

**NCMS MODEL MEDICAL STAFF BYLAWS**  
**Annotated**

## INTRODUCTION TO THE MODEL BYLAWS

North Carolina Medical Staffs are large and small, in rural and urban settings, offering specialty and tertiary general care, on a community and academic basis. To serve this diversity, the NCMS Model Medical Staff Bylaws includes options so that each Medical Staff can use the Model as best suits the needs of that particular Medical Staff. Wording in brackets [like this] are options from which the Medical Staff can choose the best solution for its problems or circumstances.

### Sources

Abbreviations for the following frequently referenced sources are used in annotations supporting the provisions of the Model:

AMA Policy Compendium	Policy of the American Medical Association
NCRule(s)	North Carolina Administrative Code
NC Gen Stat	General Statutes of North Carolina
HCQIA	Federal Health Care Quality Improvement Act of 1986
DNV Standard	DNV's National Integrated Accreditation for Healthcare Organizations (NIAHOSM) Requirements
JC Standard	2011 Joint Commission Standards for the Accreditation of Hospitals
NCMS Policy	Policy of the North Carolina Medical Society

*See the Table of Authorities on page 107 immediately following the Model for full citations to cases, statutes and other resources for physicians, Medical Staffs and their attorneys.*

### Disclaimer

**The Model Bylaws are provided for the information and education of North Carolina physicians and Medical Staffs regarding the requirements for Medical Staff organization documents and should not be construed as legal advice. No Medical Staff should consider this document to be mandatory for its adoption or use. Rather, the Model provides approaches for Medical Staffs to consider when faced with the challenges of compliance with the many laws, regulations and standards governing Medical Staff bylaws. Medical Staffs are encouraged to consult with an independent Medical Staff attorney when considering or developing Medical Staff bylaws, rules and regulations and any amendments to any Medical Staff organization documents.**

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## [PREAMBLE]

Recognizing that the Medical Staff is responsible for the quality of patient care<sup>1</sup>, [education and research] in the [ ] hospital; and that the hospital has a duty to rely upon the judgment and recommendations of the Medical Staff in such matters; and recognizing that mutually cooperative efforts of the medical staff and the hospital governing body are necessary to fulfill the standards of quality patient care within the hospital set by the Medical Staff,<sup>2</sup> the physicians[,] [and] dentists, optometrists and podiatrists practicing in this hospital hereby organize themselves in conformity with these bylaws to initiate and maintain self-government of the Medical Staff and thereby determine all matters pertaining to medical care in the hospital; to act on all matters of professional ethics and of patient care quality; and to determine all qualifications for Medical Staff membership and for clinical privileges.]

## ARTICLE I- TERMS & PURPOSES

### A. Purposes<sup>3</sup> of the Medical Staff Organization

The purposes of this organization are:

1. To engage in performance improvement activities that promote quality care for all patients admitted to or treated in any of the facilities, departments or services of the hospital;<sup>4</sup>
2. To determine the mechanisms for establishing and enforcing criteria for delegating oversight responsibilities to practitioners with independent privileges, for establishing and maintaining patient care standards and for credentialing and delineation of clinical privileges, to promote a high level of professional performance of all practitioners clinical;

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<sup>1</sup>NC Rule10A NCAC 13B.3701 states, "The facility shall have a Medical Staff organized in accordance with the facility's by-laws which shall be accountable to the governing body and which shall have responsibility for the quality of professional services provided by individuals with clinical privileges."

<sup>2</sup> JC standard MS 01.01.01, Element of Performance 6 states, "The organized medical staff enforces the medical staff bylaws, rules and regulations, and policies by recommending action to the governing body in certain circumstances, and taking action in others."

<sup>3</sup> The Overview to the Joint Commission Medical Staff chapter defines self-governance as follows: "Self-governance of the organized Medical Staff includes the following and is located in the Medical Staff's bylaws:

Initiating, developing and approving Medical Staff bylaws and rules and regulations

Approving or disapproving amendments to the Medical Staff bylaws and rules and regulations

Selecting and removing Medical Staff officers

Determining the mechanism for establishing and enforcing criteria for delegating oversight responsibilities to practitioners with independent privileges

Determining the mechanism for establishing and maintaining patient care standards and credentialing and delineation of clinical privileges

Engaging in performance improvement activities."

<sup>4</sup>Under NC Rule10A NCAC 13B.3705(b)(9), the bylaws must include "procedures for members of Medical Staff participation in quality assurance functions."

3. To provide an appropriate educational setting that will maintain scientific standards and that will lead to continuous advancement in professional knowledge and skill;
4. To provide for its self-governance by initiating, developing and approving all Medical Staff bylaws and rules and regulations, approving or disapproving any amendments to the Medical Staff bylaws and rules and regulations, and selecting and removing Medical Staff officers;<sup>5</sup> and
5. To provide a means whereby issues or disputes concerning the Medical Staff and the hospital may be discussed and resolved by the Medical Staff and the governing body.

#### **B. Purposes of these Bylaws<sup>6</sup>**

1. To establish the exclusive means of credentialing, granting or affecting Medical Staff membership and privileges.<sup>7</sup> No membership or clinical privileges criterion established by these bylaws shall be waived by action of the Medical Staff, its Medical Executive Committee, or the governing body.<sup>8</sup> No member or privileges holder is exempt from corrective action or other provisions of these bylaws because of employment by or contract with the hospital.<sup>9</sup>
2. To meet the legal requirements for the Medical Staff, the hospital and the professionals practicing at hospitals.<sup>10</sup>

#### **C. Terms**

1. “Administrator” means the individual hired by the Board to act on its behalf in the overall management of the hospital.
2. “Board” [of Directors] [of Trustees] means the governing body<sup>11</sup> of the hospital.

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<sup>5</sup>The active Medical Staff shall develop and adopt, subject to the approval of the governing body, a set of bylaws, rules or regulations, to establish a framework for self governance of Medical Staff and accountability to the governing body.” NC Rule 10 NCAC 13B.3705(a)

<sup>6</sup>Under DNV standard MS 7, Standard Requirement 1, “The medical staff shall be appointed by the governing body and operate under bylaws, rules and regulations adopted and enforced by the medical staff and approved by the governing body.”

<sup>7</sup>Implementing North Carolina Rule 10A NCAC 13B.3705(b)(2) which state, “formal appointment for membership and granting of clinical privileges shall follow procedures set forth in the by-laws, rules or regulations of the Medical Staff.”

<sup>8</sup>Elements of Performance 1 and 2 for JC standard MS.06.01.05 require that each of the criteria for privileges is used and consistently evaluated for all practitioners. Element of Performance 4 for JC standard MS .06.01.07 states, “The organization’s privilege granting/denial criteria are consistently applied for each requesting practitioner.”

<sup>9</sup>Preventing the employed members from circumventing peer review recommendations because of any financial relationship with the hospital.

<sup>10</sup>North Carolina Rules 10A NCAC 13B.3701 requires that “the facility shall have a Medical Staff organized in accordance with the facility’s by-laws which shall be accountable to the governing body and which shall have responsibility for the quality of professional services provided by individuals with clinical privileges.” Also, JC standard MS 01.01.01 Element of Performance 4 states, “medical staff bylaws, rules and regulations, and policies, the governing body bylaws, and the hospital policies are compatible with each other and are compliant with law and regulation.”

3. "Clinical privileges" or "privileges" means authorization to provide care, treatment and services as delineated consistent with these bylaws and includes the right to exercise those privileges in the hospital's facilities unless specifically restricted by action of these bylaws.<sup>12</sup>
4. "Day" means a calendar day unless other specified in a particular context as "working day," which is a non-weekend, non-holiday day.
5. "Hospital" means [\_\_\_\_\_ Hospital] [and its corporate ownership.]
6. "In good standing" means, at the time of the assessment of standing, neither his/her membership nor his/her privileges are involuntarily limited, restricted, suspended, or otherwise encumbered for disciplinary reasons.
7. "Investigation" means the process specifically initiated by action of the Medical Executive Committee to formally determine whether corrective action against a member should be recommended. An investigation does not include the usual activities of departments or of other committees of the Medical Staff in compliance with the licensing and certification requirements, or preliminary deliberations or inquiries of the Medical Executive Committee to determine whether to order an investigation.<sup>13</sup>
8. "Medical Staff"<sup>14</sup> means the organization of those granted clinical privileges, which is created and operated pursuant to the provisions of these bylaws to be responsible and accountable for the quality of patient care provided at the hospital.<sup>15</sup>
9. "Medical Staff leaders" means Medical Staff officers, department chairs, [department vice-chairs,] section heads, Medical Staff representatives, and Medical Staff members serving on committees.

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11According to NC Gen Stat Section 131E-76, "Governing body means the Board of Trustee, Board of Directors, partnership, corporation, association, person or group of persons who maintain and control the hospital."

12Consistent with American Medical Association Policy, AMA H-230.982, which states that "Privileges are conferred by the hospital governing body upon recommendation of the Medical Staff and shall include access to those hospital resources essential to the full exercise of such privileges."

13NCMS Policy on Hospital Peer Review states, "The term "investigation" should be reserved for a formal review of data that is anticipated to lead to corrective action, since this term has implications for reporting to the NPDB (National Practitioner Data Bank). Initial reviews of data should be labeled using other terminology, e.g. "quality review," "focused study," "peer review evaluation," etc. The purpose is to avoid unnecessary or inappropriate reporting to the NPDB, which may harm physicians who have no reportable quality concerns." Available to members at <http://www.ncmedsoc.org>. Under the HCQIA, "Each health care entity which- ... accepts the surrender of clinical privileges of a physician- (i) while the physician is under an investigation by the entity relating to possible incompetence or improper professional conduct shall report...." that physician's surrender to the National Practitioner Data Bank.

14"Medical Staff means the formal organization that is comprised of all those individuals who have sought and obtained clinical privileges in a facility" according to North Carolina Rule 10A NCAC 13B.3001(23).

15 North Carolina Rule 10 NCAC 13B .3701, "The facility shall have a Medical Staff organized in accordance with the facility's by-laws which shall be accountable to the governing body and which shall have the responsibility for the quality of professional services provided by individuals with clinical privileges."

10. "Member" means a professional holding current membership in the [ ] Medical Staff.
11. "Practitioner" means any individual engaged in the practice of the profession for which he or she is licensed, certified, or otherwise qualified or authorized to practice.
12. "Respondent" means the privileges holder or applicant to or member of the Medical Staff who is the subject of a hearing or appeal.
13. "Special notice" means, written notice mailed, return receipt requested, to a member, respondent, applicant, or other person, at the address as last appears in the official records of the Medical Staff or the hospital.<sup>16</sup>

## **ARTICLE II - MEDICAL STAFF ORGANIZATION<sup>17</sup>**

The Medical Staff is organized into departments and committees under elected leadership to fulfill its purposes.

### **A. Leadership<sup>18</sup>**

The Medical Staff organization elects officers, representatives, [department chairs] and committee chairs as stated in this Article.

#### **1. General**

##### **a) Qualifications**

Only [active] Medical Staff members in good standing at the time of nomination can be nominated for and serve as officers, representatives, [department chairs] and committee chairs. Only [active] physician and dentist members of the Medical Staff are eligible to be nominated for and serve as President or Vice President.<sup>19</sup> [A member elected to the office of president-elect shall not be eligible for election to the office of president-elect again until the member has ceased to hold any office for at least one year.] Failure to retain membership in good standing throughout the term of office will create a vacancy in the position.

##### **b) Training Requirements**

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<sup>16</sup> "Except in the instance of summary suspension, hospital notification of possible loss of Medical Staff membership and/or privileges must be sent by certified mail, return receipt requested, or its equivalent." AMA Policy Compendium H-230.970

<sup>17</sup> NC Rule 10A NCAC 13B/3705(b) states, "The Medical Staff bylaws, rules and regulations shall provide for at least the following: (1) organizational structure." Further, under Joint Commission standard MS 01.01.01, Element of Performance 12, the bylaws include "the structure of the medical staff."

<sup>18</sup> Under NC Rule 10A NCAC 13B/3706(a), "The Medical Staff shall be organized to accomplish its required functions and provide for the election or appointment of its officers."

<sup>19</sup> Under Medicare and Medicaid Conditions of Participation §482.22(b)(3), DNV standard MS 4 and Joint Commission standard LD 01.05.01 element of performance 7, "A doctor of medicine or osteopathy, or, if permitted by state law, a doctor of dental surgery or dental medicine, is responsible for the organization of the medical staff."

Each member of the Medical Executive Committee [officer] [department chair] [committee chair] shall fulfill annual leadership training requirements as established by the Medical Executive Committee.

**c) Compensation**

Each officer [and] [the Credentials Committee chair] [and the Quality Improvement Committee chair] shall receive an annual stipend in honor of their services to the Medical Staff in an amount set by the Medical Executive Committee and paid from Medical Staff funds. Compensation amounts shall be disclosed [annually to the medical staff] [and] [at any time to any member upon request.]

**d) Accountability**

**(1) To the Medical Staff**

Officers, representatives, [department chairs] and committee chairs are accountable to the Medical Staff in fulfilling the responsibilities of their positions as defined in this article. Medical Staff members cannot be fired from their hospital employment or be terminated from hospital contracts as a result of good-faith participation in Medical Staff activities or fulfilling leadership duties consistent with these bylaws.

**(2) To the Members**

No officer, representative, [department chair] or committee chair shall engage in any punitive or retaliatory action against any Medical Staff member because that member seeks to exercise any right established under these bylaws, including petitioning for the revocation of any Medical Staff leader's position with the Medical Staff.

**2. Nomination**

**a) By Nominating Committee**

The Nominating Committee shall meet beginning in July of each even numbered year to prepare one or more nominations meeting the qualifications for each leadership position open in the next year, and as needed to prepare nominations for vacancies. It shall secure its nominees consent to be nominated and serve. Prior to the 15th day of the month of October of each [even numbered] year, and as needed as vacancies arise, the Nominating Committee shall submit to the Medical Executive Committee one or more nominations for each office to be filled. The Medical Staff office shall post the names of the nominees [in the Medical Staff lounge] [on the Medical Staff bulletin board] [on the Medical Staff website] or otherwise provide written notice to the Medical Staff<sup>20</sup> not less than 20 days prior to the Medical Staff election.

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<sup>20</sup> Although the entire Medical Staff may not be granted voting rights, the entire Medical Staff has a stake in the leadership of the Medical Staff organization.

**b) By Petition**

Nominations also may be made by petition signed by at least [20 Members] [\_\_\_%] of the active staff and filed with the Medical Staff office at least 10 days prior to the election. The Medical Staff office shall promptly report the names of additional nominees, if any, to the Medical Staff, in the same manner as those nominated by the Nominations Committee.

**c) Other Nominations**

In the event that all nominees shall refuse, be disqualified from, or be unable to accept nomination before the election:

- (1) the Nominating Committee shall submit the names of one or more additional nominees to the annual meeting of the Medical Staff and
- (2) nominations shall be permitted from the floor.

**d) Nominations from the Floor**

Elections at a meeting of the Medical Staff shall include nominations from the floor if the nominee is present, qualified, and agrees to serve.

**3. Elections of Officers and Representatives**

**a) Schedule<sup>21</sup>**

[The president-elect [and the secretary-treasurer] shall be elected by majority vote in each [even] [odd] numbered year at the annual meeting of the staff and at the end of this term shall automatically assume the office of president and president-elect, respectively.]

[Officers shall be elected at the annual meeting of the Medical Staff.]

**b) Number of Votes**

A nominee must receive a majority of all valid votes cast for an office to be elected. If no nominee receives a majority vote, a run-off election shall be promptly held promptly between the two nominees receiving the highest number of votes cast for such office.

**c) Balloting<sup>22</sup>**

[Balloting shall be by secret written [mailed] ballot [at the annual Medical Staff meeting.] [Voting shall take place at the annual meeting by voice or hand.]

[Balloting shall take place on the website or via email.]

**d) Terms of Office**

[All officers and representatives shall serve a one (1) year term beginning January 1.] [All officers and representatives shall serve a two (2) year term beginning on the first day of January in each odd numbered year.]

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21 The schedule of elections varies based on the Medical Staff's choice of a one-year term of office or a two-year term.

22 Where members may feel inhibited about publicly voting for one nominee instead of another, because of referral patterns, hospital employment, or other factors, secret balloting should be considered.

[All officers [and representatives] may be re-elected for a succeeding term.][Officers [and representatives] may be elected to [one] [additional] [consecutive] term.] [Officers [and representatives] may not be elected to [additional] [consecutive] terms.]

#### 4. Officers<sup>23</sup>

The Medical Staff officers are the president, the president-elect, the immediate past president, [the secretary,][and][the treasurer][the secretary-treasurer].

##### a) President

The Medical Staff president is elected by the [active] Medical Staff to represent the Medical Staff as the chief medical officer at the hospital, and shall

- (1) call, preside at, and be responsible for the agenda of all meetings of the Medical Staff organization;
- (2) serve as chair of the Medical Executive Committee, and call, preside at, and be responsible for the agenda of all Medical Executive Committee meetings;
- (3) appoint Medical Staff members for [one-year] terms to all standing and special Medical Staff Committees except the Medical Executive Committee, and to any hospital Medical Staff Committees with Medical Staff representation, unless otherwise provided by these bylaws;
- (4) appoint chairs of Medical Staff committees to [one][two]year terms unless otherwise stipulated in these bylaws;
- (5) report the Medical Staff's recommendations and concerns and otherwise represent the Medical Staff at each board meeting and communicate reactions and responses to the Medical Staff and Medical Executive Committee;<sup>24</sup>
- (6) [serve as a member of the Board representing the Medical Staff, as a liaison between the two; to assist in the development of hospital policy; to maintain open communication; to participate in strategic planning; to contribute to oversight of hospital operations; and communicate reactions and responses to the Medical Staff and Medical Executive Committee]<sup>25</sup>

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23 The Overview to the Joint Commission Medical Staff chapter defines Medical Staff self-governance as including selecting and removing Medical Staff officers. JC Accreditation Manual for Healthcare Organizations.

24 Element of Performance #9 of JC Standard LD 01.03.01 states, "The governing body provides the organized Medical Staff with the opportunity to be represented at governing body meetings (through attendance and voice) by one or more of its members, as selected by the organized Medical Staff."

25 Serving as a member of the board described here differs from serving as a representative before the board as described in the section II.A.4.a.5, immediately preceding this section. Element of Performance #6 of JC Standard LD.01.01.01 states, "Medical Staff members are eligible for full membership in the hospital governance unless legally prohibited." Some boards are constituted such that Medical Staff officers may not serve. If hospital governance can permit a Medical Staff member to serve, "it is the policy of the AMA that physicians who are members of the Medical Staff shall be eligible for, and should be included in, full membership on hospital governing bodies and their action committees in the same

- (7) serve as or appoint an appropriate Medical Staff member to serve as spokesperson for the Medical Staff in its external professional and public relations; and
- (8) carry out other responsibilities as established in these bylaws or as are appropriately delegated by the Medical Executive Committee or the Medical Staff.

**b) President-Elect**

The Medical Staff president-elect is elected by the [active] Medical Staff to assume the president’s responsibilities in his/her absence, and shall

- (1) serve as a member of the Medical Executive Committee;
- (2) represent the Medical Staff at each Board meeting, along with the Medical Staff president, and communicate reactions and responses to the Medical Staff and Medical Executive Committee;<sup>26</sup>
- (3) [serve as a member of the Board representing the Medical Staff, as a liaison between the two; to assist in the development of hospital policy; to maintain open communication; to participate in strategic planning; to contribute to oversight of hospital operations; and communicate reactions and responses to the Medical Staff and Medical Executive Committee]<sup>27</sup>

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manner as are other knowledgeable and effective individuals. Other physicians also should be considered eligible for membership on the governing body. The hospital Medical Staff should have the right of representation at all meetings of the governing body by Medical Staff members elected by the Medical Staff having the right of attendance, voice and, if appropriate, vote. Compensation to Medical Staff members for service to the hospital should not preclude the physician’s membership on the hospital governing board.” AMA Policy Compendium H-235.9801. Alternatively, the Medical Staff may elect board members as Medical Staff representatives and authorize the Medical Staff president and other officers to advocate for Medical Staff interests before the board. See section II.A.5, below.

26 Element of Performance #5 of JC Standard LD.01.01.01 states, “The Medical Staff has the right to representation (through attendance and voice) by one or more Medical Staff members selected by the Medical Staff, at governing body meetings.” The president- elect can serve as representative before the board in addition to the president or other designated representatives.

27 Serving as a member of the board described here differs from serving as a representative before the board as described in the section II.A.4.a.1.d, immediately preceding this section. Element of Performance #6 of JC Standard LD.01.01.01 states, “Medical Staff members are eligible for full membership in the hospital governance unless legally prohibited.” Some boards are constituted such that Medical Staff officers may not serve as board members. If hospital governance can permit a Medical Staff member to serve, “it is the policy of the AMA that physicians who are members of the Medical Staff shall be eligible for, and should be included in, full membership on hospital governing bodies and their action committees in the same manner as are other knowledgeable and effective individuals. Other physicians also should be considered eligible for membership on the governing body. The hospital Medical Staff should have the right of representation at all meetings of the governing body by Medical Staff members elected by the Medical Staff having the right of attendance, voice and, if appropriate, vote. Compensation to Medical Staff members for service to the hospital should not preclude the physician’s membership on the hospital governing board.” AMA Policy Compendium H-235.9801. Alternatively, the Medical Staff may elect board members as Medical Staff representatives and authorize the Medical Staff president and other officers to advocate for Medical Staff interests before the board. See section II.A.5, below.

- (4) [ assume the office of the presidency upon completion of the president-elect term<sup>28</sup>; and]
- (5) carry out other responsibilities as established in these bylaws or as are appropriately delegated by the Medical Executive Committee or the Medical Staff.

**c) [Secretary<sup>29</sup>**

The Medical Staff secretary is elected by the [active] Medical Staff, and shall

- (1) serve as a member of the Medical Executive Committee;
- (2) oversee the accuracy of the minutes of all Medical Staff and Medical Executive Committee meetings, including privileging actions;<sup>30</sup>
- (3) call Medical Staff meetings on order of the President;
- (4) attend to all Medical Staff correspondence unless otherwise delegated under these Medical Staff bylaws;
- (5) perform such other duties as ordinarily pertain to the office; and
- (6) carry out other responsibilities as established in these bylaws or as are appropriately delegated by the Medical Executive Committee or the Medical Staff.]

**d) [Treasurer<sup>31</sup>**

The Medical Staff treasurer is elected by the [active] Medical Staff, and shall

- (1) serve as a member of the Medical Executive Committee;
- (2) account to the Medical Executive Committee and the Medical Staff for the disbursement and receipt of all Medical Staff funds;
- (3) [chair the Medical Staff budget Committee; ]
- (4) approve payment of those bills incurred by the Medical Staff which are consistent with the budget adopted by the Medical Executive Committee;
- (5) perform such other duties as ordinarily pertain to the office; and
- (6) carry out other responsibilities as established in these bylaws or as are appropriately delegated by the Medical Executive Committee or the Medical Staff.]

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<sup>28</sup>Note carefully that this section does not require that the president-elect automatically assume the office of president. While assumption of the office of president would be the expectation, that right is not vested at the time of election to the office of president-elect.

<sup>29</sup> This office of the Medical Staff should not be confused with a hospital clerical position or with hospital administrative personnel hired to manage the medical staff office, discussed in section II.E, "Medical Staff Organization Support." The office of Secretary can serve as a training ground for future Medical Staff Presidents.

<sup>30</sup> Typically Medical Staff office personnel actually record the minutes but the elected Medical Staff secretary should oversee the process to assure that the minutes presented for acceptance by the committee or the Medical Staff organization accurately reflect the actions taken. Pursuant to NC Rule10A NCAC 13B.3704(e), "Minutes of all actions taken by the Medical Staff and the governing board concerning clinical privileges shall be maintained by the Medical Staff and the governing board, respectively."

<sup>31</sup> This office of the Medical Staff is encouraged whenever, as called for by these bylaws, the Medical Staff has funds from member dues and other sources.

**e) [Secretary-Treasurer**

The Medical Staff secretary-treasurer is elected by the [active] Medical Staff, and shall

- (1) serve as a member of the Medical Executive Committee;
- (2) oversee the accuracy of the minutes of all Medical Staff and Medical Executive Committee meetings;<sup>32</sup>
- (3) call Medical Staff meetings on order of the President;
- (4) attend to all Medical Staff correspondence unless otherwise delegated under these Medical Staff bylaws;
- (5) account to the Medical Executive Committee and the Medical Staff for the disbursement and receipt of all Medical Staff funds;
- (6) [chair the Medical Staff budget Committee;]
- (7) perform such other duties as ordinarily pertain to the office; and
- (8) carry out other responsibilities as established in these bylaws or as are appropriately delegated by the Medical Executive Committee or the Medical Staff.]

**f) Immediate Past President**

The immediate past president of the Medical Staff shall

- (1) serve as a member of the Medical Executive Committee;
- (2) carry out other responsibilities as established in these bylaws or as are appropriately delegated by the Medical Executive Committee or the Medical Staff.

**5. Representatives**

**a) Board Representatives<sup>33</sup>**

The [2] board representatives are elected by the [active] Medical Staff to serve as voting Board members, and shall

- (1) attend all Board meetings;
- (2) designate one representative to attend and report on board issues to the Medical Executive Committee;

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<sup>32</sup> Typically, Medical Staff office personnel actually record the minutes but the elected Medical Staff secretary should oversee the process to assure that the minutes presented for acceptance by the committee or the Medical Staff organization accurately reflect the actions taken.

<sup>33</sup> Supported by AMA policy, which states, "physicians who are members of the Medical Staff shall be eligible for, and should be included in, full membership on hospital governing bodies and their action committees in the same manner as are other knowledgeable and effective individuals. Other physicians also should be considered eligible for membership on the governing body. The hospital Medical Staff should have the right of representation at all meetings of the governing body by Medical Staff members elected by the Medical Staff having the right of attendance, voice and, if appropriate, vote. Compensation to Medical Staff members for service to the hospital should not preclude the physician's membership on the hospital governing board." To achieve Medical Staff representation on the board, without encumbering the Medical Staff leadership with board membership, the Medical Staff can elect members specifically to serve as board members.

Element of Performance #6 of JC Standard LD.01.01.01 states, "Medical Staff members are eligible for full membership in the hospital governance unless legally prohibited."

- (3) report on board issues to the Medical Staff;
- (4) carry out other responsibilities as established in these bylaws or as are appropriately delegated by the Medical Executive Committee or the Medical Staff.

**b) Medical Executive Committee Members at Large<sup>34</sup>**

The [4] Medical Staff representatives are elected by the [active] Medical Staff to serve as voting Medical Executive Committee members at large, and shall:

- (1) attend all Medical Executive Committee meetings;
- (2) report on Medical Executive Committee issues to the Medical Staff;
- (3) carry out other responsibilities as established in these bylaws or as are appropriately delegated by the Medical Executive Committee or the Medical Staff.]

**c) AMA OMSS Representative<sup>35</sup>**

The Medical Staff representative and alternate representative to the American Medical Association Organized Medical Staff Section are elected by the [active] Medical Staff to represent the Medical Staff to organized medicine. The OMSS representative and alternative representative must be members of the North Carolina Medical Society and the American Medical Association, and shall

- (1) Serve as a member of and attend all Medical Executive Committee meetings;
- (2) Represent the Medical Staff at all meetings of the American Medical Association Organized Medical Staff Section;
- (3) report on AMA OMSS issues and actions to the Medical Executive Committee and the Medical Staff;
- (4) carry out other responsibilities as established in these bylaws or as are appropriately delegated by the Medical Executive Committee or the Medical Staff.

## 6. Committee Chairs

Committee chairs shall be appointed by the president to serve to [one][two] year terms unless otherwise stipulated in these bylaws and shall

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34 Allowing at large representatives may assist the Medical Staff to comply with JC Standard MS.02.01.01 EP 3, which provides that “all members of the organized Medical Staff, of any discipline or specialty, are eligible for membership on the medical staff executive committee.” Under Joint Commission Standard MS 01.01.01 Element of Performance 22 provides that the medical staff bylaws must include “That the medical staff executive committee includes physicians and may include other practitioners and any other individuals as determined by the organized medical staff.” Note that placing non-medical staff members, or non-health care professionals, on the medical executive committee is allowed by the Joint Commission, but is not mandated. This model limits medical executive committee members to members of the medical staff.

