAC 13B.3001(23).

Among the medical staff's prerogatives is the power to create a "medical review committee" to evaluate the quality, cost or need for hospitalization or health care. N.C. Gen. Stat. § 131E-76(5). (Interestingly, this is a power the staff shares with the governing body. Either the medical staff or the governing body alone may create a medical review committee. *Id.* The administration alone cannot.) This power to create a medical review committee implies the extent of the medical staff's power over clinical matters at the hospital. As the statute suggests, it is not an exclusive power, but it is a power that cannot be taken away.

The medical staff also has the power to write bylaws, rules, and regulations which all staff members must obey. The law says physicians and others with clinical privileges "shall comply with all applicable medical staff bylaws, rules and regulations." N.C. Gen. Stat. § 131E-85(d). This is mandatory.

Two things follow from this basic law. First, as we have said above, the medical staff is a legally recognized entity, a thing in the law, a body in and of itself. It is capable of doing things, making decisions, appointing committees, writing bylaws, rules, and regulations, and setting standards for hospital operations. In North Carolina medical staffs have from time to time set dues for members, hired separate counsel, and otherwise acted as an independent organization. While we are not aware of it being done in North Carolina, we know that lawyers in other states have counseled medical staffs to incorporate as not-for-profit corporations. Whether or not this is a good idea, it demonstrates the staff's separate identity.

Second, as the North Carolina Court of Appeals held in *Virmani v. Presbyterian Health Services Corp.*, 127 N.C. App. 71, 488 S.E.2d 284 (1997), *disc. review denied*, 347 N.C. 141, 492 S.E.2d 38 (1997), the hospital medical staff bylaws are a contract between the hospital and the physicians who are members of the medical staff. This decision has been reaffirmed.

[I]f a hospital's offer to extend staff privileges to a physician includes a condition that the physician adhere to certain bylaws, and if the physician accepts the hospital's offer, then those bylaws become part of a contract between the hospital



and the physician. *Virmani*, at 76 & 77, 488 S.E.2d at 288. We [the Court of Appeals] adhere to the principle of law articulated in *Virmani* that a claim for breach of contract may arise from an employer's failure to adhere to its bylaws.

Lohrmann v. Iredell Memorial Hospital Incorporated, 174 N.C. App. 63, ___ S.E.2d ___ (2005). The interesting and important conclusion here is that the organized medical staff, by writing staff bylaws which the governing body accepts, can write a contract which both the hospital and all of the staff's individual members must obey. It follows also that to the extent the bylaws describe the powers and prerogatives of the staff *vis a vis* the hospital, these powers and prerogatives are also part of a contract between the organized staff and the hospital.

Having said this, it must also be said that the hospital's governing body is the "final authority to which the administrator, the medical staff, the personnel and the auxiliary organizations are directly or indirectly responsible." 10A NCAC 13B.3501. The governing body retains the right and duty to review and approve the medical staff bylaws, 10A NCAC 13B.3502(a)(6), so the medical staff cannot unilaterally create the contract that governs it and its members relationship with the hospital. See also 10A NCAC 13B.3705(a). This is not strange; most contracts are bilateral.

However, regardless of its ultimate authority, the governing body is not unfettered. The governing body must delegate to the medical staff the authority to evaluate its members' competence and privileges and to recommend medical staff appointments and reappointments. 10A NCAC 13B.3503(10). Moreover, the governing body must "maintain effective communication with the medical staff" by, among other things, meeting with the medical staff executive committee ("MEC") and by placing the president of the medical staff on the governing body (though not necessarily as a voting member). 10A NCAC 13B.3503(12). Thus, the MEC sits at the intersection between the medical staff as a whole and the governing body. It must also be noted that the MEC "acts for the medical staff," 10A NCAC 13B.3706(b), so the medical staff may delegate most of its powers to the MEC. To the extent the organized medical staff explicitly or tacitly defers to the MEC, the MEC can bind the medical staff without much staff input.

Conclusion. Let's sum up the effect of state law and regs on the organized medical staff. The staff is an independent body. Through its MEC, it has direct access to the governing body and the right to be heard by it. The medical staff has original, direct and explicit, but not sole, authority over clinical care. Through its bylaws, it can contract with the hospital's governing body and the administration. All this gives the medical staff considerable authority and influence, if it chooses to use it.

V. Federal Law and Regulations



A. Medicare Conditions of Participation

Federal Medicare Conditions of Participation (“COP”), are found in the Code of Federal Regulations, and they have considerable effect on medical staff operations at participating hospitals. As with state law and regulations, the COP speak variously to the medical staff, the governing body, and the administration. As with state law and regulations, the final authority often lies with governing body, but the medical staff has a lot of power when it comes to its own operations and to patient care and related matters.

Hospital governing body. The COP make the governing body “legally responsible for the conduct of the hospital as an institution.” 42 CFR § 482.12. The COP assign to the governing body various explicit duties regarding the administration and the medical staff. As to administration, the governing body “must” appoint a chief executive “responsible for managing the hospital.” 42 CFR § 482.12(b). As to the staff, it “must” approve the manner in which the staff is organized. 42 CFR § 482.22(b)(1). It “must” also involve both (i) the administration and (ii) the medical staff in the development and review of the hospital’s annual operating budget and significant capital expenditures. 42 CFR § 482.12(d). Likewise, the governing body needs to see that the administration and the medical staff are both “responsible and accountable” for quality assurance and safety. 42 CFR § 482.21(e).

Turning to the governing body’s authority and responsibility *vis a vis* the medical staff, in addition to involving the staff in the operating budget and the capital budget, it “must” also, among other things, do this:

1. Ensure that the medical staff is accountable for quality patient care;
2. Ensure that the medical staff has bylaws;
3. Approve the medical staff bylaws;
4. Ensure the criteria for medical staff membership are
 - a. Character,
 - b. Competence,
 - c. Training,
 - d. Experience, and
 - e. Judgment; and
5. Appoint the members of the staff after considering the recommendations of the present staff.

See 42 CFR § 482.12(a).

Hospital administration. The COP say less about hospital administration than about either the governing body or the medical staff. As we have mentioned, there has to be a chief executive officer, and the administration has to be involved in planning the operating and capital budget. There are also COP for other essentially administrative functions such as medical



records, food and diet, and the physical environment. See 42 CFR §§ 482.24, 482.28 & 482.41. However, most administrative functions are assumed, not expressed, in the COP.

Medical staff. Turning to the COP for the medical staff, we have, of course, seen what they say about the governing body's duties and powers in relation to the staff. We have also seen the administration has little express authority *vis a vis* the staff. We have seen the staff is in some instances described as a partner to administration, as for example, when it and the administration are both involved in planning the annual budgets.

As to the staff's express duties and powers, the COP say the organized medical staff "is responsible for the quality of the medical care provided to patients by the hospital." 42 CFR § 482.22. The staff must appraise its members, and it must examine its candidates and recommend them for membership to the governing body. 42 CFR § 482.22(a). It must adopt and enforce its bylaws, which must describe the qualifications for staff membership. 42 CFR § 482.22(c). If there is an executive committee of the medical staff, it must be composed primarily of physicians (MDs and DOs), and ultimate responsibility for the organization and conduct of the staff must lie with an individual physician as its principal officer. 42 CFR § 482.22(b).

Nothing about the COP is fundamentally inconsistent with the conclusion that the medical staff is an entity with its own existence, powers and duties. Perhaps we should put this in the affirmative. The COP are consistent with the medical staff's separate existence, special powers, and unique responsibilities.

B. Health Care Quality Improvement Act

The federal Health Care Quality Improvement Act, 42 USC §§ 11101, *et seq.*, does not, strictly speaking, create legal rights or duties for the hospital's medical staff or its members, but the Act does protect staff members who participate in a professional review action involving another physician's clinical privileges, including his or her membership on a hospital medical staff. See 42 USC §§ 11111 & 11151(3). As such, the Act should define the scope and procedures in the hospital's fair hearing plan, which in turn should be part of the bylaws, adopted by the staff and approved by the governing body. By protecting the people who participate properly in the review action, and by denying protection to people who participate improperly, the Act affects the way the staff operates in fulfilling one of its key duties. Hence, the Act deserves discussion in this paper.