35 Every Medical Staff may appoint a representative and alternate to the American Medical Association Organized Medical Staff Section (“AMA OMSS”). Information regarding the AMA OMSS is available on the AMA website at <http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/organized-medical-staff-section.shtml> or by calling AMA OMSS staff at (312) 464-4761.

- a) call meetings as set by these bylaws or as necessary to fulfill committee responsibilities;
- b) preside at, and be responsible for the agenda of all meetings;
- c) communicate as appropriate<sup>36</sup> with committee and medical staff members in a timely fashion regarding committee business and member requests and concerns;
- d) carry out other responsibilities as established in these bylaws or as are appropriately delegated by the Medical Executive Committee or the Medical Staff.

## 7. [Department Chairs

Department chairs shall be elected by the [active] Medical Staff members of the department to [one][two] year terms unless otherwise stipulated in these bylaws and shall

- a) Maintain appropriate specialty board certification or establish comparable competence through the Medical Staff credentialing process;<sup>37</sup>
- b) Oversee department administration;<sup>38</sup>
- c) Continuously review the professional performance of all privileges holders in the department;<sup>39</sup>
- d) Recommend to the Medical Executive Committee all criteria for clinical privileges relevant to the care provided in the department;<sup>40</sup>
- e) Make recommendations to the Medical Executive Committee regarding all requests for privileges within the department;<sup>41</sup>
- f) Assess and recommend to the Medical Executive Committee any off-site sources for needed patient care, treatment, and services not provided by the department or the hospital;<sup>42</sup>
- g) Oversee integration of the department into the hospital's primary functions;<sup>43</sup>
- h) Oversee the coordination and integration of interdepartmental and intradepartmental services;<sup>44</sup>
- i) [Serve as a members of the Medical Executive Committee;]
- j) Oversee the development and implementation of policies and procedures that guide and support the provision of care, treatment, and services<sup>45</sup>

<sup>36</sup>To protect the confidentiality of peer review data while promoting communication to members.

<sup>37</sup> Medical Staff bylaws are to define the qualifications under JC standard MS.01.01.01, Element of Performance 13.

<sup>38</sup> As called for by JC standard MS.01.01.01, Element of Performance 36.

<sup>39</sup> As called for by JC standard MS.01.01.01, Element of Performance 36.

<sup>40</sup> As called for by JC standard MS.01.01.01, Element of Performance 36.

<sup>41</sup> As called for by JC standard MS.01.01.01, Element of Performance 36.

<sup>42</sup> As called for by JC standard MS.01.01.01, Element of Performance 36.

<sup>43</sup> As called for by JC standard MS.01.01.01, Element of Performance 36.

<sup>44</sup> As called for by JC standard MS.01.01.01, Element of Performance 36.

<sup>45</sup> As called for by JC standard MS.01.01.01, Element of Performance 36.

- k) Recommend the number of qualified and competent persons and the space and other resources needed to provide care, treatment, and services in the department;<sup>46</sup>
- l) Determine the qualifications and competence of department personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;<sup>47</sup>
- m) Continuously assess and work toward improvement of the quality of care, treatment, and services through maintenance of quality control programs, as appropriate;<sup>48</sup>
- n) Oversee orientation and continuing education of all persons in the department;<sup>49</sup>
- o) Communicate as appropriate<sup>50</sup> with department and medical staff members in a timely fashion regarding department business and member requests and concerns;
- p) Implement mechanisms to assure that services provided in the department do not exceed the scope of privileges granted;<sup>51</sup>
- q) [Appoint a vice chair from among the qualified active staff members in the department to assume the responsibilities and authority of the chair in his/her temporary absence;]
- r) Carry out other responsibilities as established in these bylaws or as are appropriately delegated by the Medical Executive Committee or the Medical Staff. ]

#### **8. [Vice Chair**

Department vice-chairs shall be elected by the [active] Medical Staff members of the department to [one][two] year terms unless otherwise stipulated in these bylaws and shall

- a) assume the responsibilities and authority of the chair in his/her temporary absence;
- b) carry out other responsibilities as established in these bylaws or as are appropriately delegated by the Chair, the Medical Executive Committee or the Medical Staff.]

#### **9. [Sections Heads]**

[Section heads shall be elected by the [active] Medical Staff members of the section to [one][two] year terms and shall

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<sup>46</sup> As called for by JC standard MS.01.01.01, Element of Performance 36.

<sup>47</sup> As called for by JC standard MS.01.01.01, Element of Performance 36.

<sup>48</sup> As called for by JC standard MS.01.01.01, Element of Performance 36.

<sup>49</sup> As called for by JC standard MS.01.01.01, Element of Performance 36.

<sup>50</sup> To protect the confidentiality of peer review data while promoting communication to members.

<sup>51</sup> DNV Standard MS 12, Standard Requirement 4 states, "There shall be a provision in the medical staff bylaws for a mechanism to ensure that all individuals with clinical privileges provide services only within the scope of privileges granted."

- a) Oversee section administration;
- b) Continuously review the professional performance of all privileges holders in the section;
- c) Recommend to the department chair all criteria for clinical privileges relevant to the care provided in the section;
- d) Make recommendations to the department chair regarding all requests for privileges within the section;<sup>52</sup>
- e) Assess and recommend to the Medical Executive Committee any off-site sources for needed patient care, treatment, and services not provided by the section or the hospital;<sup>53</sup>
- f) Oversee integration of the section into the hospital's primary functions;
- g) Oversee the development and implementation of policies and procedures that guide and support the provision of care, treatment, and services;
- h) Recommend to the department chair the number of qualified and competent persons and the space and other resources needed to provide care, treatment, and services in the section;
- i) Make recommendations to the department chair on the qualifications and competence of section personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;
- j) Continuously assess and work toward improvement of the quality of care, treatment, and services through maintenance of quality control programs, as appropriate;
- k) And carry out other responsibilities as established in these bylaws or as are appropriately delegated by the Medical Executive Committee or the Medical Staff.]

#### **10. Disclosure of Conflicts of Interest<sup>54</sup>**

In order to protect the interests of the Medical Staff in improving patient care and conducting fair peer review, all Medical Staff leaders, including officers, department chairs, section heads, Medical Staff representatives, and Medical Staff members

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52 As called for by JC standard MS.01.01.01, Element of Performance 36.

53 As called for by JC standard MS.01.01.01, Element of Performance 36.

54 Implementing the recommendations of the North Carolina Medical Society and the North Carolina Hospital Association that "... potential conflicts of interest ...be addressed in Medical Staff bylaws." As published in the "Economic Credentialing and Exclusive Contracting Report" available to NCMS members at <http://www.ncmedsoc.org>. Further, NCMS Policy on Peer Review Committees states, "the North Carolina Medical Society supports organizing peer review committees that are free of conflicts of interest whenever possible. Since conflicts of interest in the peer review process are sometimes inevitable, medical staffs should develop a process for resolving conflicts of interest that centers on the best interests of patients, includes full disclosure of conflicts and potential conflicts, and makes available fair external review option in appropriate situations." <http://www.ncmedsoc.org>\_AMA policy states that: "Candidates for election or appointment to Medical Staff offices, department or committee chairs, or the Medical Executive Committee, should disclose in writing to the Medical Staff, prior to the date of election or appointment, any personal, professional or financial affiliations or responsibilities on behalf of the Medical Staff; and encourages hospital Medical Staffs to incorporate a "disclosure of interest" provision in their Medical Staff bylaws based on this policy statement." AMA Policy Compendium H-235.970.

serving on committees shall disclose in writing potential conflicts of interest as relevant to the position held and the circumstances, consistent with these bylaws. Disclosure of conflicts shall have no bearing on a member's Medical Staff membership or clinical privileges. No member may exercise any leadership or committee role unless and until the member completes the conflict of interest disclosure form approved by the Medical Executive Committee as consistent with these bylaws. The Medical Executive Committee-approved form shall be available to any member, from the medical staff office. This section shall be the unique and exclusive mechanism for discerning and acting upon conflicts of interest applicable to Medical Staff members.<sup>55</sup>

Members shall not use or disclose any information obtained as a result of his/her Medical Staff leadership or committee position for any purpose other than the furtherance of quality medical care in the hospital.

**a) Who Discloses**

Disclosure is required

- (1) By members interested in Medical Staff leadership positions, prior to nomination, to the Nominating Committee or member who will be submitting the nomination, and, prior to election, to those eligible to vote;
- (2) By committee chairs and committee members, prior to the date the committee appointment begins, to the president;
- (3) Annually by members of the following committees to their chairs:
  - (a) Medical Executive Committee; infection control; pharmacy & Therapeutics Committee; Credentials Committee, Bylaws Committee, Institutional Review Board (or other research-related committees), Budget Committee;
  - (b) in committees, including ad hoc committees, and in meetings pursuant to the parameters below.

**b) Potential Conflicts to Be Disclosed**

Potential conflicts include:

- (1) Competitive, economic, or personal relationships, activities, or interests that may inappropriately influence a member's decisions or actions;<sup>56</sup>
- (2) Grants or other financial, academic or professional relationships involving research relating to decisions under review;<sup>57</sup>
- (3) Ownership or material financial interest held by a member or his/her immediate family in the hospital or the system of which the hospital is a part or affiliated, or a direct competitor<sup>58</sup> of the hospital;<sup>59</sup>

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<sup>55</sup> Clarifying that hospital conflict of interests policies do not apply to Medical Staff members.

<sup>56</sup> To make known matters which could prejudice a member for or against another professional in peer review, ranging from joint ventures with the hospital or a direct competitor to partnerships or employment relationships with the members or applicants being reviewed.

<sup>57</sup> To address bias by members involved in research.

- (4) Ownership or material financial interests in any company that furnishes goods or services to the hospital or is seeking to provide goods or services to the hospital;<sup>60</sup>
- (5) Current or imminent personal compensation arrangements with the hospital, or a direct competitor of the hospital, under the terms of a contract or employment;<sup>61</sup>
- (6) Ownership in or directorship or other leadership or employment by a managed care company that contracts with or could contract with the hospital;<sup>62</sup>
- (7) Receipt of gifts including goods, services, or honoraria from the hospital, any company or person who contracts with or otherwise sells to the hospital, or a direct competitor of the hospital.

**c) Conflict Resolution**

- (1) A member shall recuse himself/herself if the member reasonably believes that his/her ability to render a fair and independent decision is or may be affected by a conflict of interest.
- (2) If a majority of voting members of the committee or in the staff meeting vote that the member should be excused from discussion or voting, due to conflict of interest, the chair shall excuse the member.
- (3) If a member discloses a potential conflict of interest concerning another member and requests a vote regarding excusing that other member, the member shall leave the room while the issue is being discussed and voted upon.
- (4) The minutes of the meeting shall include the names of those excused for conflicts and the nature of the conflicts involved.

**11. Absence, Resignation and Removal**

**a) Absence**

**(1) Temporary Absence of Officers**

- (a) In case of temporary absence [of less than three weeks], the following officer coverage shall facilitate Medical Staff operation:
- (b) In the president's absence, the president-elect shall assume all duties of the president.

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<sup>58</sup>A direct competitor is one that offers the same service as the service in question, in the same geographic market.

<sup>59</sup>To make known a financial bias that favors the hospital or a direct competitor, which might influence a member's position on matters in which the hospital and Medical Staff have differing views.

<sup>60</sup>To make known a financial bias that favors the hospital or a direct competitor, which might influence a member's position on matters in which the hospital and Medical Staff have differing views.

<sup>61</sup>To make known the possibility that the hospital or a direct competitor has extraordinary influence over the member.

<sup>62</sup>To make known a financial bias that favors the hospital or a direct competitor, which might influence a member's position on matters in which the hospital and Medical Staff have differing views.

- (c) [In the absence of both the president and the president elect, the secretary [secretary-treasurer] shall assume all the duties of the president.]
- (d) [In the absence of the president, the president elect, and the secretary, the treasurer shall assume all the authority and responsibilities of the president and the secretary.]
- (e) In the absence of the president, the vice president, [the secretary][and][the treasurer] [secretary-treasurer], the immediate past president shall assume all the duties of the president, [the secretary and the treasurer.]
- (f) In the absence of the president, the vice president, [the secretary][ and][the treasurer] [the secretary treasurer] and the immediate past president, the Medical Executive Committee shall elect a presiding chair, and shall as a committee carry out all the duties and have the authority and responsibilities of the offices.

**(2) Temporary Absence of Department Chairs, [Section Heads] and Committee Chairs**

In the absence of a Department Chair, [Section Head] and Committee Chair, the vice-chair, assistant head or vice-chair shall assume all duties of the absent leader. In the absence of a vice-chair, assistant head or vice-chair, the Medical Executive Committee shall name a temporary leader to assume the duties of the position.

**b) Leave of Absence**

If a Medical Staff leader takes a leave of absence from Medical Staff membership for any reason, their Medical Staff leadership position(s) will be deemed resigned, and the position(s) will be filled consistent with these bylaws.

[If a Medical Staff leader takes a leave of absence from Medical Staff membership for any reason, the leave of absence will be addressed as a temporary absence from leadership under these bylaws.]

**c) Resignation**

**(3) Resignation of Leadership Position**

A Medical Staff leader may resign for good cause, effective immediately or upon a date specified, in writing, or verbally stating, the resignation to a Medical Staff officer or department chair. Any verbal resignation shall be immediately documented by the officer or chair receiving the resignation, with a copy to the resigning leader.

**(4) Resignation of Committee Membership**

A member may resign committee membership for good cause, effective immediately or upon a date specified, in writing to the committee chair. Failure to meet committee membership requirements will be included in the

evaluation for any renewal of Medical Staff membership and may result in denial of Medical Staff membership renewal.<sup>63</sup>

**d) Removal of Officers,<sup>64</sup> Representatives, Department Chairs, Committee Chairs, and Committee Members**

**(1) Removal of Officers and Representatives**

Any officer or representative may be removed from leadership without assigning specific cause by the affirmative vote of 51% of Active Medical Staff Members in a Medical Staff meeting attended by [mail or email balloting participated in by] a majority of the active staff members.

**(2) Removal of Department Chairs or Vice Chairs [and Section Heads or Assistant Heads]**

Any department [or section] leader may be removed from leadership without assigning specific cause by the affirmative vote of 51% of Active Medical Staff Members in a department [or section] meeting attended by [mail or email balloting participated in by] a majority of the active staff members of the department [or section].

**(3) Removal of Committee Members<sup>65</sup>**

If a member of a committee fails to carry out the duties of committee membership, or commits malfeasance as a committee member, or if any other good cause exists, that member may be removed [by vote of the committee,] [or] [by the president, subject to approval by the Medical Executive Committee] [or] [by the Medical Executive Committee]. If the member at issue is a member of the Medical Executive Committee, he/she shall not be involved in the discussion or vote on his/her removal, but may make a statement in his/her defense to the Medical Executive Committee prior to the discussion and vote.

**(4) Automatic Removal**

A leader or committee members shall be automatically removed from any and all Medical Staff organization positions upon loss of Medical Staff membership.

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63 To enforce membership duties to participate in Medical Staff organization activities.

64 Under JC MS.01.01.01 Element of Performance 18, the Medical Staff bylaws must include "The process, as determined by the organized medical staff and approved by the governing body, by which the organized medical staff selects and/or elects and removes the medical staff officers."

65 Joint Commission standard MS 01.01.01, Element of Performance 21, calls for medical staff bylaws to include "the process, as determined by the organized medical staff and approved by the governing body, for selecting and/or electing and removing the medical executive committee members." This section provides the process for removal of members from all medical staff committees, including the medical executive committee, and as part of the Medical Staff bylaws, is approved by the Medical Staff and the board.

### **(5) Effect of Removal**

Removal shall not of itself constitute a diminution of the member's Medical Staff membership or privileges, or otherwise give rise to any right to hearing or appeal.

#### **B. [Services<sup>66</sup>**

The Medical Staff is organized into the following services:

Medicine

Surgery

Obstetrics

Medical Staff members shall serve as Service Directors and fulfill the following responsibilities (see responsibilities for department chairs above at section II.A.7.)

Service Director recommendations shall become effective only when acted upon by a designated Medical Staff committee.]

**OR**

#### **B. Departments [and Sections]**

##### **[ Medicine and Surgery<sup>67</sup>**

All members will be members of either the Department of Surgery or the Department of Medicine as determined by the Medical Executive Committee. The Medical and Surgical Departments may be divided into clinical sections subject to the approval of the Medical Executive Committee.]

**OR**

#### **B. Roster of Departments**

Members may have privileges in more than one department but shall be granted membership in only one Medical Staff department.

[The roster of current Medical Staff departments and sections is available in the Medical Staff office.]<sup>68</sup>

The Medical Staff Departments are:

Anesthesiology

[Clinical Services, comprised of hospital-based specialties under hospital contract: Anesthesiology, Emergency, ICU, Pathology, Physical Medicine, Radiology, Radiation Therapy]

Emergency

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66 For non-departmentalized hospital Medical Staffs.

67 To allow for a simple departmentalization.

68 No law or standards requires listing the departments in the Medical Staff bylaws. Particularly if departments are subject to frequent mergers, additions or other changes, a listing outside the Medical Staff bylaws may be useful.

Family Medicine  
Intensive Care  
Internal Medicine  
Neurosurgery  
Obstetrics & Gynecology  
Orthopaedic Surgery  
Pathology  
Pediatrics  
Physical Medicine  
Psychiatry  
Radiation Therapy  
Radiology  
Surgery

## **12. Changes in Departments**

Recommendations to add, eliminate or consolidate departments shall be submitted by Medical Staff members to the Medical Executive Committee with documentation supporting the recommendation. The Medical Executive Committee shall study the recommendation, and if adopted, shall refer the action to the Medical Staff Bylaws Committee and Credentials Committee for recommendations as to implementation of the recommendation.

## **13. Department Functions**

As appropriately determined by the department and consistent with these bylaws, department functions shall be discharged under the leadership of the department chair. Each department

- a) Develops and recommends to the chair for further recommendation to the Medical Executive Committee the criteria for clinical privileges in the department,<sup>69</sup> specifying minimum training, experience and qualifications for each privilege.
- b) Reviews and develops recommendations for action on applicants seeking membership and privileges within the department;

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<sup>69</sup> Joint Commission standard MS standard MS.01.01.01 element of performance 36 calls for the department chair to recommend privilege criteria to the Medical Staff.

- c) Develops and recommends changes in staffing, space and other hospital resources as needed to support privileges being requested or exercised in the department;<sup>70</sup>
- d) Establishes surgical and other procedural schedules for procedures performed under privileges exercised in the department;
- e) Adopts, repeals, or revises departmental rules and regulations by a majority vote of [active] staff members of the department [present at] [participating electronically or otherwise in] any meeting at which a quorum exists. Such rules and regulations may include criteria for department members to hold departmental office which may be developed by the individual departments as appropriate. All departmental rules and regulations shall be submitted to the Medical Staff Medical Executive Committee for final review and approval prior to their implementation;
- f) Defines objective processes and outcome metrics for peer review;<sup>71</sup>
- g) Carries out functions delegated to the department by the Medical Staff, the Medical Executive Committee or otherwise by operation of these bylaws.

#### **14. [Sections]**

[Sections of clinical subspecialties and specialties may be organized within a department for purposes of education, peer review, and self-government with approval of the Medical Executive Committee. Five or more members of a department with similar clinical interests shall submit to the chair a written proposal of rationale, organization structure, rules and regulations for a section consistent with the overall department and Medical Staff policies, including commitments to serve as a section leader until the next election. If approved by the department, the petition and proposed organizational structure and rules and regulations shall be submitted to the Medical Executive Committee for approval. If approved, sections shall carry out for the section the duties stipulated for departments in this Article but shall direct recommendations to the department chair.]

#### **C Committees<sup>72</sup>**

Unless otherwise provided by these bylaws, all Medical Staff committees report to the Medical Executive Committee. Members shall be appointed by the president from among the Medical Staff membership, taking into consideration financial relationships with the hospital and other potential conflicts of interest. Subcommittees of any Medical Staff committee may be established by the committee chair to carry out such

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70 Element of Performance 1 for JC standard MS.06.01.01 states, "There is a process to determine whether sufficient space, equipment, staffing, and financial resources are in place or available within a specified time frame to support each requested privilege.

<sup>71</sup>NCMS Policy on Hospital Peer Review states "Peer review should be based on objective process and outcome metrics as monitored by the local institution and as defined by the department in question." <http://www.ncmedsoc.org>.

<sup>72</sup> According to NC Rule10A NCAC 13B .3705(b), "The Medical Staff bylaws, rules and regulations shall provide for... (5) composition, functions and attendance of standing committees."

functions of the committee as the chair assigns and to report to the parent committee. Subcommittees may include members other than those on the parent committee, but each subcommittee shall be chaired by a member of the parent committee, [except as otherwise provided in these Bylaws.] Minutes of all committee and subcommittee meetings shall be kept consistent with the Medical Staff bylaws, rules and regulations, and policies.<sup>73</sup>

In addition to the Medical Staff committees established under these bylaws, the president may, or shall at the direction of the Medical Executive Committee, appoint special committees to assist the Medical Staff in carrying out its functions. Each special committee's composition and responsibilities shall be documented in Medical Executive Committee minutes. A special committee shall meet at the call of its chair, and report monthly to the Medical Executive Committee. A special committee shall expire when its responsibilities are completed, at most within one year, unless extended for good cause or sooner terminated by the Medical Executive Committee.

### **1. Bioethics Committee<sup>74</sup>**

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73 Implementing NC Rule10A NCAC 13B/3706 (c) and (e).

74Following AMA Code of Ethics E-9.11, "Ethics Committees in Health Care Institutions," which provides, "(t)he following guidelines have been developed to aid in the establishment and functioning of ethics committees in hospitals and other health care institutions that may choose to form such committees. (1) Ethics committees in health care institutions should be educational and advisory in purpose. Generally, the function of the ethics committee should be to consider and assist in resolving unusual, complicated ethical problems involving issues that affect the care and treatment of patients within the health care institution. Recommendations of the ethics committee should impose no obligation for acceptance on the part of the institution, its governing board, Medical Staff, attending physician, or other persons. However, it should be expected that the recommendations of a dedicated ethics committee will receive serious consideration by decision makers. (2) The size of the committee should be consistent with the needs of the institution but not so large as to be unwieldy. Committee members should be selected on the basis of their concern for the welfare of the sick and infirm, their interest in ethical matters, and their reputation in the community and among their peers for integrity and mature judgment. Experience as a member of hospital or medical society committees concerned with ethical conduct or quality assurance should be considered in selecting ethics committee members. Committee members should not have other responsibilities that are likely to prove incompatible with their duties as members of the ethics committee. Preferably, a majority of the committee should consist of physicians, nurses, and other health care providers. In hospitals, Medical Staff bylaws should delineate the functions of the committee, general qualifications for membership, and manner of selection of members, in accordance with these guidelines. (3) The functions of the ethics committee should be confined exclusively to ethical matters. The Code of Medical Ethics of the American Medical Association is recommended for the guidance of ethics committees in making their own recommendations. The matters to be considered by the committee should consist of ethical subjects that a majority of its members may choose to discuss on its own initiative, matters referred to it by the Medical Executive Committee of the organized Medical Staff or by the governing board of the institution, or appropriate requests from patients, families, or health care providers. (4) In denominational health care institutions or those operated by religious orders, the recommendations of the ethics committee may be anticipated to be consistent with published religious tenets and principles. Where particular religious beliefs are to be taken into consideration in the committee's recommendations, this fact should be publicized to physicians, patients, and others concerned with the committee's recommendations. (5) In its deliberations and

### **a) Composition**

The Bioethics Committee shall be composed of [five] members selected on basis of interest and diversity of expertise and experience; [an ethicist];<sup>75</sup> a representative of the religious community appointed by the Medical Executive Committee; a representative appointed by hospital administration, and a representative appointed by the nursing staff. An Active Staff member shall chair the committee.

### **b) Duties**

- 1)** develops for adoption by the Medical Executive Committee, and approval as appropriate by the Board, any Medical Staff and hospital policies regarding the bioethics of patient care and treatment at this hospital, including the “Do Not Resuscitate” policy;
- 2)** provides consultation upon referral by the Medical Executive Committee or the Board;
- 3)** provides consultation upon appropriate request from patients, patient families, and other hospital community members;
- 4)** supports or provides educational opportunities for medical and hospital staff regarding bioethics;
- 5)** maintains confidentiality of all patient and peer review information<sup>76</sup>;
- 6)** meets [at least monthly and] at the call of the chair as necessary to fulfill its duties in a timely manner.

The consultations and recommendations of the Bioethics Committee are not binding, but rather are consultative in nature.

## **2. Budget Committee**

### **a) Composition**

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

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communication of recommendations, the procedures followed by the ethics committee should comply with institutional and ethical policies for preserving the confidentiality of information regarding patients.

(6) Committee members should be prepared to meet on short notice and to render their recommendations in a timely and prompt fashion in accordance with the demands of the situation and the issues involved.”

75 If available from a university, college or otherwise from the local community

76 North Carolina state protections for peer review confidentiality are strong and should be maximized in Medical Staff bylaws. The North Carolina peer review and medical review statutes, which establish the privilege for ‘the proceedings and records’ of peer review organizations and medical review committees, also provide for immunity to participants and witnesses in such proceedings:131E-95(a) (immunity from liability for peer review); 131E-95(b)(proceedings of a medical review committee shall not be considered public record); Shelton v. Morehead Memorial Hospital, (records, proceedings and materials of peer review and medical review committees are absolutely privileged); Woods v. Moses Cone Health System ; Cunningham v. Canon

**b) Duties**

- (1)** Determines the hospital resources and financial support the Medical Staff requires for the administrative activities involved to fulfill its duties as established under these bylaws, and works with the Board to develop related parts of the Medical Staff budget.<sup>77</sup>
- (2)** Recommends the annual Medical Staff budget to the Medical Executive Committee;
- (3)** Recommends the amount of annual dues and, if appropriate, assessments to the Medical Executive Committee;
- (4)** Meets at the call of the chair but no less frequently than monthly,
- (5)** Fulfills other responsibilities as established in these bylaws or as are appropriately delegated by the Medical Executive Committee or the Medical Staff.

**3. Bylaws Committee**

**a) Composition**

The Bylaws Committee consists of [two] members of the Medical Staff[and the Medical Staff secretary [secretary-treasurer]][ who will serve as] [and a] committee chair.

**b) Duties**

- (1)** Reviews Medical Staff bylaws, rules and regulations and policies on an annual basis and propose amendments as appropriate to the Medical Executive Committee;<sup>78</sup>
  - a. Review any and all amendments to Medical Staff bylaws, rules and regulations, policies, applications and other documents proposed by members, other committees, departments, sections, medical staff legal counsel, and administration, and provide recommendations and underlying documentation related to the review to the Medical Executive Committee and the Medical Staff;
  - b. Reviews hospital bylaws and related policies on an annual basis and alert the Medical Executive Committee of conflicts with Medical Staff bylaws, rules and regulations and policies;<sup>79</sup>

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77 AMA Principle for Strengthening the Physician-Hospital Relationship #8 states, "The organized Medical Staff works with the hospital governing board to develop a budget to satisfy those requirements and related administrative activities, which the hospital shall fund, based upon the financial resources available to the hospital." AMA Policy Compendium H-225.957

78 NC Rule10A NCAC 13B .3706(d) requires that each Medical Staff shall conduct bylaws review.

79 AMA policy states, "The AMA encourages hospital Medical Executive Committees to: (1) regularly examine the hospital/corporate bylaws, rules and regulations for any conflicts with the Medical Staff bylaws, rules and regulations or practices; (2) request that their hospital board of trustees/directors notify them of any proposed or impending changes in the hospital/corporate bylaws; and (3) advise members/applicants of the Medical Staff of the effect of these hospital/corporate bylaws, rules and regulations." AMA Policy Compendium H-225.984. Under JC Standard MS.01.01.01 Element of Performance<sup>4</sup> " the medical staff bylaws, rules and regulations, and policies, the governing body

- c. Reviews Medical Staff application forms and other forms for consistency with the Medical Staff bylaws, rules and regulations and policies,<sup>80</sup> and propose amendments as appropriate to the Medical Executive Committee;
- (2) Oversees compliance with the Medical Staff bylaws, rules and regulations and policies;<sup>81</sup>
  - a. Meets [at least monthly and] at the call of the chair as necessary to fulfill its duties in a timely manner;
  - b. Fulfills other responsibilities as established in these bylaws or as are appropriately delegated by the Medical Executive Committee or the Medical Staff.

#### 4. Cancer Committee<sup>82</sup>

##### a) Composition

The Cancer Committee consists of at least six board-certified physicians, one each from these specialties: general surgery, medical oncology, radiation oncology, diagnostic radiology, pathology, and the cancer liaison physician,<sup>83</sup> and including at least one physician representing each of the diagnostic and treatment services.<sup>84</sup> A physician member may represent both a site and a specialty.<sup>85</sup> The Cancer Committee chair is a physician who may also fulfill the role of one of the required physician specialties.<sup>86</sup> The Cancer Committee shall also include an individual from each of the following areas of the hospital: cancer program administration, oncology nursing, social services, certified tumor registrar to carry out case abstracting, and quality improvement professional. Additional physician or non-physician members include at a minimum representatives of hospice/home care nursing or administration; pain control/palliative care specialist, clinical research data manager or nurse; and

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bylaws, and the hospital policies are compatible with each other and are compliant with law and regulation. “

<sup>80</sup> Application forms are used by some hospitals to glean information for economic credentialing, to screen out applicants who compete with the hospital, or for other purposes not authorized by the medical staff bylaws.

<sup>81</sup> Under JC standard MS.01.01.01, Element of Performance 6 “the organized Medical Staff enforces the medical staff bylaws, rules and regulations, and policies...”

<sup>82</sup> This section is designed to help the Medical Staff and hospital meet the standards of the American College of Surgeons Commission on Cancer. Cancer Program Standard 2.1, “Level of responsibility and Accountability,” calls for a cancer committee, which can either be designated in hospital bylaws, Medical Staff bylaws or hospital policies and procedures, but if in bylaws, calls for a standing committee.

<sup>83</sup> Called for by American College of Surgeons Commission on Cancer, Cancer Program Standard 2.2.

<sup>84</sup> Specified under the definitions and requirements under American College of Surgeons Commission on Cancer, Cancer Program Standard 2.2.

<sup>85</sup> Specified under the definitions and requirements under American College of Surgeons Commission on Cancer, Cancer Program Standard 2.2.

<sup>86</sup> Called for by American College of Surgeons Commission on Cancer, Cancer Program Standard 2.2.

may include a nutrition specialist, pharmacists, mental health professional or psychiatrist, pastoral care representative, American Cancer Society cancer control representative, and a public member of the community served. Other physician and non-physician members also may be on the committee as needed.<sup>87</sup> All non-Medical Staff members will be eligible to vote, except on matters relating exclusively to the Medical Staff.

**b) Duties**

- (1)** Develops and evaluate annual goals and objectives for clinical, community outreach, quality improvement, and programmatic endeavors related to cancer care.
- (2)** Is accountable, through the Medical Executive Committee, to the Board, for all clinical cancer activities at the hospital.<sup>88</sup>
- (3)** Reviews and makes recommendations on all policies and procedures related to care of cancer patients.
- (4)** Works towards complete compliance with all standards required to maintain accreditation by the American College of Surgeons Commission on Cancer;
- (5)** Establishes, as appropriate, subcommittees or workgroups to fulfill cancer program goals.
- (6)** Monitors cancer-related quality management and improvement through the completion of quality management studies that focus on quality, access to care and outcomes.
- (7)** Promotes clinical research.
- (8)** Supervises the cancer registry and encourages accurate and timely abstracting, staging, and follow-up reporting.<sup>89</sup>
- (9)** Performs quality control for registry data.
- (10)** Encourages data usage and regular reporting. Designates one coordinator for each of the four areas of Cancer Committee activity cancer conference, quality control of cancer registry data, quality improvement and community outreach. The cancer liaison physician must fulfill the role of community outreach coordinator<sup>90</sup>
- (11)** Develops and evaluates the annual goals and objectives for the clinical, community outreach, quality improvement, and programmatic endeavors related to cancer care.<sup>91</sup>

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87 Additional required cancer committee members may be required for certain categories of cancer programs. See the American College of Surgeons Commission on Cancer, Cancer Program Standards 2.4.

88 American College of Surgeons Commission on Cancer, Cancer Program Standard 2.1 states, "The organizational structure of the facility or Medical Staff gives the cancer committee responsibility and accountability for the cancer program activities."

89 North Carolina hospitals are required to report certain information on patients receiving hospital services to the North Carolina Central Cancer Registry pursuant to NC Gen Stat section 130A-208.

90 Called for by American College of Surgeons Commission on Cancer, Cancer Program Standard 2.3.

91 Based on American College of Surgeons Commission on Cancer, Cancer Program Standard 2.5.

- (12) Establishes cancer conference frequency, format and multidisciplinary attendance requirements for cancer conferences on an annual basis and monitoring attendance and compliance.<sup>92</sup>
- (13) Ensures the required numbers of cases are discussed at cancer conference and that at least 75 percent of the cases discussed are prospective.<sup>93</sup>
- (14) Establishes and implements a plan to evaluate the quality of cancer registry data and activity on an annual basis.<sup>94</sup>
- (15) completes annually at least one site-specific analysis that includes comparison and outcome data and disseminates the results of the analysis to the Medical Staff;<sup>95</sup>
- (16) reviews 10% of the analytic caseload to ensure that 90% of cancer pathology reports include scientifically validated data elements;<sup>96</sup>
- (17) analyzes patient outcomes and disseminating the results of the analysis annually;
- (18) reviews 10% of the analytic caseload to ensure that AJCC staging is assigned by the managing physician and recorded on a staging form in the medical record on at least 90% of the eligible analytic cases;<sup>97</sup>
- (19) provides a formal mechanism for educating patients about cancer-related clinical trials and offering at least one cancer-related educational activity each year;<sup>98</sup>
- (20) reviews the percentage of cases accrued to cancer-related clinical trials each year;
- (21) monitors community outreach activities on an annual basis.
- (22) completes and documents annually the required studies that measure quality and outcome;<sup>99</sup>
- (23) meets at the call of the chair but at least every other month;<sup>100</sup>
- (24) fulfills other responsibilities as established in these bylaws or as are appropriately delegated by the Medical Executive Committee or the Medical Staff.

## 5. Credentials Committee

### a) Composition

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92 Based on American College of Surgeons Commission on Cancer, Cancer Program Standard 2.6 and 2.7.

93 Based on American College of Surgeons Commission on Cancer, Cancer Program Standard 2.8.

94 Based on American College of Surgeons Commission on Cancer, Cancer Program Standard 2.10.

95 Based on American College of Surgeons Commission on Cancer, Cancer Program Standard 2.11.

96 To meet American College of Surgeons Commission on Cancer, Cancer Program Standard 3.3.

97 To meet American College of Surgeons Commission on Cancer, Cancer Program Standard 3.4 and 3.5.

98 To meet American College of Surgeons Commission on Cancer, Cancer Program Standard 5.1 and 7.1.

99 American College of Surgeons Commission on Cancer, Cancer Program Standard 8.1

100 Suggested by the definition and requirements for American College of Surgeons Commission on Cancer, Cancer Program Standard 2.4.

The Credentials Committee shall be composed of [five] members representing different specialties.

**b) Duties.**

- (1) Reviews [section and] department recommendations and evaluates the information supporting all Medical Staff membership and clinical privileges applications, and makes recommendations regarding membership, staff category, privileges, restrictions and changes in privileges to the Medical Executive Committee.
- (2) Reviews [section and] department recommendations and evaluates the information supporting all applications for renewed membership and all available information and makes recommendations to the MEC concerning membership renewals and clinical privileges for the ensuing membership period.
- (3) Periodically reviews the forms, procedures and policies involved in the credentialing process and recommends changes to the Medical Executive Committee.
- (4) Meets [at least monthly and] at the call of the chair as necessary to fulfill its duties in a timely manner.

In carrying out these duties, Credentials Committee members shall comply with the conflict of interest requirements of these bylaws.

**6. Infection Control Committee<sup>101</sup>**

**a) Composition**

The Infection Control Committee shall consist of at least one representative each from the departments of medicine, surgery, obstetrics-gynecology, pediatrics, anesthesiology, [infectious diseases], pathology, [the infection control officer],<sup>102</sup> and the lead nurse for infection control.

**b) Duties**

- (1) recommends to the Medical Executive Committee preventive programs designed to minimize infection;
- (2) oversees infection control throughout the hospital including without limitation operating rooms, delivery rooms, recovery rooms and special care units; sterilization procedures; isolation procedures; professional testing; and procurement, storage, and transfusion procedures of blood or blood products;

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101 AMA policy states that: "(1) the hospital Medical Staff should have a multidisciplinary committee to oversee the surveillance, prevention and control of infection; (2) the infection control committee should report to the hospital Medical Staff Medical Executive Committee; and (3) the Medical Staff's role, responsibility and authority in the infection control activities should be included in the Medical Staff bylaws." AMA Policy Compendium H-235.969.

102 Under Medicare COP 42 C.F.R. §482.42(a) "A person or persons must be designated as infection control officer or officers to develop and implement policies governing control of infections and communicable diseases." A member of the committee can be designated infection control officer if needed.

- (3) meets at the call of the chair but no less frequently than monthly;
- (4) fulfills other responsibilities as established in these bylaws or as are appropriately delegated by the Medical Executive Committee or the Medical Staff.

## 7. Joint Conference Committee<sup>103</sup>

### a) Composition

The Joint Conference Committee consists of the Medical Staff officers and hospital board members in equal number,<sup>104</sup> selected by the board chair from its members. The chair will alternate at each meeting between Board and Medical Staff representatives.

### b) Duties

[The committee serves as the primary locus for management and resolution of disputes between Medical Staff and Board..<sup>105</sup> Disputes shall be managed, and where possible resolved by consensus, after sufficient opportunity for the committee to receive and review any documentation or other appropriate input, including meeting and working with any involved parties.<sup>106</sup>] The Joint Conference Committee reviews all hospital strategic plans prior to implementation.<sup>107</sup> The Joint Conference Committee may request any additional information from the Medical Staff or administration before acting to approve or disapprove such plan. The Joint Conference Committee meets [at least quarterly and] at the call of the chair as necessary to fulfill its duties in a timely manner.

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103 To implement in part the requirement of NC Rule10A NCAC 13B.3705(b)(7) 1 that Medical Staff bylaws shall provide for "formal liaison between the Medical Staff and the governing body."

104 AMA Principle for Strengthening the Physician-Hospital Relationship #12 states, "Areas of dispute and concern, arising between the organized Medical Staff and the hospital governing body, are addressed by well-defined processes in which the organized Medical Staff and hospital governing body are equally represented. These processes are determined by agreement between the organized Medical Staff and the hospital governing body." AMA Policy Compendium H-225.957

105 Joint Commission Standards LD 02.04.01, Element of Performance 1 states, "Senior managers and leaders of the organized Medical Staff work with the governing body to develop an ongoing process for managing conflict among leadership groups."

106 The Committee provides a forum for conflict resolution as called for under Joint Commission Standard LD.02.04.01. Under Element of Performance 4 for the standard:

"The conflict management process includes the following:

- Meeting with the involved parties as early as possible to identify the conflict
- Gathering information regarding the conflict
- Working with the parties to manage and, when possible, resolve the conflict
- Protecting the safety and quality of care."

107 AMA Principle for Strengthening the Physician-Hospital Relationship #3 states, "The leaders of the organized Medical Staff...are involved in hospital strategic planning as described in the Medical Staff bylaws." AMA Policy Compendium H-225.957

## 8. Medical Executive Committee<sup>108</sup>

[The Medical Staff as a whole serves as the Medical Executive Committee.]<sup>109</sup>

### a) Composition

The Medical Executive Committee consists of the Medical Staff officers, the [elected department chairs or in any departments under exclusive contract,][the elected representative of the department,]<sup>110</sup>[the AMA OMSS Representative,]<sup>111</sup>and [[4]<sup>112</sup>at-large members representatives. ]<sup>113</sup> The president will chair the committee. The administrator [and chief nursing executive]<sup>114</sup>may be invited by the president to attend the Medical Executive Committee meetings as needed and appropriate.<sup>115</sup>

### b) Duties

The medical executive committee

- (1) reviews the recommendations of the Medical Staff departments and committees regarding the clinical competence of applicants and Medical Staff members and other practitioners with or applying for clinical privileges and make recommendations to the Board regarding membership, membership renewal,<sup>116</sup> staff categorization, and

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108 NC Rule10A NCAC 13B/3705(b) states that “there shall be a Medical Executive Committee, or its equivalent, which represents the Medical Staff, which has the responsibility for the effectiveness of all the activities of the staff, and which acts for the Medical Staff.” JC standard MS.01.01.01, Element of Performance 20 states, “the Medical Staff bylaws must also include...the medical staff Medical Executive Committee’s function, size, and composition, and of the methods for selecting and removing its members...”

109 As noted in footnote 4 of the JC Accreditation Manual for Healthcare Organizations Medical Staff Chapter, “the Medical Staff as a whole may serve as the Medical Executive Committee. In smaller, less complex hospitals where the entire Medical Staff functions as the Medical Executive Committee, it is often designated as a committee of the whole.”

110 To permit the department rather than the hospital to name the department’s representative to the Medical Executive Committee.

111 Including the AMA OMSS representative will promote communication between the Medical Staff and AMA.

112 The number of at-large members can be adjusted to off-set hospital-employed or hospital–contracted members, so that a majority of the Medical Executive Committee is Independent.

113 Allowing at large representatives may assist the Medical Staff to comply with JC Standard MS.02.01.01 EP 3, which provides that “all members of the organized Medical Staff, of any discipline or specialty, are eligible for membership on the Medical Executive Committee.”

114 Under DNV standard MS 5, SR 2, the chief nursing executive is to attend MEC meetings on an ex-officio basis, with or without vote. Note membership is not required.

115 JC standard MS.02.01.01, Element of Performance 2 states, “The chief executive officer (CEO) of the hospital or his or her designee attends each Medical Staff Medical Executive Committee meeting on an ex-officio basis, with or without a vote. “Under DNV standard MS 5, SR 2, the chief executive officer is to attend MEC meetings on an ex-officio basis, with or without vote. Note neither accreditation body requires that the CEO or CNO be granted membership on the medical staff.

116 According to JC standard MS.02.01.01, Elements of Performance 6, “the Medical Staff Medical Executive Committee makes recommendations, as defined in the Medical Staff bylaws, directly to the governing body on at least... Medical Staff membership.”

department assignments, and renewal, termination or changes in clinical privileges;<sup>117</sup>

- (2) is authorized to act for the organized Medical Staff between meetings of the organized Medical Staff,<sup>118</sup> with the exception of election of officers and amendment of these bylaws,<sup>119</sup> and subject to any other limitations imposed by the Medical Staff bylaws, which authority can be further limited or removed by vote of two-thirds of the medical staff eligible to vote.<sup>120</sup> The Medical Executive Committee represents<sup>121</sup> and is accountable to the Medical Staff, and, except for recommendations regarding membership, privileges and corrective actions, subject to reversal of its decisions by a majority vote of the active staff,<sup>122</sup>
- (3) oversees and coordinates the activities of Medical Staff departments and committees, including resolving conflicts among them or among members<sup>123</sup>;
- (4) receives and, when requested or appropriate, acts upon committee and departmental minutes, reports and recommendations;<sup>124</sup>
- (5) adopts and implements policies of the Medical Staff;
- (6) is kept informed of any hospital activities, business developments and projects, pending decisions, policies, plans or proposals related to patient care at the earliest possible juncture and in all cases in advance of their

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117 Consistent with JC standard MS.02.01.01, Elements of Performance 11, “the Medical Staff Medical Executive Committee makes recommendations, as defined in the Medical Staff bylaws, directly to the governing body on at least...the delineation of privileges for each practitioner privileges through the Medical Staff process (and) Medical Staff membership.”

118 JC standard MS.01.01.01 states, “the Medical Staff bylaws must also include the following: that the Medical Executive Committee acts on behalf of the medical staff between meetings of the organized medical staff , within the scope of its responsibilities as defined by the organized medical staff.”

119 Under Joint Commission standard MS 01.01.01, Element of Performance 20, the medical staff bylaws must include “the authority delegated to the medical executive committee by the organized medical staff to act on the medical staff’s behalf.” Joint Commission standard MS 01.01.01, Element of Performance 2 states, “The organized medical staff adopts and amends medical staff bylaws. Adoption or amendment of medical staff bylaws cannot be delegated. “

120 Under Joint Commission standard MS 01.01.01, Element of Performance 20, the medical staff bylaws must include how the authority delegated to the medical executive committee by the organized medical staff to act on the medical staff’s behalf is removed.

121 NC Rule10A NCAC 13B/3706(b) states that the Medical Executive Committee “represents the Medical Staff.”

122 Under Joint Commission standard MS 01.01.01, Element of Performance 10, “The organized medical staff has a process which is implemented to manage conflict between the medical staff and the medical executive committee on issues including, but not limited to, proposals to adopt a rule, regulation, or policy or an amendment thereto.”

123 “The hospital manages conflict between leadership groups to protect the quality and safety of care,” under JC standard LD.02.04.01.

124 According to JC standard MS.02.01.01, Elements of Performance 12, “the Medical Staff Medical Executive Committee makes recommendations, as defined in the Medical Staff bylaws, directly to the governing body on...the Medical Executive Committee reviews and acts on reports of Medical Staff committees, departments, and other assigned activity groups.”

implementation, by hospital administration or board members, to permit the Medical Executive Committee to provide clinical input and recommendations to the board;

- (7) recommends action to the Board as appropriate on matters of a medical administrative nature including the Medical Staff structure;<sup>125</sup>
- (8) develops organ and tissue donation protocols for the Medical Staff, or adopts those developed by a committee, department or task force appointed by the president for this purpose;<sup>126</sup>
- (9) recommends to the Board, or a committee thereof, all matters relating to membership determinations, staff categorization, department assignments and corrective action, except when such is a function of the Medical Staff;
- (10) reports to the medical staff on key issues at each general staff meeting and in writing between meetings as appropriate for timely communication;
- (11) responds in a timely manner directly to individual members regarding their written concerns, to the extent possible without jeopardizing confidentiality of peer review data;
- (12) oversees the Medical Staff accounts and, when appropriate, votes to disperse funds for Medical Staff activities, including for services rendered to the Medical Staff by legal counsel and by other independent professional assistance retained by the Medical Executive Committee to protect and promote the interests of the Medical Staff;<sup>127</sup>
- (13) Implements and enforces the medical staff bylaws, rules and regulations and policies;
- (14) discharges such other duties as may be assigned to it by the Medical Staff;
- (15) meets at the call of the chair but at least monthly; and
- (16) fulfills other responsibilities as established in these bylaws or as are appropriately delegated by the Medical Staff.

## 9. Medical Staff Wellness Committee<sup>128</sup>

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125 JC standard MS.02.01.01, Elements of Performance 9 states that “the Medical Staff Medical Executive Committee makes recommendations, as defined in the Medical Staff bylaws, directly to the governing body on at least...the organized Medical Staff’s structure.”

126 Consistent with JC standard TS.01.01.01, “Leaders implement policies and procedures developed with the Medical Staff’s participation for procuring and donating organs and other tissues.”

127 Consistent with AMA policy, which states that “Organized Medical Staffs have a right to independent legal counsel. Our AMA strongly recommends that hospital Medical Staffs retain their own attorneys so that the Medical Staff will have access to its own legal advocates for guidance and to ensure the integrity, both legally and organizationally, of the self-governing Medical Staff. ... ” AMA Policy Compendium H-235.992

128 JC standard MS.11.01.01 calls on the Medical Staff to implement a health management process for licensed independent practitioners. A Medical Staff committee with a responsibility to promote quality care may qualify for protection under North Carolina peer review laws.

### **a) Composition**

The Medical Staff Wellness Committee consists of no fewer than three active Medical Staff members, a majority of which, including the chair, shall be physicians, where possible, with experience in psychiatry and addiction medicine. Except for initial appointments, each member shall serve a term of 3 years, and the terms shall be staggered to achieve continuity. Members of this committee shall not serve on Peer Review Committees or in department or Medical Executive Committee leadership while serving on this committee.<sup>129</sup>

### **b) Duties**

- (1)** receives reports and self-referrals<sup>130</sup> related to the physical, mental and emotional health and well-being of Medical Staff members, to improve patient care by assisting those members who might be impaired.
- (2)** determines whether reports are reliable,<sup>131</sup> and take in additional data and make recommendations regarding such reports.
- (3)** refers the member to the North Carolina Physician Health Program<sup>132</sup> or other appropriate sources of treatment and assistance.<sup>133</sup>
- (4)** provides advice, counseling, or monitoring, or coordinate services with outside treatment and assistance sources;
- (5)** maintains all committee information as confidential with the exception of a member whose condition or non-compliance<sup>134</sup> presents unreasonable risk of harm to patients,<sup>135</sup> in which case the committee shall refer the member for corrective action;
- (6)** develops educational programs to instruct Medical Staff to recognize behavioral problems, illness and impairment in healthcare professionals,<sup>136</sup>

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129 Under JC Standard MS.11.01.01, "The identification process is separate from actions taken for disciplinary function."

130 Element of Performance 2 for JC Standard MS.11.01.01 states that the process design should address self-referral by physicians and licensed independent professionals.

131 Element of Performance 6 for JC Standard MS.11.01.01, states that process design should address "evaluation of the credibility of a complaint, allegation, or concern."

132 For information regarding the North Carolina Physician Health Program, contact <http://www.ncphp.org/index.htm>.

133 Element of Performance 4 for JC Standard MS.11.01.01 calls for addressing referral of the affected practitioners "to the appropriate professional internal or external resources for diagnosis and treatment of the condition or concern."

134 JC standard MS 11.01.01 Element of Performance 9 calls for appropriate action to be initiated when a licensed independent practitioner fails to complete a required rehabilitation program.

135 Element of Performance 4 for JC Standard MS.11.01.01 states that the wellness process should address "maintenance of the confidentiality of the Licensed Independent Practitioners seeking referral or referred for assistance, except as limited by law, ethical obligation, or when the safety of a patient is threatened..." and under Element of Performance 8, "Reporting to the Medical Staff leadership instances in which a Licensed Independent Practitioners is providing unsafe treatment."

136 Element of Performance 1 for JC Standard MS.11.01.01 states that the process design should address education of the Medical Staff and other organization staff "about illness and impairment recognition issues specific to Licensed Independent Practitioners."

- (7) reports to the Medical Executive Committee on the activities of the committee without violating confidentiality of the members involved;
- (8) fulfills other responsibilities as established in these bylaws or as are appropriately delegated by the Medical Executive Committee or the Medical Staff; and
- (9) meets at the call of the chair, but at least quarterly.

## 10. Peer Review Committee<sup>137</sup>

### a) Composition

The Peer Review Committee consists of [[2] surgeons and [2] family physicians or internists].<sup>138</sup> Under no circumstances is Peer Review Committee membership limited to members who are employed by or under contract with or otherwise practice exclusively at the hospital.<sup>139</sup>

### b) Duties<sup>140</sup>

- (1) conducts peer review based on indicators and standards promulgated by the Quality Improvement Committee of the Medical Staff<sup>141</sup> and approved by the Medical Executive Committee.<sup>142</sup>
- (2) initiates focused review, after notifying the subject for the review,<sup>143</sup> based on information referred by the Quality Improvement

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137 Medical review committees such as this are protected under North Carolina state immunity and confidentiality statutes, specifically, NC Gen Stat Section 131E-95. Cases before North Carolina courts have been supportive, such as *Shelton v. Morehead Memorial Hospital*, 318 N.C. 76 (847 S.E.2d 824 (1986) “[Peer review protection] represents a legislative choice between competing public concerns. It embraces the goal of Medical Staff candor at the cost of impairing plaintiffs’ access to evidence” *Cameron v. New Hanover Memorial Hosp., Inc.*, 58 N.C. App. 414, 436 (293 S.E. 2d 901, 914), appeal dismissed and disc. rev. denied, 318 N.C. at 83 (1974). Providing confidentiality encourages “candor and objectivity in the internal workings of medical review committees.” *Shelton*, 318 N.C. at 83, (347 S.E.2d. at 829).

138 Peer review committee membership should at least balance proceduralists and non-proceduralists, or provide representation of individual specialties.

139 NCMS Policy on Hospital Peer Review states, “The composition of this committee should represent the diversity of the Medical Staff, including ‘economic diversity.’ ”<http://www.ncmedsoc.org>. See also, “Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations”, AMA Policy Compendium D-375.992.

140 To meet NC Rule10A NCAC 13B.3708(d) requirement that “(t)he Medical Staff shall establish and maintain a continuous review process of the care rendered to both inpatients and outpatients in every medical department of the facility.

141 NCMS Policy on Hospital Peer Review states, “The process of choosing “indicators” or “monitors” of physician performance should be overseen by a quality committee at the Medical Staff level, provided, however, that all metrics should be thoroughly vetted at the department or specialty level.” <http://www.ncmedsoc.org>.

142 NCMS Policy on Hospital Peer Review states, “Oversight of this process should lie with the Medical Executive Committee, which should approve the variance criteria (indicators/monitors) chosen.” <http://www.ncmedsoc.org/>.

143 NCMS Policy on Hospital Peer Review states, “Physicians whose cases are chosen for peer review are notified of this occurrence. They should have an opportunity to provide written input which can be considered by any peer review committee and which becomes part of the peer review file. The physician under review should also be informed of any decisions that may lead to recommendations for individual

Committee, by the Medical Executive Committee. Sources for identifying cases for peer review include, but are not limited to, chart reviews, quality indicators, data from Medical Staff committees, patient or family complaints, by an individual acting in good faith,<sup>144</sup> and event trending reports. All review will be conducted exclusively according to Medical Staff bylaws, rules and regulations and peer review policy.

- (3) requests the Medical Executive Committee to refer a matter for external peer review when warranted, consistent with these bylaws.
- (4) routinely recommends updates and other improvements in the Medical Staff peer review policy for adoption by the Medical Executive Committee.
- (5) meets at the call of the chair but at least quarterly;
- (6) fulfills other responsibilities as established in these bylaws or as are appropriately delegated by the Medical Executive Committee or the Medical Staff.

## **11. The Pharmacy & Therapeutics Committee**

### **a) Composition**

The Pharmacy & Therapeutics Committee consists of a physician from each department, a pharmacist from the hospital pharmacy and a representative from nursing. The chair shall appoint appropriate physician members of the Pharmacy & Therapeutics Committee and hospital personnel to serve on a Nutrition Subcommittee.

### **b) Duties**

- (1) develops drug utilization policies; policies regarding drug inventory and floor stock; and the hospital formulary;<sup>145</sup>
- (2) assesses the safety and technical quality of diagnosis and radiation and other therapeutic services performed at the hospital;<sup>146</sup>
- (3) review adverse drug reaction reports, clinical antibiotic usages and other drug usage practices;
- (4) conducts blood usage review;<sup>147</sup>
- (5) recommends medical equipment needs;

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remedial action or corrective action, and the physician should have an opportunity to respond, in person or in writing, to the underlying quality concerns before the recommendations are implemented.”

<http://www.ncmedsoc.org/>

144 NCMS Policy on Hospital Peer Review states, “Medical Staffs should adopt a mechanism that affords protection to physicians who, acting in good faith and the best interest of quality of care concerns, report concerns to the peer review committee, under the protection of a Medical Staff policy.”

<http://www.ncmedsoc.org/>.

145 Implementing NC Rule10A NCAC 13B.3706(d) which states, “The following reviews and functions shall be performed by Medical Staff: (5) drug utilization review.”

146 Implementing NC Rule10A NCAC 13B.3706(d) which states, “The following reviews and functions shall be performed by Medical Staff: radiation safety review.”

147 Implementing NC Rule10A NCAC 13B.3706(d) which states, “The following reviews and functions shall be performed by Medical Staff: (5) blood usage review.”

- (6) meets at the call of its chair but at least [monthly.]
- (7) oversees the activities of the Nutrition Subcommittee, which:
  - (a) on request, evaluates patients to provide for appropriate feeding;
  - (b) develops procedures for monitoring enteral and TPN feeding;
  - (c) makes recommendations on nutritionally high-risk patients upon admission;
  - (d) provides updates on nutrition information to the Medical Staff;
  - (e) makes recommendations on outpatient nutritional programs;
  - (f) provides coordination of nutritional services in the hospital and home care setting;
  - (g) meets at the call of the chair but no less frequently than quarterly,
  - (h) fulfills other responsibilities as established in these bylaws or as are appropriately delegated by the Medical Executive Committee or the Medical Staff.

## 12. Quality Improvement Committee<sup>148</sup>

### a) Composition

The committee consists of representatives of each Medical Staff department [and section] and shall be chaired by the president-elect.