In simplest terms, the Act is in two parts. The first describes how a professional review action, which includes a medical staff fair hearing, should be conducted. These procedures and standards are as follows. There must be:

1. A reasonable effort to get the facts;



2. Adequate notice to the physician who is the subject of the hearing;
3. Fair, adequate hearing procedures (with due regard to all the circumstances);
4. A reasonable belief that the facts known after 2.& 3. warrant the action taken; and
5. A reasonable belief that the action taken furthers quality health care.

See 42 USC § 11112(a). Adequate notice means giving the physician:

1. Notice that a professional review action is proposed;
2. Notice of the reasons for the proposed action;
3. Notice of the physician's right to request a hearing;
4. Notice of any deadline for requesting a hearing;
5. If a hearing is requested, at least 30 days notice of the hearing date; and
6. If a hearing is requested, a list of witnesses against the physician.

See 42 USC 11112(b)(1)&(2). An adequate hearing means giving the physician:

1. An acceptable arbitrator, impartial hearing officer, or impartial hearing panel (i.e., a hearing officer or panel that is not in direct economic competition with the physician);
2. The right to be represented by counsel or another person;
3. The right to a transcript of the hearing, at reasonable cost;
4. The right to call, examine, and cross-examine witnesses;
5. The right to submit evidence, unfettered by the strict rules of evidence; and
6. The right to submit a written statement at the end of the hearing..

See 42 USC § 11112(b)(3)(A)-(C). An adequate hearing also leads to a written recommendation by the arbitrator, hearing officer or hearing panel and a written decision by the ultimate decision maker. Each writing needs to state its basis. See 42 USC § 11112(b)(3)(D). However, these procedures may be skipped or truncated in the case of a short (14-day) summary suspension or in the case of an emergency. 42 USC § 11112(c).

The second key part of the Act protects the following people from liability for damages, provided they have participated in a professional review action that meets the standards set out in the Act and summarized above:

1. The professional review body itself;
2. Any person acting as a member of or as staff to the review body;
3. Any person under contract to the body; and
4. Any person who participates with or assists the body with respect to the action.



See 42 USC § 11111(a). Since the organized medical staff enforces its criteria for staff membership and clinical privileges through the fair hearing process, it makes sense to say that the Act describes the powers and duties of the staff as it fulfills this major responsibility.

Most of the requirements and standards in the Act are straight-forward. Most are followed without much trouble. A few do cause problems from time to time. In order to protect the members of the medical staff and the hospital administration, which participates or assists in the hearing, it is important to be sure the action bears a reasonable relation to quality health care, not just to business, and certainly not to personal animosities or interests. It is important that the notice give a good summary of the issues. And it is vitally important that the hearing officer and hearing panel members are *not* in direct economic competition with the physician who is the subject of the hearing.

VI. Joint Commission Standards

The Joint Commission, formerly the Joint Commission on Accreditation of Healthcare Organizations, surveys and accredits hospitals “to continuously improve the safety and quality of care provided to the public.” It publishes Standards concerning many aspects of patient care and hospital operations, including Standards for “leadership” and for the “medical staff.” Each Standard is supported by a Rationale, and each is measured according to one or more Elements of Performance. The source for the Standards, Rationales and Elements of Performance cited in this paper is The Joint Commission’s *Comprehensive Accreditation Manual for Hospitals: The Official Handbook*, effective January, 2009 (hereafter the “*Joint Commission Handbook*”).

Leadership Standards. Leadership is divided between the governing body, management (which we will refer to hereafter as administration, in keeping with our usage in the rest of this paper), and the organized medical staff. Most of the leadership Standards actually apply to the governing body and the administration, but leadership Standard LD.01.05.01 covers the medical staff, and, in addition, there is an entire separate set of Standards that also pertain exclusively to the staff. As under state law and the COP, the governing body “is ultimately accountable for the safety and quality of care, treatment and services” at the hospital. LD.01.03.01. Among the Elements of Performance (hereafter EP) of this Standard, the governing body:

1. Selects the chief executive;
2. Provides the hospital with the necessary resources;
3. Provides the organized medical staff with the opportunity to participate in hospital governance;
4. Provides the organized medical staff the opportunity to be represented at the governing body’s meetings by one or more of the staff’s own members, selected by the staff itself, which representatives must be allowed to attend and speak; and



5. Must permit medical staff members to serve on it, the governing body, unless legally prohibited.

The governing body must communicate with the administration and with the medical staff, and *vice versa*. LD.02.03.01. It and the other leaders are to use data and information to make their decisions. LD.03.02.01. It, and other leaders, solicit information and comments from others, as appropriate, to prepare the operating and capital budgets. LD.04.01.03; EP 1. All these Standards are consistent with state law and the COP.

Medical Staff Standards. The basis for The Joint Commission Standards for the Medical Staff lies in Standard for Leadership LD.01.05.01 and its Elements of Performance. They say there is to be a single organized staff, which is “self-governing,” “oversees the quality of care, treatment and services,” and is “accountable to the governing body.” However, the rest of the Standards for the medical staff are found elsewhere in the *Joint Commission Handbook*.

Consistent with what we have said already, the medical staff bylaws are key to the powers of the medical staff. They describe the staff’s self-governance and also its accountability to the governing body. MS.01.01.01. The Elements of Performance for this Standard say the staff develops, adopts, amends, enforces and complies with its bylaws, while the governing body approves *and also complies* with them. MS.01.01.01, EP 1-4. The idea that both the staff and the governing body must comply with the staff bylaws is consistent with the idea that the adopted and approved bylaws create a contract between the staff and the governing body. Likewise, it is also consistent with this idea of a contract that “*neither the organized medical staff nor the governing body may unilaterally amend the medical staff bylaws or rules and regulations.*” MS.01.01.03. In the eyes of The Joint Commission, a medical staff and governing body that cannot agree on bylaw amendments have “evidenced a breakdown in the *required* collaborative relationship.” Rationale for MS.01.01.03 (emphasis added).

From an operational point of view, in all but the smallest hospitals, the organized medical staff has to have a medical executive committee (MEC). MS.02.01.01. The MEC has “primary authority” over the staff’s self-government and for improving the performance of licensed practitioners with hospital privileges. Rationale for MS.02.01.01. Under this Joint Commission Standard, the MEC also provides the staff with an opportunity to interact with the administration, because the hospital CEO (or designee) is to attend each MEC meeting. MS.02.01.01, EP 2. This is very useful prerogative, and the MEC ought to insist on it being followed.

Equally important, the Elements of Performance of this Joint Commission Standard give the MEC the right to make recommendations “directly to the governing body” with respect to:

1. Medical staff membership;
2. The structure of the organized medical staff;
3. The process for reviewing credentials and delineating privileges;



4. Each practitioner's delineated privileges; and
5. Staff committee and department reports.

MS.02.01.01, EP 8, 9, 10, 11 & 12. The bylaws could, of course, give the MEC even greater direct access to the board.

Another important aspect of the organized staff's duties under The Joint Commission's Standards is the medical staff's responsibility to establish standards for and oversee patient care, treatment, and services provided by practitioners who have privileges. MS.03.01.01 and Rationale. And, similarly, it is necessary that the organized staff be "actively involved in the measurement, assessment and improvement" of most aspects of patient care, including medication, blood products, operative procedures, clinical practice patterns, sentinel events, and patient safety. MS.05.01.01, EP 4, 5, 6, 7, 8, 10 & 11.

Conclusion. We would summarize these medical staff powers under The Joint Commission Standards by saying the organized medical staff, usually operating through the MEC, has a right to know about most aspects of the hospital's operations, because most aspects of hospital operations affect patient care or staff functions. This right is enforceable because the staff's representative(s) may attend the governing body's meetings, and because the MEC may insist that the CEO (or designee) shall attend MEC meetings. The staff also has a duty to advise the other members of hospital leadership; this duty flows through nearly all of the Standards, Rationales and Elements described above. Finally, the staff has a right to be heard, which is most clearly stated in the Elements for Standard LD.01.03.01; they say the MEC representative(s) must be allowed to attend and to speak at the governing body's meetings. All this is congruent with the idea of checks and balances that flows through this paper. All this matters on a day-to-day basis because a hospital that is seriously out of compliance with The Joint Commission Standards is in danger of losing its certification.