### b) Duties

- (1) maintains and implements the written hospital-wide quality improvement plan, recommending updates and improvements, as needed, to the Medical Executive Committee;<sup>149</sup>
- (2) Develops recommendations for the establishment of standards for measuring the quality, appropriateness and improvement of patient care furnished by those holding clinical privileges,<sup>150</sup> including recommendations for the threshold criteria for defining any trend warranting evaluation;<sup>151</sup>
- (3) Establishes surgical case review processes<sup>152</sup>, and focused evaluation processes<sup>153</sup> for care consistent with these bylaws, including chart

148 Under NC Rule10A NCAC 13B.3705(b)(9), the bylaws must include “procedures for members of Medical Staff participation in quality assurance functions.”

149 Under NC Rule10A NCAC 13B.3708(c), “ The facility shall have a written plan approved by the Medical Staff, administration and governing body which generates reports to permit identification of patient care problems.”

150 NCMS Policy on Hospital Peer Review states, “The process of choosing “indicators” or “monitors” of physician performance should be overseen by a quality committee at the Medical Staff level, provided, however, that all metrics should be thoroughly vetted at the department or specialty level.”

<http://www.ncmedsoc.org>.

151 NCMS Policy on Hospital Peer Review states, “Threshold criteria should be established for defining where a trend exists that needs further evaluation. This responsibility should lie with a Medical Staff quality committee.” <http://www.ncmedsoc.org>.

152 Implementing NC Rule10A NCAC 13B .3706, which states, “The following reviews and functions shall be implemented by the Medical Staff: (1) surgical case review.”

review,<sup>154</sup> practice pattern monitoring, proctoring, external peer review, and discussion with other professionals involved in the care of the same patients,<sup>155</sup> for new members and members with new privileges,<sup>156</sup> and for focused review or investigation.<sup>157</sup>

- (4) Develops standards and recommendations for implantable devices and other medical equipment and devices used in the exercise of privileges in the department;
- (5) prioritizes and monitors the results of quality improvement activities throughout the hospital;
- (6) develops and maintains systems for monitoring the quality of hospital services ordered by Medical Staff members;<sup>158</sup>
- (7) develops and implements continuing medical education activities based on quality improvement data specific to this Medical Staff;
- (8) meets at the call of the chair but no less frequently than monthly;<sup>159</sup>
- (9) fulfills other responsibilities as established in these bylaws or as are appropriately delegated by the Medical Executive Committee or the Medical Staff.

### 13. Utilization Review Committee<sup>160</sup>

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153 Implementing NC Rule10A NCAC 13B .3706, which states, "The following reviews and functions shall be implemented by the Medical Staff: (4) medical care evaluation review." Note also, JC standard MS.08.01.01 provides, "the organized Medical Staff defines the circumstances requiring monitoring and evaluation of a practitioner's professional performance."

154 Implementing NC Rule10A NCAC 13B .3706, which states, "The following reviews and functions shall be implemented by the Medical Staff: (1) medical records review."

155 As described in the Rationale for JC MS.08.01.01.

156 Element of Performance 1 for JC standard MS.08.01.01 states that "A period of focused professional practice evaluation is implemented for all initially requested privileges."

157 Element of Performance 1 for JC standard MS.08.01.01 states that "The organized Medical Staff develops criteria to be used for evaluation the performance of practitioners when issues affecting the provision of safe, high quality patient care are identified."

158 Implementing NC Rule10 NCAC 13B. 3708(a), which states, "(t)he Medical Staff shall have in effect a system to review medical services rendered, to assess quality, to provide a process for improving performance when indicated and to monitor the outcome."

159 Under NC Rule10A NCAC 13B.3708(d), "At least quarterly, the Medical Staff shall have a meeting to examine the review process and results."

160 Medicare COP 42 C.F.R. §482.30(b) states, "Composition of utilization review committee. A UR committee consisting of two or more practitioners must carry out the UR function. At least two of the members of the committee must be doctors of medicine or osteopathy. The other members may be any of the other types of practitioners specified in §482.12(c)(1).

(1) Except as specified in paragraphs (b) (2) and (3) of this section, the UR committee must be one of the following:

- (i) A staff committee of the institution;
  - (ii) A group outside the institution—
    - (A) Established by the local medical society and some or all of the hospitals in the locality; or
    - (B) Established in a manner approved by CMS.
- (2) If, because of the small size of the institution, it is impracticable to have

### **a) Composition**

The utilization Review Committee consists of physician representatives of each Medical Staff department [and section] [and shall be chaired by the secretary [secretary-treasurer.] ]

### **b) Duties**

- (1)** maintains and implements the hospital-wide utilization review plan which shall be designed solely to promote quality care by promoting appropriate utilization of hospital resources through reducing under-utilization and over-utilization of services,<sup>161</sup> recommending updates and improvements, as needed, to the Medical Executive Committee;
- (2)** consistent with the utilization plan, reviews hospital admissions with respect to medical necessity of services and duration of hospital stay;
- (3)** meets at the call of the chair but no less frequently than monthly;
- (4)** fulfills other responsibilities as established in these bylaws or as are appropriately delegated by the Medical Executive Committee or the Medical Staff.

## **D Meetings<sup>162</sup>**

Meetings of the Medical Staff are open to all Medical Staff members, regardless of category or voting rights. Department [section] and committee meetings may be limited, in whole or in part, to members only, by the chair for discussion of privileged and/or confidential information regarding quality improvement or peer review information<sup>163</sup> or unless and until executive session is called.

### **1. Attendance Obligation**

#### **a) Meeting attendance**

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a properly functioning staff committee, the UR committee must be established as specified in paragraph (b)(1)(ii) of this section.”

<sup>161</sup> Consistent with AMA Council on Ethical and Judicial Affairs Opinion E-4.04, which states, “(t)he primary obligation of the hospital Medical Staff is to safeguard the quality of care provided within the institution. The Medical Staff has the responsibility to perform essential functions on behalf of the hospital in accordance with licensing laws and accreditation requirements. Treatment or hospitalization that is willfully excessive or inadequate constitutes unethical practice. The organized Medical Staff has an obligation to avoid wasteful practices and unnecessary treatment that may cause the hospital needless expense. In a situation where the economic interests of the hospital are in conflict with patient welfare, patient welfare takes priority.” NC Gen Stat Section 131E-86(a) authorizes hospitals to act on Medical Staff applications for clinical privileges based on “the applicant’s education, training, experience, demonstrated competence and ability, and judgment and character of the applicant, and the reasonable objectives and regulations of the hospital, including, but not limited to appropriate utilization of hospital facilities, in which privileges are sought.”

<sup>162</sup> DNV standard MS 16, Standard Requirement 2 states, “The medical staff bylaws shall require that the medical staff have periodic meetings at regular intervals to review and analyze medical records of the patients for adequacy and quality of care.”

<sup>163</sup> NC Rule10A NCAC 13B.3706(e) states, “There shall be Medical Staff and departmental meetings for the purpose of reviewing the performance of the Medical Staff, departments or services...” To the extent Medical Staff and departmental meetings address other issues, meetings should be open to members.

Except as stated below, each member of the [active] medical staff shall be required to attend:

- (1) The annual Medical Staff meeting;
- (2) At least [50%] percent of all other general staff meetings duly convened pursuant to these bylaws; and
- (3) At least [50%] percent of all meetings of each department, division, and committee to which the member is assigned.

Any member who is compelled to be absent from any Medical Staff, department, division, or committee meeting shall promptly provide to the regular presiding officer thereof the reason for such absence. Unless excused for good cause by the presiding officer of the department [,section] or committee, or the [president][secretary ][secretary-treasurer] for Medical Staff meetings, failure to meet the attendance requirements may be grounds for removal from such committee or for non-renewal of Medical Staff membership.

#### **b) Special Attendance**

A practitioner whose case or care is scheduled for discussion at a department [,section]or committee meeting shall be provided special notice of the requirement to respond in the manner determined by the department [,section]or committee. Failure by the practitioner to attend such a meeting shall result in an automatic suspension of the practitioner's privileges that shall remain in effect until the matter is resolved through any mechanism that may be appropriate, including corrective action, if necessary, unless the President, the Chair of the applicable committee or department or the Medical Executive Committee determines subsequently that there was good cause for the failure to attend and terminates the automatic suspension.

### **2. Special Meeting**

A special meeting of the Medical Staff may be called by the president or the Medical Executive Committee or shall be called by the president upon petition signed by not less than [one-fourth] of the active Medical Staff members within thirty days after the petition is received. The Medical Executive Committee shall designate the time and place of any such special meeting in the written notice delivered not less than seven nor more than fifteen days before the date of such meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

### **3. Notice**

Unless otherwise provided in these bylaws, notice of meetings may be established by resolution of the body meeting, or by pronouncement of the chair at the previous meeting. Presence at a meeting establishes receipt of notice. Notice of general and special meetings of the Medical Staff shall be provided to all Medical Staff members, regardless of voting status.<sup>164</sup>

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164 To encourage involvement and participation by all Medical Staff members.

#### **4. Quorum**

At any meeting of the Medical Staff, the presence of [one-half of] the total membership of the active Medical Staff at any regular or special meeting shall constitute a quorum for the purposes of amendment to these bylaws and the rules and regulations. The presence of twenty-five percent of the active Medical Staff shall constitute a quorum for all other actions. Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be specifically required by these bylaws.

#### **5. Electronic Participation**

Attendance, meeting of a committee, department, [section,] or the Medical Staff organization, actions including voting, notice other than special notice, and participation may be accomplished by email or other electronic and/or telephonic means where permitted by the chair of the meeting on either an individual or group basis.

Electronic voting on medical staff matters is authorized, provided there is:

- a) an active and viable forum for all medical staff members to discuss the proposal and ask questions of the Medical Executive Committee; administration, or governing body;
- b) a system to handle motions to amend the proposal or to separate it into sub-components requiring multiple votes;
- c) a voting structure that maintains voter anonymity;
- d) voting only after distribution of the complete proposal and completion of a subsequent discussion period, unless the discussion period is discontinued by the written request by at least 5% of the medical staff for an in person meeting;
- e) a system to verify the eligibility of each individual voting, such as a password or personal identifier known only to the eligible voter;
- f) a defined voting period of reasonable length, followed by an independent, objective vote count tabulation that cannot be altered by any individual.<sup>165</sup>

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<sup>165</sup> NCMS Policy on Electronic Voting On Medical Staff Matters states, "The North Carolina Medical Society supports medical staff bylaws provisions authorizing electronic voting on medical staff matters, provided the following features are part of the voting system:

- a) Electronic voting is specifically authorized in the medical staff's bylaws;
- b) There is an active and viable forum for all medical staff members to discuss the proposal and ask questions of the Medical Executive Committee, administration, or governing body;
- c) There is a system to handle motions to amend the proposal or to separate it into sub-components requiring multiple votes;
- d) Voting is anonymous, and is structured to occur only after distribution of the complete proposal and a subsequent discussion period is completed;

## 6. Agenda

The agenda and order of business at all meetings of the Medical Staff shall be determined by the President, subject to the approval of the Medical Executive Committee, and consistent with the following:

- a) The Medical Staff meeting agenda shall include acceptance of the minutes of the last regular and all special meetings held since the last regular meeting, old business, new business; reports by responsible officers, committees and departments,<sup>166</sup> and election of officers when required by these bylaws.
- b) At any general Medical Staff meeting or any special Medical Staff meeting called for the purpose of reviewing Medical Executive Committee actions, actions of the Medical Executive Committee, other than recommendations regarding membership, privileges and corrective actions,<sup>167</sup> may, at the request of any active member, be reviewed by the Medical Staff and revised by a majority of those voting.<sup>168</sup>
- c) The agenda of all other meeting shall be determined by the presiding officer of the meeting.

## 7. Executive Session<sup>169</sup>

The Medical Staff, its committees [sections] and departments are entitled to meet in executive session, limited to voting members, administrative personnel needed to keep the record, and those expressly invited by the presiding officer. Executive session may be called by the presiding officer at the request of any member, and shall be called by the presiding officer pursuant to a duly adopted motion. Actions can be taken in executive session, and have the same force and effect of actions taken in open meetings.

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e) During the discussion period the electronic voting can be discontinued on any proposal if five percent or more of medical staff members communicate in writing that an in-person meeting is requested to address the matter;

f) There is a system to verify the eligibility of each individual voting, such as a password or personal identifier known only to the eligible voter;

g) There is a defined voting period of reasonable length;

h) Votes are counted only after conclusion of the voting period;

i) There is an independent and objective vote counting system where no individual can alter vote tabulations." <http://www.ncmedsoc.org>.

166 NC Rule10A NCAC 13B.3706(e) states, "There shall be Medical Staff and departmental meetings for the purpose of reviewing the performance of the Medical Staff, departments or services, and reports and recommendations of Medical Staff and multi-disciplinary committees."

167 Peer review actions should not be the subjects of popular vote.

168 Avoids the pro-forma subjecting all decisions to the whole Medical Staff but allows any active member to call for review by the entire staff of any MEC decision other than peer review related matters.

169 "The AMA (1) supports the right of any hospital Medical Staff committee to meet in executive session, with only voting members of the Medical Staff present, in order to permit open and free discussion of issues such as peer review and to maintain confidentiality; and (2) encourages individual Medical Staffs to incorporate provisions in their bylaws to affirm this right." AMA Policy Compendium H-235.987

## **8. Parliamentary Code**

Unless otherwise specified, meetings shall be conducted according to Robert's Rule of Order [Sturgis Standard Code of Parliamentary Procedure]; however, technical or non-substantive departures from parliamentary codes shall not invalidate action taken at such a meeting.

## **E Medical Staff Organization Support**

### **1. Meeting Support**

Hospital administration shall arrange for attendance of hospital administrative staff to attend, in a non-voting capacity, at the request of the chair of the committee, department [section] or Medical Staff meeting, to maintain the record of the meeting and otherwise provide support.

### **2. Medical Staff Office**

The hospital shall provide the Medical Staff with appropriate office space, equipment, and support staff necessary to carry out the managerial, secretarial and support work required by the Medical Staff officers, departments, [sections] and committees. Confidentiality of Medical Staff records<sup>170</sup> will be maintained by the Medical Staff office. Medical staff office personnel, [including the [Medical Staff Manager/Coordinator] [and][medical director [vice president of medical affairs] shall comply with and are bound by the medical staff bylaws, rules and regulations, policies and other medical staff documents.

#### **a) Medical Staff Manager/Coordinator**

The hospital will hire administrative personnel to conduct verification of credentials, maintain Medical Staff records, provide meeting management and facilitate other functions needed for the Medical Staff organization to carry out its responsibilities as detailed in these bylaws. Medical Staff support staff shall be adequately trained and certified in Medical Staff management.<sup>171</sup>

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170 The Medical Staff office is typically the repository for Medical Staff information that North Carolina statutes and case law protect from discovery in malpractice cases brought against physicians. Medical Staff office personnel would not be permitted to reveal confidential peer review information under NC Gen Stat Section 131E-95(b), which states that "the proceedings of a medical review, the records and materials it produces and the material it considers shall be confidential and not be subject to discovery and not considered public records...and shall not be subject to discovery or introduction into evidence in any civil action against a hospital, an ambulatory surgical facility... or a provider of professional health care services..." North Carolina courts state the statute only protects "a medical review committee's (1) proceedings; (2) records and materials it produces and (3) materials it considers." Shelton v. Morehead Memorial Hospital; Woods v. Moses Cone Health System. However, NC Gen Stat Section 131E-95(c) goes on to state "information, documents, or records otherwise available are not immune from discovery or use in a civil action merely because they were presented during the proceedings of the committee. For example, in Cunningham v. Cannon, a North Carolina court held that information contained in a physician's application for clinical privileges did not receive the protections as privileged information.

171 Certification is available from the National Association Medical Staff Services at [www.namss.org](http://www.namss.org).

**b) Medical Director [Vice President of Medical Affairs]<sup>172</sup>**

If a medical director [vice president of medical affairs] is hired by the hospital, the following provisions shall apply.<sup>173</sup>

**(1) Qualifications**

The medical director [vice president of medical affairs] shall be a physician licensed to practice in North Carolina with demonstrated administrative ability. The medical director [vice president of medical affairs] shall be a member of the Medical Staff with clinical privileges if he/she will be providing any clinical services at the hospital in addition to serving as the medical director [vice president of medical affairs].

**(2) Selection**

The administrator shall coordinate any recruiting and hiring efforts involving the position of medical director with the Medical Executive Committee. The Medical Executive Committee or a subcommittee thereof designated by the Medical Executive Committee shall interview the candidates qualified for the position. The hospital's decision shall be consistent with the recommendations of the Medical Executive Committee<sup>174</sup>

**(3) Term of Office**

The medical director [vice president of medical affairs] may resign at any time by notifying the administrator in writing. Such resignation, which may or may not be contingent on formal acceptances, shall take effect on the date of receipt or at any later time specified in the notice of resignation. The medical director [vice president of medical affairs] shall not be removed

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172 "Our AMA supports the following guidelines regarding the role of the hospital medical director:

(1) The hospital governing body, management, and Medical Staff should jointly determine if there is a need to employ a medical director; establish the purpose, duties, and responsibilities of this position; establish the qualifications for this position; and provide a mechanism for Medical Staff input into the selection, evaluation, and termination of the hospital medical director.

(2) The purpose, duties, and responsibilities of the medical director should be included in the Medical Staff and hospital corporate bylaws.(3) The organized Medical Staff should maintain overall responsibility for the quality of the professional services provided by individuals with clinical privileges and should have the responsibility of reporting to the governing body.

(4) The chief elected officer of the Medical Staff should represent the Medical Staff to the administration, governing body, and external agencies. (5) Government regulations which would mandate a hospital medical director who would have authority over the Medical Staff should be opposed. (6) The hospital medical director shall be a physician." AMA Policy Compendium H.235.981

173 Clarifying that a medical director is not mandatory, but any time one is taken on, the position is governed by the Medical Staff bylaws.

174 Consistent with policy of the American Medical Association which provides that "The hospital governing body and Medical Staff should jointly determine if there is a need to employ a medical director; establish the purpose, duties, and responsibilities of this position, establish the qualification for this position and provide a mechanism for Medical Staff input into the selection, evaluation, and termination of the hospital medical director..." AMA Policy Compendium H.235.981.

without cause. The medical director [vice president of medical affairs] shall be removed upon the reasonable request of the Medical Executive Committee indicating the cause for the request. Such removal shall not of itself adversely affect the staff membership, if any, of the medical director [vice president of medical affairs] or otherwise give rise to any right of review. Any vacancy occurring in the office of the medical director [vice president of medical affairs] shall be filled according to these bylaws.

#### **(4) Duties**

- (a)** The medical director [vice president of medical affairs]'s responsibilities shall not usurp or conflict with the responsibilities of Medical Staff officers or department [or section] chairmen as described in these bylaws. The medical director [vice president of medical affairs] has no authority to represent the Medical Staff or act independently regarding the Medical Staff's functions or operations. The medical director [vice president of medical affairs] supervises the Medical Staff office personnel, and carries out such quality improvement and other duties as are specified in the medical director [vice president of medical affairs] job description as approved by the Medical Executive Committee, which approval shall not be unreasonably withheld.
- (b)** The medical director [vice president of medical affairs] will not serve as a member of any Medical Staff committee, and shall not chair or vote in Medical Staff committee meetings. The medical director [vice president of medical affairs] will have a vote if a member of a Medical Staff category that includes voting rights among its prerogatives, but only in clinical departments or sections in which the medical director [vice president of medical affairs] is a member and in general Medical Staff meetings or elections.
- (c)** The medical director [vice president of medical affairs] will serve as an advisor to the Medical Executive Committee and Medical Staff officers, department directors [section chairs] and committee chairs regarding compliance with the Medical Staff documents, including the bylaws, rules and regulations and policies.
- (d)** The medical director [vice president of medical affairs] will preserve the confidentiality of peer review, credentialing and other Medical Staff data obtained.<sup>175</sup> Information the medical director [vice president of medical

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<sup>175</sup> NC Gen Stat Section 131E-95(b) defines the confidential nature of medical review records and proceedings broadly, extending the requirement of confidentiality in such a manner as would be likely to include a medical director, as follows: "The proceedings of a medical review, the records and materials it produces and the materials it considers shall be confidential and not considered public records... and shall not be subject to discovery or introduction into evidence in any civil action against a hospital, an ambulatory surgical facility... or a provider of professional health care services.... No person who was in attendance at a meeting of the committee shall be required to testify in any civil action as to any evidence or other matters produced or presented during the proceedings of the committee or as to any findings,

affairs] obtains through Medical Staff work will not be shared in a manner which is not protected under state confidentiality and immunity statutes or which would violate the Medical Staff bylaws, rules and regulations or policy.

- (e) The medical director [vice president of medical affairs] will cooperate with any requests of Medical Staff officers, department directors, and Medical Staff committee chairpersons to preserve confidentiality and promote frank discussion of Medical Staff matters, including leaving meetings to allow discussion to proceed without administrative personnel present.
- (f) The medical director [vice president of medical affairs] will respond promptly to any Medical Staff, committee, department, section or member concern or request for information.

### **ARTICLE III DISPUTE RESOLUTION<sup>176</sup>**

Disputes arising between the Medical Staff and the Board, or between the Medical Executive Committee and the Medical Staff, are addressed exclusively by the following processes.

#### **A. Medical Staff and Board Disputes<sup>177</sup>**

Whenever

- the Board determines that it will decide a matter contrary to the recommendation of the Medical Executive Committee, other than peer review recommendations,<sup>178</sup>
- the Board, the administrator, the Medical Executive Committee, or the Medical Staff refers a matter for dispute resolution,

the matter will be submitted to the Joint Conference Committee [as described in these bylaws.][The Joint Conference Committee consists of the Medical Staff officers and an

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recommendations, evaluations, opinions or other actions of the committee or its members. However, information, documents, or records otherwise available are not immune from discovery or use in a civil action merely because they were presented during proceedings of the committee....A member of the committee or a person who testifies before the committee may testify in a civil action but cannot be asked about the person's testimony before the committee or any opinions formed as a result of the committee hearings. "

<sup>176</sup> The Joint Commission requires dispute management processes but does not require that they be included in medical staff bylaws. Technically, therefore, these processes could be adopted instead as free-standing medical staff policies.

<sup>177</sup> The Committee provides a forum for conflict resolution among leadership groups such as the board and the Medical Staff as called for under Joint Commission Standard LD.02.04.01.

<sup>178</sup> Peer review matters are determined through the hearing and appellate review processes set forth in Article VII.

equal number of hospital Board members<sup>179</sup> selected by the Board chair. The chair will alternate at each meeting between Board and Medical Staff representatives. Disputes shall be managed, and where possible resolved by consensus, after sufficient opportunity for the committee to receive and review any documentation or other appropriate input, including meeting and working with any involved parties.<sup>180</sup>]

## **B. Medical Staff and Medical Executive Committee Disputes<sup>181</sup>**

Whenever

- the Executive Committee votes against wording in a petition by Medical Staff members to amend the Medical Staff bylaws, rules and regulations, or policies,
- a petition signed by not less than [one-fourth] of the active Medical Staff members registers disagreement with any action other than peer review recommendations<sup>182</sup> taken by the Medical Executive Committee, or by a department or committee of the Medical Staff.

the matter will be addressed and resolved by action adopted by a majority of the voting members at the next scheduled Medical Staff meeting at which a quorum is present, unless no meeting is scheduled within 30 days, in which case a special meeting will be called pursuant to the terms of the Medical Staff bylaws. Medical Staff action can include delegating resolution of the matter to a standing or ad hoc committee of the medical staff, which committee may be supported by Medical Staff legal counsel and an independent facilitator, as determined by the committee. Under no circumstance can the dispute be delegated to the hospital board or administration for resolution.

## **C. External Dispute Resolution**

Should the internal dispute resolution process established for the Medical Staff and Medical Executive Committee, or the Medical Staff and Board, fail after reasonable

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179 AMA Principle for Strengthening the Physician-Hospital Relationship #12 states, "Areas of dispute and concern, arising between the organized Medical Staff and the hospital governing body, are addressed by well-defined processes in which the organized Medical Staff and hospital governing body are equally represented. These processes are determined by agreement between the organized Medical Staff and the hospital governing body." AMA Policy Compendium H-225.957

180 Under Joint Commission Standard LD.02.04.01, Element of Performance 4:

"The conflict management process includes the following:

- Meeting with the involved parties as early as possible to identify the conflict
- Gathering information regarding the conflict
- Working with the parties to manage and, when possible, resolve the conflict
- Protecting the safety and quality of care."

181 To implement MS 01.01.01 Element of Performance 10, which states in pertinent part, "The organized medical staff has a process which is implemented to manage conflict between the medical staff and the medical executive committee on issues including, but not limited to, proposals to adopt a rule, regulation, or policy or an amendment thereto. ..."

182 Peer review matters are determined through the hearing and appellate review processes set forth in Article VII.

attempts to resolve the dispute, the dispute shall be referred to a mutually acceptable mediation process for resolution.

#### **D. Disputes Involving Medical Staff Bylaws, Rules and Regulations and Policies**

No dispute management or resolution process can amend the Medical Staff Bylaws, rules and regulations or policies.<sup>183</sup> Bylaws, rules and regulations and policy amendments proposed as a result of a dispute management process must be acted upon by the Medical Staff and Board as required by these Bylaws.

### **ARTICLE IV MEMBERSHIP<sup>184</sup>**

#### **A. Basis of Membership**

Membership in the Medical Staff can be granted only according to the processes established in these bylaws and held only by professionals meeting the qualifications established under these bylaws.

Membership in the Medical Staff can be revoked only according to the processes established in these bylaws. Medical Staff members cannot be fired from hospital employment or lose their hospital contracts as a result of good-faith participation in Medical Staff activities or leadership roles or otherwise fulfilling duties of Medical Staff membership.<sup>185</sup>

#### **B. Qualifications<sup>186</sup>**

Each Medical Staff member shall:

1. Hold an MD or DO degree; a DDS degree, an OD degree, or a DPM degree, or its equivalent;

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<sup>183</sup> Joint Commission standard MS 01.01.01, Element of Performance 2 states “The organized medical staff adopts and amends medical staff bylaws. Adoption or amendment of medical staff bylaws cannot be delegated. After adoption or amendment by the organized medical staff, the proposed bylaws are submitted to the governing body for action. Bylaws become effective only upon governing body approval.”

<sup>184</sup>The medical staff bylaws are to include “The process for appointment and re-appointment to membership on the medical staff...” under Joint Commission standard MS 01.01.01, Element of Performance 27.

<sup>185</sup> Medical Staff members elected to serve in leadership positions for and by the Medical Staff should not be subject to hospital manipulation or retaliation in fulfilling their Medical Staff organization duties.

<sup>186</sup> Meeting NC Rule10A NCAC 13B.3705b, which requires that the Medical Staff bylaws, rules and regulations include:“(2) qualifications for membership.” Further, Joint Commission standard MS 01.01.01, Element of Performance 13 calls for “the qualifications for appointment to the medical staff” to be included in the medical staff bylaws. Under DNV standard MS 8 states, “The medical staff bylaws shall describe the qualifications to be met by a candidate in order for the medical staff to recommend that the governing body appoint the candidate, ...”

2. Be currently licensed to practice medicine, podiatry, optometry, or dentistry by the state of North Carolina;<sup>187</sup>
3. Have clinical experience appropriate for the privileges requested;<sup>188</sup>
4. Hold current Drug Enforcement Agency registration if relevant to the member's privileges;
5. Comply with generally accepted standards of practice;
6. Abide by the ethical principles established by his/her profession;<sup>189</sup>
7. Maintain health and mental status sufficient to perform medical and professional duties;
8. Be able to provide continuous care or demonstrates to the satisfaction of the Credentials [Medical Executive] Committee reliable and adequate coverage arrangements with other Medical Staff members to meet patient needs;
9. Attest that he/she has not been convicted of any crime related to Medical Staff membership qualifications, functions or duties, as determined by the Medical Executive Committee;
10. Be insured against professional liability for all clinical privileges requested;<sup>190</sup> however, a temporary loss of professional liability insurance coverage (whether or not limited to "tail" coverage) shall not be grounds for immediate termination of Medical Staff membership. The Medical Executive Committee shall determine the length and other conditions of an individual waiver of the coverage requirement.<sup>191</sup>

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187 Mandated by NC Rule10A NCAC 13B.3703(4), which states, "members of the Medical Staff and others granted clinical privileges in the facility shall hold current licenses to practice in North Carolina."

Endorsements or restrictions on licenses issued by the NC Board of Medicine should be considered.

188 Implementing NCMS Policy on Full Medical Staff Membership, <http://www.ncmedsoc.org>

189 NC Rule10A NCAC 13B. 3503(13) requires "...the Medical Staff to established controls that are designed to provide that standards of ethical professional practices are met."

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

191 Based on AMA policy, which states, "Our AMA will:

- (1) Approach the American Hospital Association (AHA) to assess interest in commencing a dialogue regarding professional liability coverage requirements for Medical Staff members; develop with the AHA mutually acceptable alternatives to physicians facing "forced voluntary resignation" from the Medical Staff for not purchasing "tail" coverage or requiring the mandatory purchase of "tail" coverage; and, establish guidance on a reasonable time-frame in which physicians can obtain tail coverage when required;
- (2) Advocate for better disclosures by professional medical liability insurance carriers to their policyholders about the continuing financial health of the carrier; and advocate that carriers create and maintain a listing of alternate professional liability insurance carriers in good financial health which can provide physicians replacement tail or other coverage if the carrier becomes insolvent; and
- (3) Support model Medical Staff bylaw language stating: "Where continuous professional liability insurance coverage is a condition of Medical Staff membership, a temporary loss of professional

11. Not be excluded from participating in Medicare, Medicaid or any other federal health care program when such exclusion has been affirmatively imposed by government enforcement authorities, or accepted by the practitioner, as a sanction for unlawful conduct.<sup>192</sup>
12. Appropriately utilize hospital facilities to provide quality patient care, consistent with the utilization review plan as recommended by the Medical Executive Committee.<sup>193</sup>

### **C. Effect of Other Affiliations or Memberships**

No professionals are entitled to Medical Staff membership solely because they are employed by this hospital or its subsidiaries, have contracts with this hospital, have or have had Medical Staff membership or privileges at another health care facility, participate or do not participate in a particular medical group, managed care organization, IPA, PPO, PHO, hospital-sponsored foundation, or other organization or in contracts with a third-party payor which contracts with this hospital. Lawful pursuit of business interests by members shall not adversely affect Medical Staff membership.

### **D. Discrimination Prohibited**

No person otherwise qualified as provided in these bylaws shall be denied Medical Staff membership or particular clinical privileges solely on the basis of ethnic background, race, culture, gender, sexual preference, language, religion, mental capacity and physical disability.<sup>194</sup>

### **E. Term**

#### **1. Length**

Each membership term is limited to two years,<sup>195</sup> subject to renewal consistent with these bylaws [, which terms shall be staggered, based on the month membership was originally granted].<sup>196</sup>

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liability insurance coverage (whether or not limited to "tail" coverage) is not grounds for immediate termination of Medical Staff membership. The Medical Executive Committee shall determine the length and other conditions of an individual waiver of the coverage requirement." AMA Policy Compendium D-435.978

192 Federal law does not mandate that all Medical Staff members serve as Medicare providers, but does restrict hospitals from billing for services ordered or provided by professionals who are excluded by the federally funded programs. Therefore, current exclusion should be disclosed. Medicare exclusion status should be verified from the DHHS Office of the Inspector General.

193 Bylaws section II.C.13.b(1) provides for the utilization review committee to recommend improvements to the utilization review plan to the Medical Executive Committee.

194 NC Gen Stat Section 131E-85 states that "...privileges shall be determined by the governing body of the hospital on a non-discriminatory basis." Under JC Standard MS 06.01.07, Element of Performance 3, "Gender, race, creed, and national origin are not used in making decisions regarding the granting or denying of clinical privileges." JC Standard MS 07.01.01 Element of Performance 4, "Gender, race, creed, and national origin are not used in making decisions regarding the granting or denying of medical staff membership."

195 Implementing NC Rule10A NCAC 13B .3704(c) which states "Medical Staff appointments shall be reviewed at least once every two years by the governing board." Further, JC Standard MS.06.01.07,

## 2. Resignation

Any Medical Staff member may resign membership by providing written notice, stating the effective date of resignation, to the Medical Staff office.

## F. Duties

Medical Staff members shall:

1. abide by the Medical Staff bylaws, rules and regulations and policies;<sup>197</sup>
2. accept assignment to serve on standing and special Medical Staff committees;
3. cooperate with Medical Staff committees and representatives in the discharge of Medical Staff functions, including responding promptly and appropriately to correspondence, including special notices;
4. submit to mental or physical screenings, as requested by the Medical Executive Committee, to establish continuing qualification for membership;
5. support fair peer review by participating appropriately in Medical Staff peer review activities, such as providing information to Medical Staff committees regarding matters under review or investigation, serving on Hearing Committees and acting as proctors as requested;
6. obtain consultation when a patient's condition could be improved by involvement of another member or other professional, or when otherwise appropriate;<sup>198</sup>
7. refrain from any retaliation against any other member of the Medical Staff because that member claims a right or privilege afforded by, or seeks implementation of any provision of, these Medical Staff bylaws.

## G. [Dues<sup>199</sup>

Members shall pay annual dues in [an amount set by the Medical Executive Committee the first meeting of the Medical Staff year] [the amount of \$\_\_\_\_\_]. Failure to pay

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Element of Performance 8 allows privileges to be granted for a period not to exceed two years. Further, the HCQIA imposes a duty on hospitals to check the National Practitioner Data Bank at least every two years on every Medical Staff member and every practitioner who holds clinical privileges. Membership and privileges are most efficiently coordinated in the credentialing process.

<sup>196</sup> Staggering membership may improve the efficiency of the credentialing process.

<sup>197</sup> Implementing JC standard MS 01.01.01, Element of Performance 5, "The medical staff complies with the medical staff bylaws, rules and regulations, and policies."

<sup>198</sup> JC standard MS.03.01.03, Element of Performance 3 states, "The organized Medical Staff, through its designated mechanism, determines the circumstances under which consultation or management by a physician or other licensed independent practitioner is required." DNV Standard 18 states, "The medical staff shall define in its bylaws the circumstances and criteria under which consultation or management by a physician or other qualified licensed independent practitioner is required."

<sup>199</sup> Maintaining a treasury will permit the Medical Staff ready access to assistance from consultants and others, a means of providing incentives to leadership and membership, a source to support priorities of the Medical Staff and to otherwise support the Medical Staff organization.

dues in a timely manner shall be grounds for ineligibility for membership renewal or corrective action.]

#### **H. Voting**

Voting by mail ballot or in meetings of the Medical Staff, its committees, departments, [sections] and any subdivisions, shall be conducted in accordance with the bylaws. All [active][medical] staff members have the right to vote in Medical Staff meetings and in meetings of any committee, [section], and department in which they are members. Any member who, by virtue of position, attends a meeting in more than one capacity is entitled to only one vote. Unless otherwise specified in the bylaws or at the time of appointment, only Medical Staff members may vote on committee business. Under no circumstances shall an abstention or failure to vote be counted as either an affirmative or negative vote. Voting by proxy is not permitted.<sup>200</sup>

#### **I. Emergency Call<sup>201</sup>**

[Members shall serve on call to the emergency department as determined by the department in which privileges are held.]<sup>202</sup>[Members shall serve on call consistent with compensation contracts entered into individually with the hospital.]<sup>203</sup> [Medical Staff members who are [[55] years of age and older], [ graduated from medical school at least 25 years ago],[and have served 10 years as an active medical staff member] shall be exempt from call duties.][Medical Staff members who have served [10] years on the active staff shall be exempt from call duties.] Medical Staff members who have been granted a leave of absence as outlined in the Medical Staff bylaws shall be exempt from call duties during the time of the leave.] [Members who have upon written request received a waiver from the Medical Executive Committee based on disability, hardship,

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200 AMA policy provides that "Proxy voting prior to or at Medical Staff meetings should not be permitted in Medical Staff bylaws." AMA Policy Compendium 235.972. Robert's Rules of Order §45 (Tenth Edition) states that "[o]rdinarily [proxy voting] should neither be allowed nor required, because proxy voting is incompatible with the essential characteristics of a deliberative assembly in which membership is individual, personal and nontransferable."

201 EMTALA Interpretative Guidelines state that Medical Staff bylaws or policies and procedures must define the on-call physician's responsibilities to respond, examine and treat patients. There is no federal or state law requiring that medical staff members take unassigned emergency call. The medical staff should use the available resources to develop an equitable approach to covering the unassigned call needs to the hospital. If additional resources are needed to provide adequate unassigned call coverage, those resources should be requested from the governing body of the hospital.

202 EMTALA does not require physicians to serve on call but does require hospitals to arrange for call coverage. Because the burden of call varies according to specialty, departments are best situated to determine whether department members must provide on call services to the emergency department and if so, to find an approach that works for the specialties in the department.

203 Consistent with the Emergency Department Unassigned Call Coverage Policy of the North Carolina Medical Society, which states, "the North Carolina Medical Society supports payment by hospitals to physicians who take unassigned call coverage," <http://www.ncmedsoc.org>. Further, compensation for on-call service provided to hospitals is supported by AMA Policy Compendium D-130.997, "Reimbursement of On-Call Physicians."

Medical Staff leadership demands, or other reason shall be exempt from call duties for the term of the waiver. ]<sup>204</sup>

## **J. Leave of Absence**

### **1. Member Request**

Any Medical Staff member may obtain a voluntary leave of absence from the Medical Staff when he/she will be unavailable to provide services and fulfill Medical Staff duties for a period of more than [four] consecutive months, upon submitting a notice to the Medical Staff office stating the approximate period of leave desired, which may not exceed twelve months or the end of the current membership term, whichever is shorter. The notice shall also state the date the leave will begin, [which will not be sooner than 30 days from the date of the notice if possible<sup>205</sup>] by which date the member must have completed all outstanding medical records at the hospital. If medical records are not completed when the leave of absence begins, the Medical Executive Committee may deny reinstatement. Members are not entitled to more than one leave of absence during a two-year membership term unless the exception is approved by the Medical Executive Committee. Abuse of the ability to obtain leaves of absence can be grounds for denial of membership renewal. However, requests for leave of absence to fulfill military service obligations [or medical missionary or other humanitarian service], to obtain additional professional training, or to obtain treatment for a medical or behavioral condition shall not be denied or result in denial of membership renewal.

During the period of the leave, the member shall not exercise clinical privileges at the hospital and membership rights and responsibilities shall be inactive, but the obligation to pay dues, if any, shall continue, unless waived by the Medical Executive Committee.

### **2. Members' Reinstatement Responsibilities**

At least [six] weeks prior to the end of the leave period, the Medical Staff office shall provide the member with a termination of leave form as promulgated by the Medical Executive Committee. The member shall submit a summary of relevant activities during the leave. The Medical Executive Committee shall make a recommendation to the Board that will be processed in the same manner as all recommendations on Medical Staff membership renewal. If the member's term of Medical Staff membership has expired during the leave of absence, the request for reinstatement shall be made, processed and acted upon in the same manner as an application for membership renewal.

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<sup>204</sup> CMS has concluded that exceptions to on-call requirements are consistent with EMTALA. CMS Memorandum Ref #S&C-02-34, "On-Call Requirements-EMTALA" (June 13, 2002).

<sup>205</sup> Leaves of absence could be occasioned by sudden onset of illness or other emergency.

Failure, without good cause, to return the completed termination of leave form shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of membership, privileges, and prerogatives. Such automatic termination shall be entitled to hearing and appeal rights as provided under these Bylaws for the sole purpose of determining whether the failure to request reinstatement was unintentional or excusable, or otherwise. A request for Medical Staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial membership.

## **K. Categories**<sup>206</sup>

Members are classified by category.

### **1. Active Staff**

#### **a) Practice**

Active members

- (1)** regularly admit, attend ,or provide services to patients in the hospital; [admit, attend, or provide services to at least [25] patients in the hospital per year];<sup>207</sup> and/or
- (2)** serve as department chairs, [section chairs,] representatives, or officers of the Medical Staff.

[A member of the Active Staff who, upon application for membership renewal, does not meet the specified qualifications in this section shall upon request be placed on probationary status for a one-year period during which time he/she shall have no Medical Staff voting privileges. At the conclusion of the probationary period, his/her status shall be reviewed by the appropriate Department [and section] and the Credentials Committee, which shall recommend to the Medical Executive Committee

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206 Implementing NC Rule10 NCAC 13B.3704 which provides that "(t)he active Medical Staff may establish other categories for membership in the Medical Staff. These categories for membership shall be identified and defined in the Medical Staff bylaws, rules or regulations adopted by the active Medical Staff." Under DNV Standard MS 7, Standard Requirement 3, "The medical staff bylaws shall describe the organization of the medical staff and include a statement of the duties and privileges of each category of medical staff to ensure that acceptable standards are met for providing patient care for all diagnostic, medical, surgical and rehabilitative services." Joint Commission Standard MS 01.01.01, Element of Performance calls for bylaws to include "A statement of the duties and privileges related to each category of the medical staff (for example, active, courtesy)..." and addresses the confusion caused by the use of the term "privileges" in the context of medical staff categories as follows, "The word "privileges" can be interpreted in several ways. The Joint Commission interprets it, solely for the purposes of this element of performance, to mean the duties and prerogatives of each category, and not the clinical privileges to provide patient care, treatment, and services related to each category."

207 "Those members of the Medical Staff who regularly and routinely admit patients to a facility constitute the active Medical Staff." North Carolina Rules 10A NCAC 13B.3001(23).

whether to renew voting active membership, or to move to a Medical Staff category for which the member qualifies.]<sup>208</sup>

#### **b) Prerogatives**

Active staff members are entitled to

- (1) Exercise privileges granted in accordance with these bylaws;<sup>209</sup>
- (2) Vote at Medical Staff meetings and in meetings of the departments [sections,] and committees of which they are members;<sup>210</sup>
- (3) Stand for nomination and election and, if elected, serve as Medical Staff officers, department [and section] leaders and Medical Staff representatives.<sup>211</sup>

### **2. Affiliate Staff**

#### **a) Practice**

Affiliate members

- (1) Do not admit patients [independently];<sup>212</sup>
- (2) Refer patients to [hospitalists and other] members with admitting privileges;
- (3) Follow and visit patients in the hospital.

#### **b) Prerogatives**

Affiliate staff members are entitled to

- (1) Exercise privileges granted in accordance with these bylaws;<sup>213</sup>
- (2) [Vote at Medical Staff meetings and in meetings of the departments [,sections,] and committees of which they are members.]

### **3. Consulting Staff**

#### **a) Practice**

Consulting staff members:

- (1) Consult on request of Medical Staff members

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208 Permits an active member time to build up practice after serving in office, without losing active staff status.

209 Specifying that the member is entitled to exercise the privileges granted should trump the interpretation expressed in the *Plummer v. Community Hospital* decision, in which the court held that a hospital could prevent a member from using his/her privileges by granting an exclusive contract to another provider.

210 North Carolina Rule 10A NCAC 13B.3704 (a) states, "Every member of the active staff shall be eligible to vote at Medical Staff meetings and to hold office."

211 North Carolina Rule 10A NCAC 13B.3704 (a) states, "Every member of the active staff shall be eligible to vote at Medical Staff meetings and to hold office."

212 If the Medical Staff allows dependent privileges for physicians who do not have an active hospital practice but wish to maintain a relationship with the Medical Staff.

213 Specifying that the member is entitled to exercise the privileges granted should trump the interpretation expressed in the *Plummer v. Community Hospital* decision, in which the court held that a hospital could prevent a member from using his/her privileges by granting an exclusive contract to another provider.

(2) Attend, admit or provide services to patients in the hospital;

**b) Prerogatives**

Consulting staff members are entitled to:

- (1) Exercise privileges granted in accordance with these bylaws;<sup>214</sup>
- (2) [Vote at Medical Staff meetings and in meetings of the departments [sections,] and committees of which they are members.] Consulting staff members who are distant providers of telemedicine services shall be excused from any meeting attendance requirements and may not exercise voting rights.

**4. Courtesy Staff**

**a) Practice**

Courtesy staff members attend, admit or provide services to fewer than [25] patients in the hospital during one year. Courtesy staff members who exceed the patient limit will be given the option to apply for active staff status. Any courtesy staff member reaching the limit in two consecutive years must either move to active staff membership or resign Medical Staff membership.

**b) Prerogatives**

Courtesy staff members are entitled to

- (1) Exercise privileges granted in accordance with these bylaws;<sup>215</sup>
- (2) [Vote at Medical Staff meetings and in meetings of the departments [sections,] and committees of which they are members.]

**5. Administrative Staff**

**a) Practice**

The Administrative staff consists of those members hired or contracted to perform only administrative duties [full time] and do not have clinical privileges.

**b) Prerogatives**

Administrative staff members are permitted to attend Medical Staff department [section,] and committee meetings without vote.

**6. [Federally Employed Military Staff]**

**a) [Practice**

Federally employed military staff members

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<sup>214</sup> Specifying that the member is entitled to exercise the privileges granted should trump the interpretation expressed in the Plummer v. Community Hospital decision, in which the court held that a hospital could prevent a member from using his/her privileges by granting an exclusive contract to another provider.

<sup>215</sup> Specifying that the member is entitled to exercise the privileges granted should trump the interpretation expressed in the Plummer v. Community Hospital decision, in which the court held that a hospital could prevent a member from using his/her privileges by granting an exclusive contract to another provider.

- (1) Are exempt from North Carolina licensure requirements but must be licensed in at least one other state;
- (2) Are members in good standing of the active or provisional Medical Staff of Federal military facilities with whom the Medical Staff has a memorandum of understanding in which specific operation criteria are delineated.
- (3) Attend, admit or provide services in the hospital to patients who are eligible for care at military health care facilities;

**b) Prerogatives**

Federally employed military staff members are entitled to

- (1) Exercise privileges granted in accordance with these bylaws;<sup>216</sup>
- (2) [Vote at meetings of the departments [sections,] and committees of which they are members.]

**7. [Call Coverage Staff**

**a) Practice**

Call coverage staff members come to the hospital when so scheduled to provide emergency call coverage and admit patients consistent with privileges granted to them pursuant to these bylaws.

**b) Prerogatives**

Call coverage staff members are entitled to:

- (1) Exercise privileges granted in accordance with these bylaws<sup>217</sup> while on call;
- (2) Attend Medical Staff meetings and meetings of the departments [sections,] and committees of which they are members, without voting rights.]

**8. Honorary Staff**

**a) Practice**

Honorary staff members

- (1) Are invited to the category by the Medical Executive Committee to honor their past service to the Medical Staff, without meeting Medical Staff membership requirements.
- (2) Do not have clinical privileges.

**b) Prerogatives**

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<sup>216</sup> Specifying that the member is entitled to exercise the privileges granted should trump the interpretation expressed in the Plummer v. Community Hospital decision, in which the court held that a hospital could prevent a member from using his/her privileges by granting an exclusive contract to another provider.

<sup>217</sup> Specifying that the member is entitled to exercise the privileges granted should trump the interpretation expressed in the Plummer v. Community Hospital decision, in which the court held that a hospital could prevent a member from using his/her privileges by granting an exclusive contract to another provider.

Honorary staff members

- (1) Do not hold office or vote but may serve on Medical Staff committees with vote;
- (2) Do not pay Medical Staff dues;
- (3) May attend all continuing education and Medical Staff meetings.

### 9. Modification in Category

A Medical Staff member may at any time request a promotion<sup>218</sup> in his/her staff category or clinical privileges or modification of department assignment by submitting a written application, on a form approved by the Medical Executive Committee, to the Medical Staff office. Promotion may be recommended by the Credentials Committee to the Medical Executive Committee following review of the member's performance within the hospital.<sup>219</sup> Change in category also may be recommended by the Credentials Committee to the Medical Executive Committee without the member's request if the member's practice no longer comports with the category to which the member has been assigned. Members may resign membership in any category, or resign privileges, by providing notice to the medical staff office.

## ARTICLE V- CREDENTIALING<sup>220</sup>

Except in the limited cases specified in these Medical Staff bylaws, no person shall exercise clinical privileges in the hospital unless and until that person applies for and is granted Medical Staff membership and/or privileges as set forth in these bylaws, or, with respect to allied health professionals, has been granted privileges under applicable Medical Staff processes established in these Medical Staff bylaws.

Except as otherwise specifically provided by these bylaws pertaining to exclusive contracts, Medical Staff membership and clinical privileges shall only be determined using criteria furthering the quality of health care, treatment and services provided at the hospital. Economic credentialing shall not be implemented at this hospital.<sup>221</sup>

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218 A member should not have to apply to resign privileges or move to a lower category.

219 Called for under JC standard MS.06.01.05 Element of Performance 1.

220 NC Rule10A NCAC 13B.3703 states, "Formal appointment for membership and granting of clinical privileges shall follow procedures set forth in the by-laws, rules or regulations of the Medical Staff." The medical staff bylaws are to include "The process for credentialing and re-credentialing licensed independent practitioners" under Joint Commission standard MS 01.01.01, Element of Performance 26. Under JC standard MS .06.01.03, Element of Performance 2, "the credentialing process is based on recommendations by the organized Medical Staff."

221 "The North Carolina Medical Society opposes the practice of economic credentialing, defined as the use of economic criteria unrelated to quality of care or professional competency in determining an individual's qualifications for initial or continuing hospital Medical Staff membership or privileges." NCMS Policy on Economic Credentialing, <http://www.ncmedsoc.org>. Economic credentialing is strongly opposed by the American Medical Association. AMA Compendium H-230.975.

In connection with all applications for membership and/or privileges, the applicant shall have the burden of producing sufficient information of clinical and professional performance to permit an adequate evaluation of the applicant's qualifications and suitability for the clinical privileges and staff category requested, to resolve any reasonable concerns about these matters, and to satisfy any request for such information.

#### **A. Application Form**

Application for Medical Staff membership and privileges is made in writing on a form approved by the Medical Executive Committee<sup>222</sup> and signed by the applicant. Application forms are submitted to the Medical Staff office along with a non-refundable application fee [as set by the Medical Executive Committee annually] [of \$ \_\_\_\_\_]<sup>223</sup> payable to the Medical Staff. No application will be processed without payment of the fee. The application form requests at least:

1. Age, years and schools of graduation, date of licensure, statement of postgraduate and other training and experience,<sup>224</sup> and other information demonstrating that the applicant meets all qualifications for membership established by these bylaws;
2. The Medical Staff category, department [section] and specific clinical privileges the applicant seeks;<sup>225</sup>
3. Access to morbidity and mortality data and other applicant-specific data reviewed by an organization that currently privileges the applicant, if available,<sup>226</sup> to establish current clinical competence;<sup>227</sup>
4. Recommendations from [two]<sup>228</sup> peers practicing in the same specialty, who are personally familiar with the applicant's ability to practice;<sup>229</sup>
5. Any surname previously used by the applicant, such as maiden name, other married names, and any aliases;

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222 The application form should be reviewed routinely to determine that it does not seek information that is irrelevant to the requirements set by the Medical Staff bylaws, such as economic or political information.

223 Application fees discourage frivolous applications and defray the time and costs of processing. Paying application fees to the Medical Staff organization provides revenue for Medical Staff functions, and at least in part compensates for the hours spent by Medical Staff leaders and members in application review.

224 Required under NC Rule10A NCAC 13B.3703(1).

225 Under NC Rule10A NCAC 13B.3703(1), application for membership includes a "... statement of the scope of the clinical privileges sought by the applicant."

226 Called for by JC standard MS.06.01.05 Element of Performance 2

227 To meet the requirements of JC standard MS.06.01.05 Element of Performance 8 that the organized Medical Staff evaluate practitioner specific data and morbidity and mortality data before recommending privileges.

228 DNV Standard MS 8, Standard Requirement 1c calls for two peer references for initial applicants.

229 Consistent with JC standard MS.07.01.03 Element of Performance 4, which states that "Peer recommendations are obtained from a practitioner in the same professional discipline as the applicant with personal knowledge of the applicant's ability to practice."

6. Information as to whether the applicant's membership and/or clinical privileges have ever, voluntarily or involuntarily,<sup>230</sup> been revoked, suspended, reduced or not renewed by any other healthcare facility, medical or professional group or organization, and whether any professional license, certificate or registration issued to the applicant has ever voluntarily or involuntarily<sup>231</sup> been revoked, suspended, reduced, terminated or not renewed. The application will also request information as to whether the applicant's DEA registration has ever been suspended or revoked or voluntarily or involuntarily relinquished<sup>232</sup>.
7. A statement that no health problems exist that could affect his or her ability to perform the privileges requested.<sup>233</sup> The applicant agrees to supply health status information as deemed appropriate by the Medical Executive Committee, which may include a complete history and physical examination. Any such examination shall be at the applicant's expense by a physician approved by the Medical Executive Committee.<sup>234</sup>
8. Agreement to present to the Medical Staff office a valid and current hospital picture identification or government-issued picture identification;<sup>235</sup>
9. Information on all final judgments or settlements in professional liability cases against the applicant.<sup>236</sup>
10. A statement that the applicant is or is not currently excluded from participation in Medicare or any other federally funded program.<sup>237</sup>
11. The continuing education the applicant has undertaken since his/her most recent approved application for clinical privileges.<sup>238</sup>

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230 JC standard MS.06.01.05, Element of Performance 8 asks that the Medical Staff evaluate both voluntary and involuntary action.

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232 JC standard MS.06.01.05, Element of Performance 8 asks that the Medical Staff evaluate both voluntary and involuntary action.

233 Based on JC standard MS.06.01.05, Element of Performance 5.

234 JC notes regarding ability to perform requested privileges state, "In instances where there is doubt about an applicant's ability to perform privileges requested, an evaluation by an external and internal source may be required. The request for an evaluation rests with the organized Medical Staff." JC Accreditation Manual for Healthcare Organizations, page 28-29.

235 Called for by JC standard MS.06.01.03 Element of Performance 5.

236 JC standard MS.06.01.05 Element of Performance 8 states that before recommending privileges, the organized Medical Staff evaluates any evidence of an unusual pattern or excessive number of professional liability actions resulting in a final judgment against the applicant. AMA policy more specifically states, "The AMA opposes the need for reporting on Medical Staff and other non-licensing board applications, including insurance company credentialing applications, (excepting professional liability insurance applications) any threatened, pending, or closed professional liability claims where the claim did not result in payment on behalf of that physician." AMA Policy Compendium H-435.963

237 No federal law forces any Medical Staff member to serve as a Medicare provider, but hospitals are restricted from billing for services ordered or provided by professionals who are currently excluded from the federally funded programs. Therefore, current exclusion should be disclosed. Medicare exclusion status should be verified from the DHHS Office of the Inspector General.

238 "Verification by the hospital of the qualifications of the applicant as stated in the application including evidence of continuing education" is required under NC Rule10A NCAC 13B.3703(2).

The applicant is responsible for ensuring that the information requested in the application is sent to the Medical Staff office. If the application is missing information or needs clarification, the Medical Staff office will contact the applicant electronically or otherwise expeditiously. The applicant is responsible to satisfy any reasonable request for additional information or clarification. If the applicant fails to provide all required information within [90] days of receipt of the application in the Medical Staff office, despite notice of information that is outstanding, the application will be considered to have been withdrawn, and the applicant shall not be entitled to hearing rights provided under these Bylaws. The applicant may reapply when he/she can provide complete information.

When the Medical Staff office has received and verified all required information,<sup>239</sup> and has obtained information on the applicant from the National Practitioner Data Bank, the Medical Staff office shall classify the application as completed.

### **B. Effect of Application**

Each applicant agrees to appear for interviews in regard to application, authorizes the Medical Staff to consult with members of Medical Staffs of other hospitals with which the applicant has been associated and with others who may have information bearing on applicant's competence and ethical qualifications, consents to review of all records and documents related to the applicant's professional qualifications for staff membership. The applicant releases from any liability all representatives of the hospital and Medical Staff for their acts performed in good faith and without malice or negligence in connection with verifying and evaluating the application and the applicant's credentials and safeguarding the confidentiality of the application and related information, and releases from any liability all individuals and organizations who provide information to the hospital in good faith and without malice concerning the applicant's competence, ethics, character and other qualifications for staff membership and clinical privileges, including information which otherwise may be privileged or confidential,<sup>240</sup> The applicant also agrees to be bound by the Medical Staff bylaws, rules and regulations during the course of the application process, whether or not the membership and privileges requested are granted.<sup>241</sup>

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239 "Verification by the hospital of the qualifications of the applicant as stated in the application" is required under NC Rule 10A NCAC 13B.3703(2).