VII. Medical Staff Bylaws, Rules, and Regulations

We have said before that, in North Carolina and many other places, the bylaws are, or at least can be, a contract between the medical staff members and the hospital. It follows they also are, or can be, a contract between the staff as an organization and the hospital. As long as the bylaws are a contract, the organized medical staff has a solid place to stand and advocate for patients and for its members.

Of course, even if the bylaws are a contract, the contract is no better than its terms. This part of the paper will point out some issues that ought to be addressed in the bylaws to give the medical staff the authority it is supposed to exercise under the Conditions of Participation and The Joint Commission Standards.



A. Acknowledge a Contractual Relationship

Bylaws should contain a clause acknowledging that they constitute a contract between the hospital and the organized medical staff as an entity, as well as a contract between the hospital and individual members of the staff.

If either the staff or the hospital would prefer not to have the bylaws expressly described in contractual terms, it would still be important for the bylaws to say the hospital, the organized staff, and its members individually all acknowledge they are bound by them.

Conversely, and in light of *Virmani*, the bylaws should not purport to deny a contractual relationship between the hospital and the staff, as an entity and as individuals. In other words, the bylaws should not attempt to avoid the decision in *Virmani*.

Applicants to the staff are a special case. In North Carolina, consistent with *Virmani*, the bylaws could state they do not constitute a contract between the hospital, the staff or the staff members, on one hand, and an applicant to the staff, on the other hand. Still, everyone does want applicants to be bound by the bylaws. Both the bylaws themselves and the application for membership could address their specific effect on applicants.

B. Acknowledge the Adoption and Amendment Process and Authority

As we mentioned above, The Joint Commission Standards say the medical staff adopts, amends and complies with its bylaws, while the governing body approves and complies with them. State law and the Conditions of Participation are generally to the same effect. The bylaws should clearly restate this division of authority. It would also be very important to say the bylaws cannot be amended unilaterally by the governing body.

In a related point, it would be important to say the governing body cannot adopt hospital bylaws, rules or regulations that are inconsistent with the medical staff bylaws or enforce them when to do so would violate or contradict the bylaws.

While the governing body has, and must have, the right to approve the bylaws and amendments, there is no reason why the governing body cannot agree to a deadline for approving amendments. The bylaws could, for example, say that any amendment adopted by the medical staff is deemed approved and becomes effective automatically, unless the governing body votes to disapprove it within a reasonable period of time. The idea is to prevent the governing body's "pocket veto" of an amendment the organized staff has adopted.



C. Medical Matters

The Joint Commission Standards and the federal Conditions of Participation clearly give the organized staff the right to set the qualifications for staff membership, create the categories for staff membership, establish the mechanism for granting clinical privileges, and conduct the inquiry and hearing that may lead to the loss or membership or privileges. The organized staff should carefully and clearly delineate all these matters in the bylaws, using as closely as possible the language of the Joint Commission and the COP and being careful to keep the protection of HCQIA. As is said above, the staff's greatest strength is its medical education and clinical expertise. It must not abdicate this.

D. Business Matters

In modern American healthcare, hospitals and physicians have real economic interests, with unavoidable conflicts between hospitals, between physicians, and between hospitals and physicians.

Economic Credentialing. The AMA suggests the bylaws should forbid economic credentialing, defined by the AMA 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 medical staff membership or privileges." American Medical Association, *Physician's Guide to Medical Staff Organization Bylaws* (4th Ed.), page 22.

Conflict of Interest. Given that conflicts are likely and some conflicts are unavoidable, the AMA suggests the bylaws should not be used as a means to limit competition by restricting membership and privileges. The AMA's *Conflict of Interest Guidelines for Organized Medical Staffs* (2007) say as follows: "Medical staff bylaws shall state that neither the existence of a conflict of interest, nor the disclosure thereof, shall affect [organized medical staff] membership or privileges." Instead, personal and financial conflicts on the part of staff members and officers shall be handled by (1) disclosure, (2) abstention, or (3) recusal, appropriate to the seriousness of the conflict.