240 NCMS Policy on Physician Background Checks states, "The North Carolina Medical Society opposes any requirement that an applicant for medical staff privileges release credentialing bodies or background search firms from liability for negligent or intentional misuse of information attributed to the applicant, for failure to take reasonable steps to verify the accuracy of the findings, or for failure to safeguard the confidentiality of the information obtained." <http://www.ncmedsoc.org>.

241 North Carolina Rule 10A NCAC 13B.3705(8) require Medical Staff bylaws include "methods developed to formally verify that each Medical Staff member on appointment or reappointment agrees to abide by current Medical Staff bylaws and facility bylaws." Implementing Joint Commission MS 01.01.01 Element of Performance 27, which calls for the medical staff bylaws to include "the process for appointment and re-appointment to membership on the medical staff."

## C. Application Process<sup>242</sup>

The application process is coordinated by the Medical Staff office.

### 1. [Section and] Department Review

The completed application and all supporting information are reviewed by the [section and] department [chair] in which the applicant seeks privileges. [The section review and recommendation is provided to the department chair.] The department reviews the application and its supporting documentation, which review may include a personal or telephone interview of the applicant by the department chair and members of the department. Individual performance data will be reviewed, if available, for variation from benchmarks.<sup>243</sup>The department recommendation regarding membership, membership category, and privileges, and any recommended limitations, based on its evaluation of evidence of the applicant's training, experience, and demonstrated ability, is reported to [the Credentials Committee.][the Medical Executive Committee.]

### 2. Credentials Committee Review

The Credentials Committee reviews the [section and] department recommendations, and evaluates the supporting information. The Credentials Committee may elect to interview the applicant [by telephone] and seek additional information to complete its recommendation on the application. The Credentials Committee makes a recommendation to the Medical Executive Committee as to membership and membership category, privileges and any limitations on those privileges, based on its evaluation of the evidence of the applicant's training, experience and ability to meet all qualifications established by these bylaws.

### 3. Medical Executive Committee Review

#### a) Medical Executive Committee Action

At its next scheduled meeting following receipt of the department [and Credentials Committee] recommendation, the Medical Executive Committee shall act on the application. If necessary, it may return the application back to the [Credential Committee] department for further evaluation or to obtain additional information, specifying a date for the recommendation to be provided to the Medical Executive Committee. The Medical Executive Committee action may be deferred, for good cause, to the next scheduled Medical Executive Committee meeting. The Medical Executive Committee recommendation shall specify action on membership, and if membership is recommended, membership category, clinical privileges, any limitations on privileges, and any other conditions to be attached on membership and privileges.

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<sup>242</sup> Implementing NC Rule 10A NCAC 13B .3706, which states, "The following reviews and functions shall be implemented by the Medical Staff: (1) credentialing review."

<sup>243</sup> DNV Standard MS 8, Standard Requirement 1e calls for, "if available, review of individual performance data for variation from benchmark. Variation shall go to peer review for determination of validity, written explanation of findings and, if appropriate, an action plan to include improvement strategies.."

### **b) Effect of Medical Executive Committee Action**

The Medical Executive Committee's favorable recommendation shall be forwarded to the Board for action consistent with these bylaws.

The applicant is provided notice according to these bylaws of any adverse recommendation of the Medical Executive Committee. The hearing provisions of these bylaws will govern any subsequent action.

Whenever the Medical Executive Committee recommends membership, but recommends denial or restriction of a requested privilege, the favorable recommendation shall be transmitted to the Board for action, and the unfavorable recommendation will be the subject of notice according to these bylaws, and governed by the hearing provisions of these bylaws.

## **4. Board Action Following Medical Executive Committee Action**

The Board acts on membership and privileges only after there has been a recommendation from the Medical Executive Committee,<sup>244</sup> or if a hearing was held on an unfavorable recommendation, after a Hearing Committee decision.<sup>245</sup>

### **a) Board Adopts Medical Executive Committee Action**

The Board acts on favorable medical executive recommendations, and on unfavorable Medical Executive Committee recommendations on Medical Staff memberships and privileges in which no hearing was held, at the next Board meeting. The Board gives great weight to the recommendation of the Medical Executive Committee<sup>246</sup>. Board adoption of the Medical Executive Committee recommendation constitutes the final action. The administrator notifies the applicant of the final action.<sup>247</sup>

### **b) Board Rejects Medical Executive Committee Action**

If the Board's preliminary decision is contrary to the favorable recommendation of the Medical Executive Committee in whole or in part, the Board shall refer the matter to the joint conference committee for review and report back to the

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244 Implementing NC Rule10A NCAC 13B .3503 which states, "[t]he governing body shall: (7) consider the advice of the Medical Staff in granting and defining the scope of clinical privileges to individuals."

According to JC standard MS.02.01.01, Elements of Performance 6 and 11, "the Medical Staff Medical Executive Committee makes recommendations, as defined in the Medical Staff bylaws, directly to the governing body on at least...the delineation of privileges for each practitioner privileges through the Medical Staff process (and) Medical Staff membership."

245 See Article VIII for the process that governs actions following a hearing.

246 Consistent with NC Rule10A NCAC 13B .3503, which states, "[t]he governing body shall: (7) consider the advice of the Medical Staff in granting and defining the scope of the clinical privileges to individuals... [and] (8) require the applicants be informed of the disposition of their application for Medical Staff membership or clinical privileges, or both, within an established period of time after their application has been submitted."

247 NC Rule10A NCAC 13B .3703(3) requires that application procedures provide for "written notice to the applicant from the Medical Staff and governing body, regarding appointment or reappointment which specifies the approval or denial of clinical privileges and the scope of the privileges granted."

Board.<sup>248</sup> If the Board's preliminary decision remains adverse to the applicant in whole or in part, the administrator provides notice to the applicant according to these bylaws.<sup>249</sup> The hearing provisions of these bylaws will govern any subsequent action.

#### **D. Application for Membership Renewal<sup>250</sup>**

At least [5 months] prior to the expiration of a membership term, the Medical Staff office sends membership renewal application forms to the member. The Medical Staff office sends a reminder to the member if no information has been received on the application. If the member does not file a completed application for membership renewal, the membership will expire at the end of the membership term.

##### **1. Supporting Information**

The membership renewal application shall request updates to the information provided in previous membership application process. In the event that there is a delay in obtaining any required information, or if clarification of information is needed, the applicant will be notified of his/her responsibility to obtain the necessary information. All applications for membership and privileges renewal are processed in the same manner as applications for new membership under these bylaws. The membership renewal application process results in re-determination of the member's eligibility for Medical Staff membership and assignment to the requested Medical Staff membership category.

The membership renewal application will be considered in conjunction with review of the member-specific morbidity and mortality data, as compared with aggregate data,<sup>251</sup> the Medical Staff record of the member's compliance with membership duties under these bylaws, and other information about the member's practice at the hospital.<sup>252</sup>

##### **2. Insufficient Information**

To obtain additional information as needed regarding a member's membership renewal application, the relevant department [and section] requests that the

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248 Implementing NC Rule10A NCAC 13B.3503(7) which states, "When the governing body does not concur in the Medical Staff recommendation regarding the clinical privileges of an individual, there shall be a review of the recommendation by a joint committee of the Medical Staff and governing body before a final decision is reached by the governing body.

249 NC Rule10A NCAC 13B .3703(3) requires that application procedures provide for "written notice to the applicant from the Medical Staff and governing body, regarding appointment or reappointment which specifies the approval or denial of clinical privileges and the scope of the privileges granted."

250 Meeting the requirement of NC Rule10A NCAC 13B.3704(c) that "(m)edical staff appointments shall be reviewed at least once every two years by the governing board."

251 Called for under JC standard MS.06.01.05, Element of Performance 8.

252 JC standard MS.06.01.05, Element of Performance2 states, "(w)hen renewing privileges, review of the practitioner's performance within the organization."

member provide additional recommendations from peers in the same specialty personally familiar with the member's practice.<sup>253</sup>

#### **E. Process Timeline<sup>254</sup>**

The Board acts on the application within [90] days from the date the application is deemed fully verified and completed by the Medical Staff office.

#### **F. Expedited Credentialing Process<sup>255</sup>**

A completed application for membership or membership renewal can be expedited if it documents each of these criteria:<sup>256</sup>

- No current or previously successful challenges to any professional licensure or registration;
- No involuntary termination of Medical Staff membership at any other organization;
- No involuntary limitation, reduction, denial, or loss of clinical privileges to date;
- No excessive number or unusual pattern of professional liability actions resulting in final judgment against the applicant.<sup>257</sup>

Applications meeting these criteria are reviewed by the relevant department chair(s); if approved, by the credentials chair; if approved, by the Medical Executive Committee, in lieu of the application process described in these bylaws. If any of these Medical Staff authorities makes any adverse recommendation, the application shall no longer be eligible for expedition, and shall revert to the regular application process. An expedited application may be acted upon by a committee of the hospital Board, if permitted by the hospital's bylaws or policy.

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253 "Upon renewal of privileges, when insufficient practitioner-specific data are available, the Medical Staff obtains and evaluates peer recommendations." JC standard MS.07.01.03, Element of Performance 2.  
254 JC standard MS.06.01.05 Element of Performance 10 states, "(c) completed applications for privileges are acted on within the time period specified in the Medical Staff bylaws." JC standard MS.06.01.07, Element of Performance 3, "the organization completes the credentialing and privileging decision process in a timely manner." NC Rule 10A NCAC 13B .3053 requires that the governing body shall "require that applicant be informed of the disposition of their application for Medical Staff membership or clinical privileges, or both, within an established period of time after their application has been submitted." DNV Standard MS 11, Standard Requirement 4 states that "a complete application shall be acted on within a reasonable period of time, as specified in the medical staff bylaws."

255 Implementing JC standard MS.06.01.11, which states that "an expedited governing body approval process may be used for initial appointment and reappointment to the Medical Staff and when granting privileges when criteria for that process are met."

256 JC standard MS.06.01.11 Element of Performance 1 states, "The organized Medical Staff develops criteria for an expedited process for granting privileges."

257 As called for by Elements of Performance 4-7 for JC standard MS.08.01.01.

## **G. Credentials Files<sup>258</sup>**

All Medical Staff credentialing files shall be subject to confidentiality requirements and protections of state and federal law.<sup>259</sup>

### **1. Hospital Closure**

In the event of closure of the Hospital, the credentialing files shall be placed with a custodian mutually acceptable to the Medical Staff and the Hospital.<sup>260</sup>

### **2. Access To Credentials Files**

Upon taking a corrective action, access to the subject's credentials file shall be governed by the hearing procedures established in these Medical Staff bylaws. In all other circumstances, access is governed by this section.

- a) Only those Medical Staff leaders and administrative personnel whose duties require access to the credentials files of a particular credentials file are permitted to request and review its contents.
- b) Representatives of the North Carolina Department of Health and Human Services shall have access to credentials files only to the extent required by law.<sup>261</sup>
- c) Medical Staff members shall be granted access to their own credentials file upon request,<sup>262</sup> but only under the following conditions:

(1) The member shall request access in writing, on a form provided by the Medical Staff office, directed to the president of the medical staff or designee;

(2) The member may review the file only in the Medical Staff office, at a time convenient to the member and the Medical Staff office manager [the chair of the Medical Staff or designee], in whose presence the member's review will take place. The member may receive a copy of only those documents provided by or addressed personally to the member. A written summary of all other information, including Medical Staff

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258 Implementing AMA policy, which states, "The AMA urges Medical Staffs (1) to establish and incorporate into their Medical Staff bylaws policies covering the management and maintenance of credentials files..."AMA Policy Compendium H-230.983

259 North Carolina's confidentiality protections are described by the court in Shelton v. Morehead Memorial as a "broad grant of immunity from liability for damages 'in any civil action of any act, statement or proceeding undertaken, made or performed within the scope of functions of the committee.'" (emphasis in original).

260 NC Rule10A NCAC 13B .3903 mandates that "[i]f a hospital discontinues operation, its management shall make known to the Division where its records are stored. Records shall be stored in a business offering retrieval services for at least 11 years after the closure date."

261 NC Rule10A NCAC 13B .3704 d) states that "representatives of the Department (of Health and Human Services) shall have access to the files in accordance with G.S.131 E-80."

262 It is appropriate to allow every individual to see his or her own file, but important that information is not removed from the file, or that access is not granted more generously to some than it is to others.

committee findings, letters of reference, proctoring reports, complaints, and incident reports, [but not disclosing the source of the information] shall be provided, if requested, to the member by the Medical Staff office manager [the president of the Medical Staff or designee], within a reasonable period of time.

- (3) Members may request that the Medical Executive Committee correct or delete inaccuracies from their files. Such requests must be in writing, supporting the request. The member shall be notified promptly, in writing, of the decision of the Medical Executive Committee. In any case, a member shall have the right to add a statement to his or her credentials file responding to any information contained in the file.

### **3. Contents of Credentials Files**

Documentation [of an unusual quality or source] about the professional competence or the professional, criminal or ethical misconduct of a member<sup>263</sup> other than routine information from Medical Staff quality improvement activities shall be directed by the Medical Staff office to the relevant department chair to determine whether the information is obviously specious, incorrect or unreliable and should be discarded rather than inserted into the member's credentials file.

### **4. Use of Credentials File in Credentialing<sup>264</sup>**

Prior to making its recommendation on membership renewal, the credentials committee reviews the contents of the members' credentials file. In the event that adverse information is not utilized as the basis for a request for corrective action or adverse recommendation in the membership renewal process, the Credentials Committee shall recommend to the Medical Executive Committee that the adverse information be removed from the file and discarded. The Medical Executive Committee may determine that such information is required for continuing evaluation of the member's character competence or professional performance.

## **ARTICLE VI- PRIVILEGING<sup>265</sup>**

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<sup>263</sup>NCMS Policy on Physician Background Checks states, "The North Carolina Medical Society supports the inclusion in the medical staff credentialing process of only those aspects of an applicant's personal background that relate to professional competence or to professional, criminal, or ethical misconduct." <http://www.ncmedsoc.org>.

<sup>264</sup>To ensure that credentials information is used in the credentialing process, and to allow for credentials files to be purged of irrelevant data at least during the biannual membership renewal process if not more frequently.

<sup>265</sup>NC Rule10A NCAC 13B/3705(b) states, "The Medical Staff bylaws, rules and regulations shall provide for at least the following: (3) procedures for admission, retention, assignment, and reduction or withdrawal of privileges..." Further, Joint Commission Standard MS 01.01.01, Element of Performance 14

Only those clinical privileges granted to the member by the Board, upon Medical Executive Committee recommendation, in accordance with these bylaws, can be exercised in the hospital.

Clinical privileges may be modified or terminated by the Board only upon recommendation of the Medical Executive Committee, and only for reasons directly related to quality of patient care<sup>266</sup> and other provisions of the Medical Staff bylaws.

#### **A. Requirements for Privileges<sup>267</sup>**

##### **1. Application**

To request privileges, an applicant or member must complete the privileging request form establishing the criteria for each privilege recommended by the department and approved by the Medical Executive Committee.<sup>268</sup> Privilege requests must be made in conjunction with membership and membership renewal application,<sup>269</sup> but also may be made during the membership term if additional privileges are sought.

All requests for clinical privileges shall be processed pursuant to the procedures described in Article IV<sup>270</sup> and accordingly determined, based on the applicant's education, training,<sup>271</sup> professional competence, compliance with accepted standards of care, current health status,<sup>272</sup> and the other requirements consistent with the criteria adopted consistent with these bylaws.<sup>273</sup>

##### **2. Board Certification**

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states that the medical staff bylaws include "The process for privileging and re-privileging licensed independent practitioners..."

266 Consistent with AMA policy, which states, "The AMA opposes the use of economic criteria not related to quality to determine an individual physician's qualifications for the granting or renewal of Medical Staff membership or privileges." AMA Policy Compendium H-230.976.

267 Required by NC Rule 10 NCAC 13B .3705, which states, " The Medical Staff bylaws, rules and regulations shall provide for at least the following: (3) procedures for admission, retention, assignment, and reduction or withdrawal of privileges."

268 Mandated by NC Rule 10 NCAC 13B .3705 which states formal procedures for granting of clinical privileges shall include at least, a "...statement of postgraduate or special training and experience with a statement of the scope of the clinical privileges sought by the applicant."

269 Required under NC Rule 10A NCAC 13B.3704(c) which states "(m)edical staff appointments shall be reviewed at least once every two years by the governing board."

270 North Carolina regulations state, "Formal appointment for membership and granting of clinical privileges shall follow procedures set forth in the bylaws, rules or regulations of the Medical Staff."

271 Mandated by NC Rule 290-9-7-.11 (a) 2(vii).which states formal appointment for clinical privileges shall require, "...statement of postgraduate or special training and experience with a statement of the scope of the clinical privileges sought by the applicant."

272 JC standard MS.06.01.05, Element of Performance 5, states "The process for granting privilege(s) includes the following: An applicant submits a statement that no health problems exist that could affect his or her ability to perform the privileges requested."

273 DNV standard MS 12, Standard Requirement 1 states, "The medical staff bylaws shall include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to those individuals that request privileges."

Departments [The Medical Executive Committee] may [shall] include in the criteria for privileges specific board certification and eligibility requirements relevant to specific clinical privileges.

### **3. Resource Availability<sup>274</sup>**

For every privileges request, the department's recommendation for clinical privileges affirms that the hospital has the ability at the time or will have at a specified time to provide adequate facilities and supportive services for the applicant.

### **4. Proctoring<sup>275</sup>**

New Medical Staff members, and those granted new clinical privileges, undergo proctoring. Performance on an appropriate number of cases within a specified time period, as established by the [department] rules and regulations, shall be observed by the chair or the chair's designee. When the required number of cases has been proctored, the department shall review the proctoring reports and recommend to the Medical Executive Committee, based on the evaluation of the types and numbers of cases observed and the member's performance, acceptance of the member's satisfaction of the relevant proctoring requirements, continuation of a period of

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274 Called for by JC standard MS.06.01.01, Element of Performance 1, "There is a process to determine whether sufficient space, equipment, staffing and financial resources are in place or available within a specified time frame to support each requested privilege."

275 Effective January 1, 2008, JC standard MS.08.01.01, Element of Performance 1 calls for "A period of focused professional practice evaluation is implemented for all initially requested privileges." Among the options for focused professional practice evaluation includes proctoring, which AMA policy supports for initial members, as follows: "AMA policy states that clinical proctoring is an important tool for education and the evaluation of clinical competence of new physicians seeking privileges or existing Medical Staff members requesting new privileges. Therefore, the AMA: (1) encourages hospital Medical Staffs to develop proctoring programs, with appropriate Medical Staff bylaws provisions, to evaluate the clinical competency of new physicians seeking privileges and existing Medical Staff members requesting new privileges; and (2) encourages hospital Medical Staffs to consider including the following provisions in their Medical Staff bylaws for use in their proctoring program: (a) Except as otherwise determined by the Medical Executive Committee, all initial appointees to the Medical Staff and all members granted new clinical privileges shall be subject to a period of proctoring. (b) Each appointee or recipient of new clinical privileges shall be assigned to a department where performance of an appropriate number of cases as established by the Medical Executive Committee, or the department as designee of the Medical Executive Committee, shall be observed by the chair of the department, or the chair's designee, during the period of proctoring specified in the department's rules and regulations, to determine the suitability to continue to exercise the clinical privileges granted in that department. The exercise of clinical privileges in any other department shall also be subject to direct observation by that department's chair or the chair's designee. (c) The members shall remain subject to such proctoring until the Medical Executive Committee has been furnished with: a report signed by the chair of the department(s) to which the member is assigned as well as other department(s) in which the appointee may exercise clinical privileges, describing the types and numbers of cases observed and the evaluation of the applicant's performance, a statement that the applicant appears to meet all of the qualifications for unsupervised practice in that department, has discharged all of the responsibilities of staff membership, and has not exceeded or abused the prerogative of the category to which the appointment was made, and that the member has satisfactorily demonstrated the ability to exercise the clinical privileges initially granted in those departments." AMA Policy Compendium H-375.974

proctoring on some or all privileges for stated reasons, or termination of some or all privileges.

## **B. Types of Privileges**

### **1. [Dependent Privileges]<sup>276</sup>**

Dependent privileges restrict members to admit and care for patients only in conjunction with a physician holding independent privileges. Members holding dependent privileges are responsible for obtaining the involvement of appropriate members with independent privileges in their admissions and inpatient care. Dependent privileges alone do not render the member ineligible for any category or affect ability to vote, serve on committees or hold office.]

#### **1. Admitting Privileges<sup>277</sup>**

Privileges to admit patients to the hospital must be specifically requested and are granted only to qualified requestors meeting the clinical criteria for admitting privileges recommended by departments to the Medical Executive Committee. Admitting privileges are not exclusive to hospital employees, members with hospital contracts, or to any single specialty.<sup>278</sup>

#### **2. Contract Privileges<sup>279</sup>**

Medical Staff members may provide services under contract with the hospital subject to the following conditions.

- a) A member providing services pursuant to a hospital contract, exclusive or otherwise, must qualify for and be granted clinical privileges and satisfy the same Medical Staff membership qualifications in the same manner, and must fulfill all of the obligations of the appropriate membership category, as any other applicant or Medical Staff member.
- b) Prior to the issuing of any new or renewed exclusive contract, the Medical Executive Committee must review the quality of care ramifications of continued exclusivity or of imposition of exclusivity on any department/

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276 Limited privileges may be used as a means of permitting community physicians whose practice does not or no longer includes inpatient care to maintain Medical Staff membership, contact with their hospitalized patients, and a connection with hospitalists or other Medical Staff members who are treating their patients while hospitalized.

277 "The AMA believes that hospital admitting privileges should be granted in accordance with state law and in accordance with criteria for standards of medical care established by the individual hospital Medical Staff." AMA Policy Compendium H-230.992

278 To address the concern that hospitalists might become the only ones permitted to admit.

279 Implementing North Carolina Medical Society Policy on Exclusive Contracts, which states, " Resolved, that the North Carolina Medical Society opposes the practice of hospital organizations executing exclusive contracts with physicians without prior consulting and approval of the Medical Staff of each contract; and be it further Resolved, that the North Carolina Medical Society supports model Medical Staff bylaws defining the proper scope of Medical Staff involvement in exclusive contracting..." See also, the "Economic Credentialing and Exclusive Contracting Report," available to NCMS members at <http://www.ncmedsoc.org>.

service or privileges and make a recommendation to the Board as to whether exclusivity is appropriate.<sup>280</sup> The Medical Executive Committee shall collect information from the members of medical specialties that would be affected, from the hospital administration, and from other interested parties, in order to make an informed recommendation;<sup>281</sup> however, the actual terms of the contract and any financial information related to the contract, including but not limited to the remuneration to be paid to Medical Staff members under contract, are not relevant and therefore shall neither be disclosed to the Medical Executive Committee nor discussed as part of this exclusive contracting evaluation process.<sup>282</sup>

- c) No privileges will be terminated, restricted, or reduced by operation of any hospital contract for any reason without the same rights of hearing and appeal as are available to all members of the Medical Staff.<sup>283</sup>

### **3. Dentists', Optometrists' And Podiatrists' Privileges**

- a) Admitting and other clinical privileges of dentists, optometrists and podiatrists may not exceed the scope of their licensure;
- b) Patients admitted by dentists, optometrists and podiatrists must receive all necessary and appropriate medical evaluations and care;
- c) Any dispute between a dentist, optometrist or podiatrist and a physician member regarding proposed treatment must be promptly resolved by the department director [president].

### **4. Disaster Privileges**

#### **a) Conditions<sup>284</sup>**

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280 Element of Performance 1 for JC standard LD.04.03.09 states, "Clinical leaders and medical staff have an opportunity to provide advice about the sources of clinical services to be provided through contractual agreement."

281 "The AMA believes that the Medical Staff should review and make recommendations to the governing body related to exclusive contract arrangements, prior to any decision being made, in the following situations: (1) the decision to execute an exclusive contract in a previously open department or service; (2) the decision to renew or otherwise modify an exclusive contract in a particular department or service; (3) the decision to terminate an exclusive contract in a particular department or service; and (4) prior to termination of the contract the Medical Staff should hold a hearing, as defined by the Medical Staff and hospital to permit interested parties to express their views on the hospital's proposed action." AMA Policy Compendium H-225.985

282 Clarification that the financial ramifications including pay scale is not under review by the Medical Staff. The Medical Staff organization is responsible for the quality of patient care and is neither qualified nor authorized to make financial decisions. Any evaluation that is not relevant to quality will not be protected under peer review law.

283 Failure to provide hearing rights to all physicians and dentists against whom an action based on quality patient care is recommended unnecessarily risks eligibility for federal peer review protection under the HCQIA.

284 To meet Element of Performance 1 for JC Standard EM.02.02.13, "The hospital grants disaster privileges to volunteer licensed independent practitioners only when the Emergency Operations Plan has been activated and the hospital is unable to meet immediate patient needs."

Disaster privileges may be granted only when the hospital cannot meet immediate patient needs and the hospital disaster plan has been activated. Individuals with disaster privileges shall be identified as described in hospital disaster plan. The department [Medical Staff] rules and regulations delineate supervision responsibilities over disaster privileges holders and all matters relating to the exercise of disaster privileges.

#### **b) Circumstances**

The president or his/her designees<sup>285</sup>, may, on a case-by-case basis, grant disaster privileges but only upon presentation of a valid picture identification issued by a state, or federal agency and any of the following: <sup>286</sup>

- (1) A current Hospital picture identification that clearly identifies professional designation;
- (2) A current license to practice;
- (3) Primary source verification of the license;
- (4) Identification establishing that the individual is a member of a Disaster Medical Assistance Team (DMAT), MRC, ESAR-VHP, or other state or federal organizations or groups;
- (5) Identification granted by a federal, state or municipal entity establishing that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances;
- (6) Identification by current hospital staff or Medical Staff member(s) with personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during a disaster.

#### **c) Verification**

Primary source verification of the credentials of individuals with disaster privileges is a high priority and is initiated as soon as the immediate situation is under control. Verification and determination as to continuation of privileges are completed within 72 hours from the time the volunteer practitioner presents to the organization. <sup>287</sup>

### **5. Emergency Service**

In case of emergency in which serious permanent harm or aggravation of injury or disease could result to a patient, or in which the life of a patient is in immediate danger, any Medical Staff member with clinical privileges shall be permitted, and the hospital staff will assist, to provide appropriate care within the scope of the member's license although not within the scope of current privileges. Any and all emergency service shall be subsequently reviewed by the member's department.

### **6. New Privileges**

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<sup>285</sup> The individual responsible for granting disaster privileges is identified in the bylaws to comply with JC standard EM.02.02.13 Element of Performance 2.

<sup>286</sup> As called for by Element of Performance 5 of JC standard EM.02.02.13.

<sup>287</sup> As called for by Elements of Performance 7 and 8 of JC standard EM.02.02.13.

Requests to provide services or perform procedures not currently being provided at the hospital are submitted in writing to the Medical Staff office, and include a description of the privileges requested and the equipment, space, personnel, and resources required to safely provide the new procedure or services. The department(s) submits a recommendation to the Medical Executive Committee, including criteria for any privilege the department recommends adding. If the Medical Executive Committee supports addition of the service, it shall forward its recommendation to the Board for final action. If the Board adopts the recommendation, the requestor will be provided the opportunity to apply for the new privilege(s).

## 7. Telemedicine Privileges<sup>288</sup>

Only those privileges specifically recommended by the Medical Executive Committee to be provided via telemedicine are available at this hospital<sup>289</sup>. Licensed independent practitioners at a different facility (referred to as the “distant site”) who wish to provide services to patients at this hospital via telemedicine link must be licensed to practice in North Carolina<sup>290</sup> and must apply for telemedicine privileges at

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<sup>288</sup> If the medical staff and hospital elect to make telemedicine services available to patients at the hospital, then there must be a process for granting telemedicine privileges to the physicians and other providers at the distant site. JC standard MS 13.01.01 states, “For originating sites only: Licensed independent practitioners who are responsible for the care, treatment, and services of the patient via telemedicine link are subject to the credentialing and privileging processes of the originating site.” The standard’s elements of performance provide these options for credentialing telemedicine providers: “1. All licensed independent practitioners who are responsible for the patient’s care, treatment, and services via telemedicine link are credentialed and privileged to do so at the originating site through one of the following mechanisms: - The originating site fully privileges and credentials the practitioner according to Standards MS.06.01.03 through MS.06.01.13. - The originating site privileges practitioners using credentialing information from the distant site if the distant site is a Joint Commission–accredited organization.