Exclusive credentialing. Medical staff bylaws should not require a physician to be a member of *only* that particular hospital's staff. To do otherwise might affect patient care.

Employed or Contracted Physicians. Medical staff bylaws should address the possibility of hospital-employed or hospital-contracted physicians. Issues to consider are whether the employed physicians should be eligible for staff leadership positions, and whether they should have exclusive credentials for certain procedures or services (i.e., the staff shall be closed to other physicians in this specialty).



E. Professional Matters

The medical staff properly must monitor and enforce adequate professional conduct, for the good of the patients and public.

Ethics. Bylaws should refer specifically to a published set of professional ethical standards, such as the *AMA Code of Medical Ethics*. This provides clarity and objectivity. Felony crimes and misdemeanors that reflect on fundamental honesty are appropriate subjects for medical staff action.

Conduct. Bylaws should link physician conduct to its actual or reasonably foreseeable effect on patient care. Only conduct that does, or could reasonably be expected to, adversely affect patient care should be material to medical staff membership and privileges.

VII. Examples of Some Typical Medical Staff Issues

A. CMS Certification

Riverdale Hospital is out of compliance with certain conditions of participation. CMS says corrective action will be needed to avoid decertification.

What authority and prerogatives should the organized medical staff have to ensure timely corrective action is taken at Riverdale?

B. Allied Professionals and Staff

Metropolis Hospital has too few nurses on a med-surg ward during the night shift. Some of these nurses are inexperienced. A post-surgical patient (knee replacement) is found walking the halls at midnight some 15 hours following surgery. A novice LPN puts the patient back to bed and sedates him. The LPN does not call a physician or a senior nurse. In the morning the patient is found dead in his bed.

What authority and prerogatives should the organized medical staff have to help avoid such an event at Metropolis? To correct things so it does not happen again?



C. Closed Staff and Exclusive Contracts

Smallville Hospital has for years awarded exclusive contracts to practices that provide anesthesia, radiology, pathology and emergency medicine. Now Smallville would like to offer an exclusive contract to a single cardiovascular surgery practice to do all open heart procedures. At present there are three groups whose surgeons have heart privileges at Smallville. Suppose as well:

1. At present none of the surgeons with privileges is fully busy doing hearts; there is not enough work for them all.

2. There are different mortality and morbidity rates among the present surgeons, ranging from good to below national averages.

3. Smallville means to award the contract on the basis of an open competition and to solicit proposals from the existing three groups and any others which want to compete for the contract.

Only the winning group would have heart privileges at Smallville. Other existing surgeons would have to surrender their privileges.

What role should the organized staff have in such a proposal?

D. Employed Physicians

Gotham City Hospital decides to offer employment to all the primary care physicians on its staff and to recruit additional PCPs for employment, as well. Any physician who accepts employment will be asked to agree to automatically and immediately resign from the Gotham's medical staff, without appeal and hearing rights, (i) in the event the physician resigns employment *without* cause or (ii) in the event the physician is terminated from employment *for* cause.

How might the medial staff address such a proposal?

E. Conflicts of Interest.

Dr. No is President of the Medical Staff at Fleming-Bond Memorial Hospital. Dr. No is also a gastroenterologist whose group has its own, free-standing, endoscopy suite. Fleming-Bond Hospital's governing body wants to exclude any person who, in its



judgment, has an economic conflict of interest from any part of its meetings that relate to the potential development or expansion of any of the hospital's service lines.

Should the organized staff accede to any attempt to block Dr. No from these parts of the governing body's meetings? Must it?

F. Disruptive Behavior

Dr. Who at Tardis Hospital is distant, haughty, curt, and dismissive to everyone from the administrator to the folks behind the Starbuck's counter. Dr. Who is not loud, profane, obscene or violent. Two other doctors in the same specialty, but from a different practice, accuse Dr. Who of being disruptive after he corrects a nurse in public and walks off without hearing the nurse's explanation. Assume the nurse is a good nurse, but also assume Dr. Who had reason to be concerned about the nurse's work in this case.

What should the organized medical staff do about this complaint?