- The originating site uses the credentialing and privileging decision from the distant site to make a final privileging decision if all the following requirements are met:

1. The distant site is a Joint Commission–accredited hospital or ambulatory care organization. 2. The practitioner is privileged at the distant site for those services to be provided at the originating site. 3. For hospitals that use Joint Commission accreditation for deemed status purposes: The distant site provides the originating site with a current list of licensed independent practitioners’ privileges. 4. The originating site has evidence of an internal review of the practitioner’s performance of these privileges and sends to the distant site information that is useful to assess the practitioner’s quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes related to sentinel events considered reviewable by The Joint Commission that result from the telemedicine services provided; and complaints about the distant site licensed independent practitioner from patients, licensed independent practitioners, or staff at the originating site.”

<sup>289</sup> JC standard MS.13.01.03 states, “the Medical Staffs at both the originating and distant sites recommend the clinical services to be provided by licensed independent practitioner through a telemedical link at their respective sites.”

<sup>290</sup> NCMS Policy on Hospital Peer Review states, “the North Carolina Medical Society supports a full and unrestricted medical licensure requirement for physicians, with no differentiation by specialty, who wish to regularly practice telemedicine in North Carolina.” <http://www.ncmedsoc.org>.

this hospital. Any grant of telemedicine privileges is based on the recommendation of the Medical Executive Committee<sup>291</sup>

## **8. Temporary Privileges**

The administrator grants temporary privileges if requested by a practitioner, upon written recommendation of [the department chair where the privileges will be exercised and] the president,<sup>292</sup> only in the following two circumstances and subject to the conditions of this section.

### **a) Circumstances**

Temporary privileges are only available to pending applicants or to fulfill an important patient need,<sup>293</sup> as described in this section.

#### **(1) Pending Applications**

Temporary privileges can be granted to applicants who requests them while their applications for initial privileges is awaiting review and approval of the Medical Executive Committee and the Board, after verification of the following:<sup>294</sup>

- a complete application for Medical Staff membership and privileges
- current licensure
- relevant training or experience
- current competence
- ability to perform the clinical privileges requested
- other criteria required by the Medical Staff bylaws
- National Practitioner Data Bank query and evaluation of information received
- no current or previously successful challenge to licensure or registration,
- no involuntary termination of Medical Staff membership at any hospital or other entity,

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<sup>291</sup> JC standard LD 04.03.09, Element of Performance 23 states, "The originating site has a written agreement with the distant site that specifies the following: -The distant site is a contractor of services to the hospital. -The governing body of the distant site is responsible for having a process that is consistent with the credentialing and privileging requirements in the "Medical Staff" (MS) chapter .... - The distant site furnishes services in a manner that permits the originating site to be in compliance with the Medicare Conditions of Participation. -The governing body of the originating site grants privileges to a distant site licensed independent practitioner based on the originating site's medical staff recommendations, which rely on information provided by the distant site."

<sup>292</sup> JC standard MS.06.01.13 Element of Performance 5 states that temporary privileges are granted on the recommendation of the Medical Staff president or authorized designee.

<sup>293</sup> The Rationale for JC standard MS.06.01.13 states, "there are two circumstances in which temporary privileges may be granted. Each circumstance has different criteria for granting privileges. The circumstances for which the granting of temporary privileges are acceptable include the following: To fulfill an important patient care, treatment, and service need when a new applicant with a complete application that raises no concerns is awaiting review and approval of the Medical Staff Medical Executive Committee and the governing body."

<sup>294</sup> Each element called for under Element of Performance 3 of JC standard MS.06.01.13.

- no involuntary limitation, reduction , denial or loss of clinical privileges.

Temporary privileges should not be recommended if a department or the Credentials Committee has already recommended against a favorable action or there are doubts that the applicant will be granted Medical Staff membership and privileges by the Board. Temporary privileges shall automatically terminate if the applicant’s initial membership application is withdrawn.<sup>295</sup> All temporary privileges granted are time limited and shall automatically terminate at the end of the designated period, which shall not exceed 120 days cumulatively.<sup>296</sup>

**(2) Patient Care Need**

Temporary privileges can be granted for a period of [90] days<sup>297</sup> to fulfill an important patient care, treatment or service<sup>298</sup> need, such as providing specific medical skills needed to care for a patient that no one on the Medical Staff possesses, covering for an absent Medical Staff member or otherwise filling in when a Medical Staff member is not available to provide the care needed,<sup>299</sup> after verification of current licensure and current competence.<sup>300</sup>

The privileges are limited to the specific need that was the basis of the application. A practitioner requesting temporary privileges more than [twice] in one year will be required to apply for Medical Staff membership and privileges or face denial of an additional round of temporary privileges.

**b) Conditions**

All persons requesting or receiving temporary privileges shall be bound by the Medical Staff bylaws and rules and regulations. If temporary privileges are denied or terminated for a reportable reason, hearing rights shall apply.<sup>301</sup>

Requirements for observation, consultation and/or reporting may be imposed by the department chair responsible for supervision.

**9. History and Physical Privileges<sup>302</sup>**

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295 Added to clarify that temporary privileges granted during the pendency of an application cease automatically, should the application be withdrawn.

296 The limit established by Element of Performance #6 for JC standard MS.06.01.13.

297 Temporary privileges to meet an important patient care need may be granted for a period of time defined in the Medical Staff bylaws” under JC standard MS.06.01.13 Element of Performance 1.

298 As stated in the rationale for JC standard MS.06.01.13.

299 The standards no longer mention “locum tenens” but if the bylaws provide for granting temporary privileges to meet the important patient need caused by a physician’s absence, locum tenens should be accommodated.

300 As called for by Element of Performance #2 for JC standard MS.06.01.13.

301 Under the HCQIA, any decision adversely affecting privileges of any kind for more than thirty days should give rise to hearing rights to qualify for federal immunity protection.

302 JC standard MS 03.01.01, Element of Performance 8 states, “The medical staff requires that a practitioner who has been granted privileges by the hospital to do so performs a patient’s medical history and physical examination and required updates.” The Interpretive Guidelines for DNV MS 17 states, “A doctor of medicine or osteopathy or alternatively, a physician’s assistant or advance practice nurse, may

Every patient receives a history and physical within twenty-four hours of admission, unless a previous history and physical performed within thirty days of admission is on record, in which case that history and physical will be updated within twenty-four hours of admission.<sup>303</sup> Every patient admitted for surgery must have a history and physical within 24 hours prior to surgery, unless a previous history and physical performed within thirty days prior to the surgery is on record, in which case that history and physical will be updated within twenty-four hours of the surgery. Only those granted privileges to do so conduct history and physicals or update histories and physicals. Privileges to conduct a history and physical or an update to a history and physical are granted only to:

**a) Physicians<sup>304</sup>**

Privileges to conduct or update histories and physicals for patients admitted, consistent with the time requirements stated in this section, may be granted to qualified physicians who are members of the medical staff or seeking temporary privileges.

**b) Oral/maxillofacial surgeons<sup>305</sup>**

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

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perform a history and physical if so privileged by the medical staff and permitted by State law and scope of practice. The responsible physician must review and approve the history and physical as specified by the medical staff.”

303 Under JC Standard MS 01.01.01, Element of Performance 16, “ The medical staff bylaws include the following: The requirements for completing and documenting medical histories and physical examinations. The medical history and physical examination are completed and documented by a physician, an oromaxillofacial surgeon, or other qualified licensed individual in accordance with state law and hospital policy.” Under DNV MS 17, SR 1, “The medical staff bylaws shall include a requirement that a medical history and physical examination (HP) for each patient shall be done no more than 30 days before or twenty four (24) hours after an admission or registration, but prior to surgery or other procedure requiring anesthesia services and placed in the patient’s medical record within twenty four (24) hours after admission. The HP must be in the medical record prior to any high-risk procedure.

SR.1a. An HP completed within 30 days prior to admission or registration shall include an entry in the medical record documenting an examination for any change in the patient’s current medical condition completed by a doctor of medicine or osteopathy, oromaxillofacial surgeon or other qualified individual who has been granted these privileges by the medical staff in accordance with State law.

SR.1b. This examination and update of the patient’s current medical condition shall be completed and placed in the medical record within twenty four (24) hours after admission or registration, but prior to surgery or other procedure requiring anesthesia services.”

304 “Our AMA believes that the best interests of hospitalized patients are served when admission history and physical exams are performed by a physician, recognizing that portions of the histories and physical exams may be delegated by the physician to others whose credentials are accepted by the medical staff.” AMA Policy Compendium H-215.995

305 Under the Interpretive Guidelines for DNV MS 17 “If the patient is admitted only for oral or maxillofacial surgery, the H&P may be performed by an oral and maxillofacial surgeon who has been granted such privileges by the medical staff, in accordance with State law.”

### C. Relinquishing Privileges<sup>306</sup>

A Medical Staff member who wishes to relinquish or limit particular clinical privileges sends written notice to the [Medical Executive Committee] appropriate department chair(s) identifying the particular clinical privileges to be relinquished or limited, and to the Medical Staff office for inclusion in the member's credentials file. The request to relinquish or limit clinical privileges shall be effective immediately on receipt by the Medical Staff office unless a later date is specified in the notice.

## ARTICLE VII- PEER REVIEW<sup>307</sup>

For purposes of this article, the term member means a Medical Staff member or other practitioner providing services under privileges granted by the hospital. All members shall participate in peer review activities as requested or appointed pursuant to these bylaws in good faith, consistent with state and federal legal standards.<sup>308</sup>

### A. Ongoing and Focused Peer Review Standards<sup>309</sup>

The Medical Executive Committee approves the type of data to collect for use in ongoing professional practice evaluation,<sup>310</sup> and the criteria to be used for focused peer review of a member or other practitioner's services provided whenever quality patient care issues are identified. The Medical Executive Committee is responsible for

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306 To provide a means for members to surrender privileges on their own terms for their own reasons.

307 Implementing NC Rule10A NCAC 13B .3708(d) which states that "the Medical Staff shall establish and maintain a continuous review process of the care rendered to both inpatient and outpatients in every medical department of the facility. " Further, JC standard MS.08.01.01 states, "the organized Medical Staff develops criteria to be used for evaluating the performance of practitioners when issues affecting the provision of safe, high quality patient care are identified."

308 Under the HCQIA, peer review actions meeting its "standards for professional review actions" qualify for federal peer review immunity protection. The HCQIA standards are that the peer review action "must be taken (1) in the reasonable belief that the action was in the furtherance of quality health care,(2) after a reasonable effort to obtain the facts of the matter, (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3)." NC Gen Stat Section 131E-95(a) places conditions on state law immunity as follows: "A member of a duly appointed medical review who acts without malice or fraud shall not be subject to liability for damages in any civil action on account of any act, statement, or proceeding undertaken, made, or performed within the scope of the functions of the committee."

309 NC Rule10A NCAC 13B.3708(b) states, "The Medical Staff shall establish criteria for the evaluation of the quality of care." Also, JC Standard MS.08.01.01 states, "The organized Medical Staff defines the circumstances requiring monitoring and evaluation of a practitioner's professional performance."

310 As called for by JC standard MS.08.01.03, Element of Performance 2, which states, "The type of data to be collected is determined by individual departments and approved by the organized Medical Staff." Department determinations of the type of data are referred to the quality improvement committee for action and recommendation to the Medical Executive Committee for approval on behalf of the Medical Staff.

consistent use of criteria in peer review.<sup>311</sup>The results of ongoing and focused peer review are the bases for decisions regarding membership and privileges.<sup>312</sup> Only those peer review standards adopted by the Medical Executive Committee shall be used in evaluating members.<sup>313</sup>

#### **B. Behavior Adversely Affecting Patient Care<sup>314</sup>**

Behavior by any Medical Staff member while on hospital property<sup>315</sup> that generates a complaint by another Medical Staff member, a member of the hospital clinical or

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311 Under Element of Performance 4 of JC standard MS.08.01.01, "focused professional practice evaluation is consistently implemented in accordance with the criteria and requirements defined by the organized Medical Staff." The Medical Executive Committee is well positioned to see that all peer review recommendations uniformly utilize the criteria that the Medical Executive Committee has defined.

312 Implementing Element of Performance 3, JC MS standard.08.01.03, "Information resulting from the ongoing professional practice evaluation is used to determine whether to continue, limit, or revoke any existing privilege(s)."

313 To limit peer review to standards adopted by peers rather than imposed by third party payors or the hospital.

314 DNV Standard MS 14 states, "The medical staff bylaws shall provide a mechanism for management of medical staff corrective or rehabilitative action. ..."AMA Council on Ethics and Judicial Opinion E-9.045 states, "This Opinion is limited to the conduct of individual physicians and does not refer to physicians acting as a collective, which is considered separately in Opinion 9.025, "Collective Action and Patient Advocacy." (1) Personal conduct, whether verbal or physical, that negatively affects or that potentially may negatively affect patient care constitutes disruptive behavior. (This includes but is not limited to conduct that interferes with one's ability to work with other members of the health care team.) However, criticism that is offered in good faith with the aim of improving patient care should not be construed as disruptive behavior. (2) Each Medical Staff should develop and adopt bylaw provisions or policies for intervening in situations where a physician's behavior is identified as disruptive. The Medical Staff bylaw provisions or policies should contain procedural safeguards that protect due process. Physicians exhibiting disruptive behavior should be referred to a Medical Staff wellness-or equivalent-committee. (3) In developing policies that address physicians with disruptive behavior, attention should be paid to the following elements: (a) Clearly stating principal objectives in terms that ensure high standards of patient care and promote a professional practice and work environment. (b) Describing the behavior or types of behavior that will prompt intervention. (c) Providing a channel through which disruptive behavior can be reported and appropriately recorded. A single incident may not be sufficient for action, but each individual report may help identify a pattern that requires intervention. (d) Establishing a process to review or verify reports of disruptive behavior. (e) Establishing a process to notify a physician whose behavior is disruptive that a report has been made, and providing the physician with an opportunity to respond to the report. (f) Including means of monitoring whether a physician's disruptive conduct improves after intervention. (g) Providing for evaluative and corrective actions that are commensurate with the behavior, such as self-correction and structured rehabilitation. Suspension of responsibilities or privileges should be a mechanism of final resort. Additionally, institutions should consider whether the reporting requirements of Opinion 9.031, "Reporting Impaired, Incompetent, or Unethical Colleagues," apply in particular cases. (h) Identifying which individuals will be involved in the various stages of the process, from reviewing reports to notifying physicians and monitoring conduct after intervention. (i) Providing clear guidelines for the protection of confidentiality. (j) Ensuring that individuals who report physicians with disruptive behavior are duly protected. (I, II, VIII) Issued December 2000 based on the report "Physicians With Disruptive Behavior," adopted June 2000. AMA Policy Compendium E-9.045

315 The behavior of members outside the hospital need not regulated by the Medical Staff; however, behavior in the hospital parking garage or on the lawn should be included.

administrative staff, or individuals in contact with the Medical Staff member at the hospital other than patients,<sup>316</sup> will be responded to exclusively<sup>317</sup> according to these bylaws.

### **1. Definition of Behavior Adversely Affecting Patient Care**

Inappropriate conduct, sexual harassment or other forms of offensive behavior by a Medical Staff member which jeopardizes quality patient care or the ability of others to provide quality patient care at the hospital, or threatens, or constitutes verbal, physical or visual abuse of, patients or others involved with providing patient care<sup>318</sup> at the hospital is disruptive behavior<sup>319</sup> prohibited by these bylaws. Verbal, visual or physical abuse directed against any individual (e.g., against another Medical Staff member, house staff, hospital employees or patients) on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, age, marital status, sex or sexual orientation will be considered inappropriate conduct. Unwelcome sexual advances, requests for sexual favors, or verbal, visual or physical activity through which submission to sexual advances is made an explicit or implicit condition of employment or future employment-related decisions, unwelcome conduct of a sexual nature which has the purpose or effect of unreasonably interfering with a person's work performance or which creates an offensive, intimidating or otherwise hostile work environment is sexual harassment.<sup>320</sup> Nothing in this section or these Bylaws is intended to prohibit acceptable behavior,<sup>321</sup> which includes constructive criticism, patient advocacy, exercise of rights granted under these bylaws, fair competition, or pursuit of business interests by practitioners.

### **2. Referral for Assistance**

Behavior that indicates that the Medical Staff member suffers from a physical, mental or emotional condition will be referred to the Medical Staff Wellness Committee or otherwise evaluated to promote assisting the Medical Staff member while protecting others.<sup>322</sup>

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316 Problems between the member and his/her patient are addressed by the standards applicable to the physician (or other professional)/patient relationship.

317 Clarification that while other Codes of Conduct may be established by the hospital to govern its employees or contractors, Medical Staff members shall be governed solely by these terms.

318 The behavior to be addressed by the Medical Staff has to fall within the purview of the Medical Staff organization-professionalism and patient care quality. If the behavior is not related to patient care or professional ethics, the federal legal protections provided for peer review under the HCQIA are not likely to apply.

319 Joint Commission standard LD 03.01.01, Element of Performance 4 calls for the code of conduct to "define acceptable, disruptive and inappropriate conduct."

320 Based on federal law prohibiting sexual harassment.

321 Joint Commission standard LD 03.01.01, Element of Performance 4 calls for the code of conduct to "define acceptable, disruptive and inappropriate conduct."

322 The well-being of the Medical Staff member is a concern that must be preserved in the context of protecting those interacting with the member.

### 3. Severity Levels

To aid in responding appropriately to a complaint, behavior adversely affecting patient care is classified here into three levels of severity. Level I behavior is the most severe violation. Any corrective action will be commensurate with the nature and severity of the behavior.

**Level I:** Physical violence or other physical abuse which is directed at people; sexual harassment or harassment involving unwanted physical contact.

**Level II:** Verbal abuse such as unwarranted<sup>323</sup> yelling, swearing or cursing; threatening, humiliating, sexual or otherwise inappropriate comments directed at a person or persons verbally; visual abuse such as threatening, humiliating, sexual or otherwise inappropriate writing or picture(s) directed at a person or person, or physical violence or abuse directed in anger at an inanimate object; repeat offenses.

**Level III:** Verbal abuse which is directed at-large, but has been reasonably perceived by a witness to be disruptive behavior as defined above imposing burdensome, idiosyncratic requirements on nursing staff, residents or others which are not generally accepted in the medical profession and which, in light of the particular circumstances, cannot be reasonably expected to result in improved patient care or significant administrative efficiency.

### 4. Evaluating Behavior Adversely Affecting Patient Care

Behavior by members of the Medical Staff that affects or may affect patient care, or refusal of members to cooperate with the disruptive behavior procedures, may result in corrective action, which shall be carried out according to the Medical Staff bylaws. Behavior by members of the Medical Staff which has no impact on patient care, and therefore does not meet the threshold requirements for resolution under this bylaws section but constitutes violence or harassment as described under hospital human resources policies, may be resolved by administrative action as described below.<sup>324</sup> Repeated instances of behavior that adversely affects patient care will be considered cumulatively and action shall be taken accordingly.

#### a) Medical Staff Behavior Complaint Process

Complaints about a Medical Staff member's behavior must be in writing, signed and directed to the Medical Executive Committee. The president shall provide the complainant with a written acknowledgement of the complaint and the bylaws or those sections of the bylaws addressing conduct, and shall appoint a review subcommittee [of two] to review the complaint immediately. The

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<sup>323</sup> Recognizing that in emergency situations, calling out for instruments, drugs, or help may actually be appropriate.

<sup>324</sup> Action by Medical Staff members that do not affect patient care should not go without response, but are outside the Medical Staff's scope.

committee and the president shall make an initial determination of authenticity<sup>325</sup> and severity, and act accordingly. In all cases, the member involved shall be provided with a copy of these bylaws and a copy of the complaint.<sup>326</sup> [The president may initially protect the identity of the complainant if, in his/her judgment, such protection is appropriate and does not prevent the member from adequately defending himself/herself against the allegations.] Requests by a complainant that "nothing should be done" about an event and that the report is "for information only" cannot be granted.

Complaints will be processed according to the level of severity assigned:

**Level I:** The committee interviews the complainant, any witnesses and the Medical Staff member within 24 hours of receiving the complaint.

**Level II:** The committee interviews the complainant, any witnesses and the Medical Staff member within 5 working days of receiving the complaint.

**Level III:** The committee interviews the complainant, any witnesses and the Medical Staff member within 10 days of receiving the complaint.

Subsequent to this fact-gathering, the committee shall recommend one or more of the following actions to the Medical Executive Committee:

- take no action against the member based on a finding that the behavior was not inappropriate;
- issue a warning;
- refer the member to the Medical Staff Well-Being Committee;
- recommend corrective action pursuant to the Medical Staff bylaws.

Any corrective action will be commensurate with the nature and severity of the member's behavior.

#### **b) Behavior Complaints Not Handled By Medical Staff Behavior Complaint Process**

Threatening, harassing or other offensive behavior which is directed against a Medical Staff member by a hospital employee, Board member, contractor, or other member of the hospital community shall be reported by the member to the hospital pursuant to hospital policy governing conduct.<sup>327</sup> Behavior by a Medical Staff member towards a hospital employee, Board member, contractor or other member of the hospital community, which does not fall within the definition of behavior adversely affecting patient care above, but violates hospital policy governing conduct, shall be dealt with according to that hospital

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325 To screen out false reports. Element of Performance 6 for JC standard MS. 11.01.01 states that the process should address "evaluation of the credibility of a complaint, allegation or concern."

326 To permit the accused member to prepare a meaningful response.

327 To ensure that Medical Staff members are protected against disruptive behavior.

policy, so long as the hospital policy has been approved by the Medical Executive Committee.<sup>328</sup>

### **C. External Peer Review<sup>329</sup>**

External peer review will take place as part of focused review, investigation, application processing, or at any other time only under the following circumstances, if and only if deemed appropriate by the relevant Medical Staff department, the Medical Executive Committee or the Board:

- Vague or conflicting recommendations from committee or department review(s) where conclusions from this review could directly and adversely affect an individual's membership or privileges.
- Lack of internal expertise, in that no one on the Medical Staff has adequate expertise in the clinical procedure or area under review.
- When the Medical Staff needs an expert witness for a fair hearing, for evaluation of a credentials file or for assistance in developing a benchmark for quality monitoring.
- To promote impartiality in peer review.
- A member subject to review or investigation can request the hospital or Medical Staff to obtain external peer review, and shall have an opportunity to reasonably object to the selection of a particular external peer reviewer.

### **D. Investigation**

#### **1. Authority**

The Medical Executive Committee has the exclusive authority to initiate an investigation involving a member, and shall do so when reliable information indicates

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<sup>328</sup> It is necessary that the Medical Executive Committee screen and approve the hospital policy to prevent the hospital policy from conflicting with or circumventing the Medical Staff policy. Nonetheless, the hospital must be permitted to take the action it needs to take to respond to Medical Staff member sexually harassing a gift shop worker, which is outside the patient-care related behavior covered by this Medical Staff policy.

<sup>329</sup> NCMS Policy on Peer Review Committees states, "the North Carolina Medical Society supports organizing peer review committees that are free of conflicts of interest whenever possible. Since conflicts of interest in the peer review process are sometimes inevitable, medical staffs should develop a process for resolving conflicts of interest that centers on the best interests of patients, includes full disclosure of conflicts and potential conflicts, and makes available fair external review option in appropriate situations." <http://www.ncmedsoc.org>. NCMS Policy on Hospital Peer Review states, "Where EPR (external peer review) occurs, the Task Force recommends that selection of external peer reviewers occur from among a diverse group of physicians and individuals with no economic relationships to the doctor to be reviewed. Potential names of external reviewers should be submitted in advance to the physician under review, and he or she should have an opportunity to object to any particular individual. Such objections should not rise to the level of veto power, which could obstruct the process. In general, EPR should be reserved for circumstances in which internal review has raised the possibility of a restriction or reduction of privileges or where objectivity of internal peer review may have the appearance of being compromised because of Medical Staff demographics. A physician under review always has the option to request external peer review prior to a final decision implementing corrective action." <http://www.ncmedsoc.org>.

a member's actions may be detrimental to patients, unethical, contrary to the Medical Staff bylaws and rules and regulations, or below applicable professional standards. The Medical Executive Committee may also initiate investigation if it determines that a request for corrective action or other report resulting from the Medical Staff behavior complaint process, from ongoing professional practice evaluation, external peer review, focused review or any other peer review or quality improvement process warrants investigation.

At all times the Medical Executive Committee retains both authority and discretion to refer the member to the Medical Staff wellness committee, to terminate an investigation, to impose summary suspension, and/or to take whatever action may be warranted by the circumstances consistent with these bylaws.

## **2. Procedure**

### **a) Investigating Committee<sup>330</sup>**

The Medical Executive Committee conducts the investigation or delegates the investigation to a standing Medical Staff committee or special Medical Staff committee appointed for the purpose of conducting the investigation. The members of any investigating committee must have no economic interest in the outcome of the investigation and shall conduct the investigation impartially. The Medical Executive Committee sends special notice to the member that an investigation is being conducted and extending the opportunity to provide information in a manner and upon such terms as the investigating committee deems appropriate. The individual or body investigating the matter may in its discretion interview the member but an investigating committee interview is not a hearing and does not entitle the member to any procedural rights. The investigating committee prepares a written report of the investigation to the Medical Executive Committee within the time frame set by the Medical Executive Committee. The report may include recommendations for action.

### **b) Result of Investigation**

In a timely manner, at the conclusion of the investigation, [but in any event within 60 days after receipt of the request or allegation,] [unless deferred by the Medical Executive Committee for good cause] the Medical Executive Committee

- (1)** Determines that the allegation was not substantiated or otherwise determines that no further action is warranted, and, if appropriate, that any reference to the investigation be removed from the Medical Staff member's file;
- (2)** Defers action, for a reasonable time, for good cause;
- (3)** Refers the member [to the Medical Staff Wellness Committee] for evaluation and/or therapy;
- (4)** Takes corrective action consistent with these bylaws.

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<sup>330</sup> Such a committee should qualify as a "medical review committee" and the attendant protections under North Carolina law, consistent with NC Gen Stat Section 131E-95.

The Medical Executive Committee shall provide special notice of the conclusions and recommendation to the affected Medical Staff member.

#### **E. Corrective Actions<sup>331</sup>**

Based on an investigation, the Medical Staff behavior complaint process, reports or requests from Medical Staff departments or committees or on otherwise reliable information that a member's actions are detrimental to patients, unethical, contrary to the Medical Staff bylaws and rules and regulations, or below applicable professional standards, the Medical Executive Committee

- Issues a warning, letter of admonition or letter of reprimand;
- Recommends supervision<sup>332</sup> or mandatory consultation for a stated period of time or number of cases;
- Recommends reduction, suspension or revocation of clinical privileges;
- Recommends suspension or revocation of Medical Staff membership;
- Takes other corrective actions as warranted by the facts.

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331NC Rule10A NCAC 13B/3705(b) states, "The Medical Staff bylaws, rules and regulations shall provide for at least the following: (6)...procedures for disciplinary actions." Further, Joint Commission standard MS 01.01.01, Element of Performance 33 calls for the medical staff bylaws to include, "The process for recommending termination or suspension of medical staff membership and/or termination, suspension, or reduction of clinical privileges." Under DNV standard MS 7, Standard Requirement 4, "Medical staff bylaws shall include provisions for mechanisms for corrective action, including indications and procedures for automatic and summary suspension of medical staff membership or clinical privileges."

332 "Our AMA policy states that Medical Staff supervision refers to the imposition, usually involuntary and usually subsequent to an adverse event, of significant consultation, oversight, or close monitoring of a physician who has privileges and whose clinical competence, cognitive skills, procedural skills, or outcomes have been questioned. Supervision usually is limited to particular competencies under question and may apply to any site of service." AMA Policy Compendium H-375.968. Further, "Our AMA advocates that the conduct of Medical Staff supervision be included in Medical Staff bylaws and be guided by the following principles: (1) Physicians serving as Medical Staff supervisors should be indemnified at the facility's expense from malpractice claims and other litigation arising out of the supervision function. (2) Physicians being supervised should be indemnified at the facility's expense for any damages that might occur as a result of implementing interventions recommended by Medical Staff supervisors. (3) AMA principles of peer review as found in Policies H-320.968 [2,d], H-285.998 [5], and H-320.982 [2c,d] should be adhered to in the conduct of Medical Staff supervision. (4) The Medical Staff member serving as supervisor should be determined through a formal process by the department chair or Medical Staff Medical Executive Committee. (5) The scope of the Medical Staff supervision should be limited to the provision of services that have been restricted, are clearly questionable, or are under question, as determined by the department chair or Medical Staff Medical Executive Committee. (6) The duration of the Medical Staff supervision should be limited to the amount of time necessary to adequately assess the degree of clinical competence in the area of skill being assessed. (7) Medical Staff supervision should include a sufficient volume of procedures or admissions for meaningful assessment. (8) Medical Staff supervisors should provide periodic performance reports on each patient to the appropriate designated Medical Staff committee. The reports should be transcribed or transcribed by the Medical Staff office to assure confidentiality. The confidentiality of Medical Staff supervision reports must be strictly maintained. (9) Physicians whose performance is supervised should have access to the performance reports submitted by Medical Staff supervisors and should be given the opportunity to comment on the contents of the reports." AMA Policy Compendium H-375.967.

The Medical Executive Committee may also recommend for corrective action, by the hospital if non-medical staff members are responsible, any person whose reports of actions or requests for corrective action are frivolous, malicious or abuse of process.

#### **F. Summary Suspension<sup>333</sup>**

Summary suspension is imposed by a Medical Staff authority to immediately suspend the privilege(s) and/or membership involved until further notice. The subject is provided special notice immediately.

##### **a) Basis<sup>334</sup>**

Summary suspension of any or all privileges and/or Medical Staff membership can be imposed only if necessary to prevent imminent danger to the health of an individual<sup>335</sup>. Summary suspension is not imposed to punish past conduct.

Summary suspension is peer review activity, which may or may not lead to a final adverse action, but is not itself a final peer review action.

##### **b) Medical Staff Authority**

The president, president-elect, [the secretary,][the treasurer,] [the secretary-treasurer], and the chair(s) of the department(s) [chairs of sections] in which the member has privileges each has authority to summarily suspend all or any portion of the privileges of a member

##### **c) Medical Executive Committee Action**

As soon as practicable but within three days after a summary suspension is imposed, the Medical Executive Committee convenes to review the summary suspension, and ratify the action or terminate or modify the suspension, each of which actions would be immediately implemented. The Medical Executive Committee may also recommend such further corrective action as is appropriate to the facts, combine another corrective action with any remaining summary suspension action, or recommends sanctions that do not trigger procedural rights. The Medical Executive Committee immediately provides special notice of its action to the member.

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<sup>333</sup> JC standard MS 01.01.01 Element of Performance 32 states the medical staff bylaws must also include “the process for summary suspension of a practitioner’s medical staff membership or clinical privileges.

<sup>334</sup> JC standard MS 01.01.01 Element of Performance 30 states the medical staff bylaws must also include “indications for recommending termination or suspension of medical staff membership, and/or termination, suspension, or reduction of clinical privileges.”

<sup>335</sup> The HCQIA extends federal immunity to summary suspensions that are carried out to prevent imminent danger to individuals.

## G. Automatic Suspension<sup>336</sup>

Automatic suspension is triggered by an objective occurrence identified by these bylaws, without action by the Medical Staff, to immediately suspend privilege(s) or membership effective upon information received by the Medical Staff office.

### a) Bases<sup>337</sup>

- (1) **Controlled Substances**<sup>338</sup>– Any revocation, probation, or suspension of the member’s registration or certification to prescribe automatically cause a suspension of the member’s ability to order or prescribe medications in the hospital.
- (2) **Failure to Pay Dues** – Failure to pay Medical Staff dues after [two] notices stating the amount due [without good cause], and the ramifications of failure to pay dues as of the fifteenth (15th) day after the date of final notice automatically suspend the member’s privileges and membership until dues are paid.
- (3) **License**.<sup>339</sup> Any revocation, probation, or suspension of the member’s license to practice automatically suspends the member’s privileges and membership.
- (4) **Medical Record Delinquency**<sup>340</sup>– Failure to complete medical records according to the schedule established in the Medical Staff rules and regulations<sup>341</sup> generates a written [electronic][telephonic] warning that failure to complete records will result in automatic suspension of privileges within five days of the notice. The day before suspension will be imposed, the member receives special notice of the date and time automatic suspension will be imposed. Suspension continues until all medical records responsibilities are fulfilled.

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<sup>336</sup> JC standard MS.01.01.01 Element of Performance 31 states that the medical staff bylaws must also include “the process for automatic suspension of a practitioner’s medical staff membership or clinical privileges.” Automatic suspension is not required, but if utilized must be described.

<sup>337</sup> JC standard MS.01.01.01 Element of Performance 28 states that medical staff bylaws must include the “indications for automatic suspension of a practitioner’s medical staff membership or clinical privileges.”

<sup>338</sup> DNV Standard MS 12, Standard Requirement 5b calls for medical staff bylaws to provide a mechanism for consideration of automatic suspension of clinical privileges in cases of revocation/restriction/suspension/probation of Federal Narcotics Registration Certificate (DEA) of professional license.

<sup>339</sup> DNV Standard MS 12, Standard Requirement 5a calls for medical staff bylaws to provide a mechanism for consideration of automatic suspension of clinical privileges in cases of revocation/restriction of professional license.

<sup>340</sup> DNV Standard MS 16, Standard Requirement 1 states, “The medical staff bylaws shall include the requirement for the preparation and maintenance of a complete and accurate medical record for each patient and policies and procedures for dealing with medical record delinquencies.” Further, DNV Standard MS 12, Standard Requirement 5d calls for medical staff bylaws to provide a mechanism for consideration of automatic suspension of clinical privileges in cases of non-compliance with written medical record delinquency or deficiency requirements.

<sup>341</sup> Under NC Rule 10A NCAC 13B.3705(b)(6), Medical Staff bylaws, rules and regulations should include “policies for the completion of medical records and procedures for disciplinary actions.”

**(5) Professional Liability Insurance Lapse**<sup>342</sup>– Failure to maintain the amount of professional liability insurance as required under these Bylaws will result in automatic suspension of membership, until the member provides verification to the Medical Staff office of adequate professional liability coverage. The affected member may petition the Medical Executive Committee to allow the suspended practitioner [six months] to provide evidence to the Medical Executive Committee of professional liability coverage in the amount required, or to accept an alternative solution for the loss of insurance.

**(6) Current Medicare [or Medicaid] Exclusion**<sup>343</sup> - Action by the Medicare or other federally funded program[or Medicaid] will result in the automatic suspension of membership and privileges for the course of the exclusion.

**(7) Failure to Attend Department [Section] Meeting After Special Notice** – Failure by the practitioner to attend a department [section] meeting to which the practitioner has received special notice that the practitioner’s actions will be discussed, as provided in these bylaws,<sup>344</sup> shall result in an automatic suspension of the practitioner’s privileges, which shall remain in effect until the matter is resolved.

**b) Medical Executive Committee Action**

Members may provide the Medical Staff office information that that the underlying cause of the automatic suspension is incorrect which will be considered by the Medical Executive Committee unless the president sooner overturns the suspension based on incontrovertible evidence that the suspension was an error. At its next meeting, the Medical Executive Committee shall review all automatic suspensions occurring since its last meeting and may recommend further corrective action or any action it deems appropriate.

**c) Effect of Automatic Suspension**

If a member is automatically suspended for more than six consecutive months, he or she shall be deemed to have voluntarily resigned Medical Staff membership and/or the affected privileges. Automatic suspension or limitation does not give rise to procedural rights under these bylaws.

**Comment [ES1]:** Clarification that only exclusion rather than other forms of sanction give

<sup>342</sup> DNV Standard MS 12, Standard Requirement 5c calls for medical staff bylaws to provide a mechanism for consideration of automatic suspension of clinical privileges in cases of failure to maintain the specified amount of professional liability insurance.

<sup>343</sup> DNV Standard MS 12, Standard Requirement 6 calls for medical staff bylaws to “provide a mechanism for immediate and automatic suspension of clinical privileges due to the termination or revocation of the practitioner’s Medicare or Medicaid status.” Since hospitals are restricted from billing for services ordered or provided by professionals who are excluded by the federally funded programs, members or privileges holders who are excluded during the term of their membership or privileges should be suspended based on the exclusion.

<sup>344</sup> Under section II.D.1.b, Special Attendance.

## H. Patient Coverage in the Event of Corrective Action

Upon the imposition of a suspension of any kind, or any corrective action that limits the member's ability to provide care or services to inpatients, the president shall have the authority to provide for alternative coverage of those patients. The wishes of the patients shall be followed in the selection of an alternative member, if possible.

## I. Abuse of Process

Threats, retaliation or attempted retaliation by members against complainants will give rise to corrective action pursuant to the Medical Staff bylaws. Individuals who submit a complaint or complaints which are determined to be false shall be subject to corrective action under the Medical Staff bylaws or hospital employment policies, whichever applies to the individual.

## ARTICLE VII- HEARING AND APPEALS PROCESS<sup>345</sup>

### A. Initiation of Hearing

#### 1. Triggering Events

##### a) Recommendations or Actions:

The following recommendations or actions, if recommended or taken by the Medical Executive Committee or proposed to be taken or taken by the Board under circumstances in which no prior right to request a hearing existed,<sup>346</sup> entitle the respondent to a hearing under timely and proper request.

- (1) Denial of initial or renewed Medical Staff membership;
- (2) Suspension of staff membership;
- (3) Revocation or reduction of staff membership;
- (4) Denial or restriction of requested clinical privileges;
- (5) Reduction, summary suspension, restriction, or revocation of clinical privileges;

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345 Implementing NC Rule 10A NCAC 13B .3705 which states, "The Medical Staff bylaws, rules and regulations shall provide for at least the following: (4) procedures for fair hearing and appellate review mechanisms for denial of staff appointments, reappointments, suspension or revocation of clinical privileges." Joint Commission standard MS 01.01.01 Element of Performance 34, calls for medical staff bylaws to include "The fair hearing and appeal process (see also Standard MS.10.01.01 regarding the fair hearing and appeal process), which at a minimum shall include:

- The process for scheduling hearings and appeals
- The process for conducting hearings and appeals."

DNV Standard MS 12, Standard Requirement 7 states, "The medical staff bylaws shall contain fair hearing and appeal provisions for any adverse actions regarding the appointment, reappointment, suspension, reduction or revocation of privileges of any individual who has applied for or has been granted clinical privileges."

346 The Board may propose an adverse action on an application which has received only favorable action from the Medical Staff, but the applicant should not be denied hearing rights regarding the proposed final action.

- (6) Imposition of any mandatory concurrent consultation or supervision requirement;
- (7) [Restriction or denial of access to the hospital facilities and resources necessary to exercise clinical privileges.]<sup>347</sup>

**b) Notice of Adverse Recommendation or Action:**

The administrator promptly gives the respondent special notice of an adverse recommendation or action informing the respondent:<sup>348</sup>

- (1) Of the recommendation or action, and the reasons for it, including identification of the Medical Staff bylaw section, rule, regulation or policy allegedly violated, description of the respondent's alleged acts or omissions, a list by number of the specific or representative patient records in question and/or the other reason or subject matter forming the basis for the adverse action;
- (2) That the respondent has thirty (30) days after receiving the notice within which to submit a written request for a hearing to the administrator, either in person or by certified or registered mail;
- (3) Of the rights related to the hearing available to the respondent pursuant to these bylaws.

**c) Waiver by Failure to Request A Hearing:**

A respondent who fails to request a hearing within the time frame and in the manner here specified waives the right to any hearing or appellate review to which the respondent might otherwise have been entitled. Such waiver applies only to the matters that were the basis for the adverse recommendation or action triggering the notice. A waiver of a hearing on the Medical Executive Committee recommendation shall also constitute a respondent waiver of a right to appeal the board's adoption of that recommendation. The Board considers the adverse recommendation as soon as practicable following the waiver. The Board's action has the following effect:

- (1) If the Board's action accords in all respects with the Medical Executive Committee's recommendations, it shall then become effective as the final decision of the Board.
- (2) If, on the basis of the same information and material considered by the Medical Executive Committee in formulating its recommendation, the Board proposes a different adverse action, then the matter shall be resubmitted to the Medical Executive Committee as a new adverse

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347 Clinical privileges are defined in this Model as "authorization to provide care, treatment and services as delineated consistent with these bylaws and includes the right to exercise those privileges in the hospital's facilities unless specifically restricted by action of these bylaws." If that definition is not included in Medical Staff bylaws, this subsection should help to clarify that a hospital action or proposed action that restricts a member from exercising privileges gives rise to hearing rights, thus avoiding the outcome in *Plummer v Community General Hospital*.

348 These elements are all to be disclosed in the notice, under the HCQIA hearing standards.

action, subject to the notice and hearing procedures set forth in these bylaws.

## **B. Hearing Prerequisites**

### **1. Notice of Time and Place for Hearing:**

Within seven (7) days after receiving a request for hearing, the administrator shall arrange and schedule a hearing, and shall send the respondent special notice of the time, place and date of the hearing, and a list of the witnesses (if any) expected to testify at the hearing.<sup>349</sup> The hearing date shall be not less than thirty (30) nor more than sixty (60) days after the administrator has given special notice to the respondent, unless there are valid reasons for non-receipt of the special notice; in which case the date of the hearing can be extended.

A hearing for a respondent who is under suspension must be held not later than twenty-one (21) days after the respondent has been given special notice, if the respondent so request.<sup>350</sup>

### **2. Statement of Issues And Events:**

The notice of hearing must contain a concise statement of the respondent 's alleged acts or omissions, a list by number of the specific or representative patient records in question, and any other reasons or subject matter forming the basis for the adverse action or recommendation which is the subject of the hearing. A list of witnesses expected to testify at the hearing on behalf of the Medical Executive Committee or the Board will be included in the notice. The right to the hearing may be forfeited if the respondent fails, without good cause, to appear.

### **3. Appointment of Hearing Committee:**

- a) **Medical Staff Members:** A hearing occasioned by an adverse recommendation by the Medical Executive Committee or an adverse action by the Board is conducted by a Hearing Committee appointed by the administrator from a list of Medical Staff members<sup>351</sup> who are not in economic competition with the respondent<sup>352</sup> or otherwise biased against the respondent, provided by the president. The president shall designate one of the members as chair of the committee.

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349 Called for by HCQIA hearing standards.

350 The HCQIA hearing standards require thirty days from the notice of the hearing until the commencement of the hearing. While a shorter notice period during suspension is warranted, it must be with the consent of the subject.

351 "Our AMA encourages peer review of the performance of hospital Medical Staff physicians, which is objective and supervised by physicians. Membership on peer review committees and hearing panels should be open to all physicians on the Medical Staff and should not be restricted to those physicians who have an exclusive contract with the hospital, salaried physicians, or those on the faculty." AMA Policy Compendium H-375.990

352 To allow the Medical Staff input into the membership of the committee while satisfying the HCQIA requirement that the hospital appoint the committee.

- b) **Service on Hearing Committee:** A Medical Staff member is not disqualified from serving on a Hearing Committee solely because of prior knowledge of the facts involved or what the member supposes the facts to be. The member or members whose adverse recommendation or action initiated the hearing shall not serve on the Hearing Committee.<sup>353</sup>
- c) **Voir Dire:** The respondent shall have the right to a reasonable opportunity to challenge the impartiality of the Hearing Committee members and the hearing officer. The hearing officer shall establish the procedure by which this right may be exercised, which may include reasonable requirements that questions be proposed in writing in advance of the hearing and that the questions be presented and responded to by the hearing officer. The hearing officer shall rule on any challenges in accordance with applicable legal principles defining standards of impartiality for hearing panels and hearing officers in proceedings of this type.<sup>354</sup>

### C. Hearing Procedure

#### 4. Personal Presence:

The personal presence of the respondent is required at the hearing. [A respondent who fails without good cause to appear and proceed at the hearing waives the right to hearing and appeal with the same consequences as provided above regarding waivers.] If the respondent fails without good cause to appear and proceed with the hearing requested, the Hearing Committee will review the adverse recommendation or decision, as well as any pertinent available information and recommend that the adverse recommendation or decision involved be considered as voluntarily accepted, or recommend that the recommendation be rejected, or that a different corrective action be recommended. If the Hearing Committee recommends that the adverse recommendation or decision be considered as voluntarily accepted, further hearing and appeal rights are waived, and the recommendation will be forwarded to the Board for final action. If the Hearing Committee recommends that the recommendation be completely rejected, the Medical Executive Committee will be provided with the opportunity to appeal under the appeal process established by these bylaws. If the Hearing Committee recommends that a different corrective action be recommended, the recommendation will be treated as a new recommendation for corrective action under these bylaws.

#### 5. Presiding Officer:

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<sup>353</sup> The Hearing Committee should be comprised of “peers,” that is, Medical Staff members. To promote the impartiality that is crucial to a fair hearing, the members should not have involvement in the action up to that point.

<sup>354</sup> NCMS Policy on Hospital Peer Review states, “physicians under review should have an opportunity to voice good faith objections to inclusion of any members of a Fair Hearing panel. Such objections should not rise to the level of veto power, which would obstruct the process.” <http://www.ncmedsoc.org>.

The hearing officer, if appointed, or if not appointed, the Hearing Committee chair, shall be the presiding officer. If a hearing officer is appointed, the hearing officer, who shall be an attorney-at-law who does not routinely represent the hospital, the respondent, or the Medical Staff, shall be mutually agreed upon by the president in consultation with the Medical Executive Committee, on behalf of the Medical Staff, and by the administrator, on behalf of the Board, and shall be appointed by the administrator on behalf of the Board.<sup>355</sup> The hearing officer may not be in direct economic competition with the practitioner involved.<sup>356</sup>

The presiding officer shall maintain decorum and assure that all participants have a reasonable opportunity to present relevant oral and documentary evidence. The presiding officer shall determine the order of procedure during the hearing and shall make all rulings on matters of procedure. A hearing officer shall have no vote on the committee, but may participate in the committee deliberations and write the final recommendation and report as directed by the committee.

#### **6. Representation:**

The respondent may be accompanied and represented at the hearing by an attorney or by any other person of the respondent's choice.<sup>357</sup> The Medical Executive Committee or Board, depending on whose recommendation or action prompted the hearing, shall appoint an attorney or other individual to represent it.

#### **7. Rights of Parties:**

During a hearing, each party may:

- a) Call and examine witnesses;
- b) Introduce exhibits;
- c) Cross-examine any witness on any matter relevant to the issues;
- d) Impeach any witness;
- e) Rebut any evidence
- f) If the respondent does not testify on his or her own behalf, the respondent may be called and examined as if under cross-examination.

#### **8. Pre-Hearing Meeting:**

The presiding officer may require a pre-hearing conference for purposes of document exchange, establishing basic rules concerning the number and type of witnesses who may be called by either party, the length of testimony, role of legal counsel, length of direct and cross-examination, order and length of initial and closing arguments as

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<sup>355</sup> To accommodate the HCQIA requirement that the hospital should appoint the hearing officer, while allowing the Medical Staff to participate in the decision.

<sup>356</sup> Consistent with HCQIA standards.

<sup>357</sup> The subject has the right to be represented by an attorney or any other person of the subject's choice, under HCQIA hearing standards.

well as other matters deemed necessary to the conduct of a fair, orderly and efficient hearing process.

#### **9. Procedure and Evidence:**

The hearing need not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons might customarily rely in the conduct of serious affairs may be considered regardless of the admissibility of such evidence in a court of law. Each party shall be entitled, prior to or during the hearing, and at the close of the hearing,<sup>358</sup> to submit memoranda which shall become part of the hearing record.

#### **10. Official Notice:**

In reaching a decision, the Hearing Committee may take official notice, either before or after submission of the matter for decision, or any generally accepted technical or scientific matter relating to the issues under consideration and of any facts that may be judicially noticed by the courts of the state where the hearing is held. Parties present at the hearing must be informed of the matters to be noticed, and those matters must be noted in the hearing record. Any party shall be given opportunity, on timely request, to request that a matter be officially noticed and to refute any official noticed matter by evidence or by written or oral presentation of authority, in a manner to be determined by the Hearing Committee.

#### **11. Burden of Proof:<sup>359</sup>**

The Medical Executive Committee shall have the initial duty to present evidence in support of its action or recommendation. The respondent shall be obligated to present evidence in response. A member applying for privileges he or she does not currently hold or an applicant applying for Medical Staff membership and privileges shall bear the burden of persuading the Hearing Committee, by a preponderance of the evidence, of his or her qualifications by producing information that allows for adequate evaluation and resolution of reasonable concerns concerning his or her current qualifications for membership and privileges. The respondent shall not be permitted to introduce information requested by the Medical Staff but not produced during the application process without establishing that the information could not have been produced previously in the exercise of reasonable diligence.

Except as provided above, throughout the hearing, the Medical Executive Committee shall bear the burden of persuading the Hearing Committee, by a preponderance of

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<sup>358</sup> Under the HCQIA standards, the subject has the right to submit a written statement at the close of hearing also.

<sup>359</sup> Burden of proof should follow the data; that is, that the applicant, who has more information of his/her own credentials than the Medical Staff has, bears the burden of proving competence; but the Medical Staff, which must have adverse data to deny a current member's renewal application, must prove its case.

the evidence,<sup>360</sup> that its action or recommendation is reasonable and warranted. If the evidence on a particular issue is so evenly balanced that the Hearing Committee is unable to say that the evidence on either side preponderates, the Hearing Committee must find on that issue against the party who had the burden of proving it. In evaluating the evidence, the Hearing Committee should consider all of the evidence bearing on every issue regardless of which party produced it or had the burden of proof on the issue.

#### **12. Hearing Record:**

A record of the hearing shall be made by a court reporter. Transcripts shall be made available upon request of any party, at reasonable cost.<sup>361</sup>

#### **13. Postponement:**

Request for postponement of a hearing may be granted by the Hearing Committee only upon showing a good cause and only if the request is made as soon as is reasonably practical.

#### **14. Presence of Hearing Committee Members and Vote:**

A majority of the Hearing Committee must be present throughout the hearing and deliberations. If a committee member is absent from any substantial part of the proceedings, that member may not participate in the deliberations or the decision.

#### **15. Recesses and Adjournment:**

The presiding officer may recess and reconvene the hearing without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. The Hearing Committee must reconvene in a timely manner and in any event the recess must not exceed ten (10) days. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. At the close of hearing, both the parties to the hearing may provide the Hearing Committee with a written statement.<sup>362</sup> The Hearing Committee shall, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon conclusion of its deliberations, the hearing shall be adjourned. Adjournment shall be no later than seven (7) days after the hearing is closed.

### **D. Hearing Committee and Further Action**

#### **1. Hearing Committee Report:**

Within ten (10) days after final adjournment of the hearing, the Hearing Committee makes a written report of its findings and recommendations, with specific reference

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<sup>360</sup> "Preponderance of the evidence" means evidence that has more convincing force than that opposed to it.

<sup>361</sup> All records should be made consistently by court reporter, rather than make the form of record a subject of request and possibly dispute by one party or the other. A reliable record is critical for all parties involved. Under the HCQIA, the subject has a right to the record at reasonable cost.

<sup>362</sup> The HCQIA calls for the right to submit a written statement at the close of the hearing.

to the hearing record and other documentation considered, and forwards the report along with the record and other documentation to the Medical Executive Committee.

## **2. Notice and Effect of Results:**

### **a) Notice:**

The administrator promptly sends a copy of the result and the basis for the decision to the respondent by special notice, to the president, and to the Board.

### **b) Effect of Favorable Result:**

If the Hearing Committee's result is favorable to the respondent, the administrator shall include in the notice to the Medical Executive Committee its right to request an appellate review by the Board as provided in these bylaws.<sup>363</sup> If there is no appeal by the Medical Executive Committee, the Board may act on the Hearing Committee result or refer the matter back to the Medical Executive Committee for further consideration. Any referral back shall state the reasons, set a time within which a subsequent recommendation must be made, and may include a directive for any additional hearing. After receiving a subsequent recommendation and any new evidence, the Board takes action.

If the Board's action is favorable, it becomes the final action. If the Board determines that the Hearing Committee's result is not supported by the evidence or was not reached consistent with these bylaws, it may reject it and impose the original Medical Executive Committee recommendation or a variant thereof. If the Board determines to impose a variant of the original action, and such action would adversely and differently affect the respondent, the administrator then promptly provides the respondent with special notice informing the respondent of the right to request a new hearing on the changed action.

### **c) Effect of An Adverse Result:**

If the decision by the Hearing Committee is adverse to the respondent, then special notice of the Hearing Committee decision shall notify the respondent of the right to request an appellate review by the Board as provided in these bylaws. If there is no appeal, the Board shall act on the Hearing Committee result. The Board may adopt the Hearing Committee's result as the final action. If the Board determines that the Hearing Committee's result is not supported by the evidence or was not reached consistent with these bylaws, it may reject it and impose a variant thereof or determine that no action against the respondent should be taken. If the Board imposes a variant adverse action, the administrator shall then promptly provide the respondent with special notice

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<sup>363</sup> While the Medical Executive Committee should not have authority to override the Hearing Committee, it should have standing as a party to challenge the Hearing Committee's decision if it chooses.

informing the respondent of the right to request an appellate review by the Board.

## **E. Initiation and Prerequisites of Appellate Review**

### **1. Request for Appellate Review:**

A party has ten (10) days after receiving special notice to file a written request for an appellate review. The request must be delivered to the administrator in person or by certified or registered mail and may include a request for a copy of the Hearing Committee report and record and all other material, favorable to unfavorable, if not previously forwarded, that was considered in taking the adverse recommendation or action. If the party wishes to be represented by an attorney at any appellate review appearance, the request for appellate review must so state.

### **2. Waiver by Failure to Request Appellate Review:**

A respondent who fails to request an appellate review within the timeframe and in the manner specified waives any right to a review.

### **3. Notice of Time And Place for Appellate Review:**

The administrator delivers a timely and proper request to the chair of the Board. As soon as practicable, the Board schedules and arranges for an appellate review which shall be not less than ten (10) days nor more than twenty-one (21) days after the administrator received the request; provided, however, that appellate review for an member who is under a suspension then in effect shall be held as soon as the arrangements for it may be reasonably made, but not later than twenty-one (21) days after the administrator received the request. At least ten (10) days prior to the appellate review, the administrator sends the respondent special notice of the time, place and date of the review. The time may be extended by the appellate review body for good cause and if a request is made as soon as is reasonably practical.

### **4. Appellate Review Body:**

The Board shall determine whether the appellate review shall be conducted by the Board as a whole or by an appellate review committee of three (3) members of the Board appointed by the chair of the Board. If a committee is appointed, one of its members shall be designated as chair, and its decision shall be adopted by the Board as the final action at its next meeting unless it is not supported by the evidence or reached in a manner inconsistent with these bylaws.<sup>364</sup> No members may participate in or act on the appeal if they are in direct economic competition with the appellant or member or otherwise biased against the individual or personally benefit from the outcome.<sup>365</sup>

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<sup>364</sup> The use of a committee to hear the appeal should not slow the result unnecessarily by having the board re-evaluate the committee's decision. To streamline the process, the board should adopt the committee's action without further ado, unless the committee failed to follow the rules set out here.

<sup>365</sup> The appellate body must be impartial also.

## **F. Appellate Review Procedure and Final Action**

### **1. Nature of Proceedings:**

The proceedings by the review body are a review based upon the hearing record, the Hearing Committee's report, all subsequent results and action, the written statements, if any, provided below and any other material that may be presented and accepted under this article.

### **2. Written Statements:**

The parties may submit written statements detailing the findings of fact, conclusions and procedural matters with which each disagrees and the reasons therefor. The written statements may cover any matters raised at any step in the hearing process. The statements are submitted to the appellate review body through the administrator at least ten (10) days prior to the scheduled date of the review, except if the time is waived by the review body. The administrator shall provide a copy of the statements to the opposing parties at least ten (10) days prior to the scheduled date of the appellate review.

### **3. Presiding Officer:**

The chair of the appellate review body is the presiding officer, who shall determine the order of procedure during the review, make all required rulings and maintain decorum.

### **4. Oral Statements:**

The appellate review body allows the parties or their representatives to personally appear and make oral statements in favor of their positions.<sup>366</sup> Any party or representative appearing is required to answer questions put by any member of the review body.

### **5. Consideration of New or Additional Matters:**

New or additional matters or evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in the record may be introduced at the appellate review only in the discretion of the review body and as the review body deems appropriate, only if the party requesting consideration of the matter of evidence shows that it could not have been discovered with reasonable diligence in time of the initial hearing and that the new or additional matters would have reasonable likelihood of changing the result. The requesting party shall provide, through the administrator, a written, substantive description of the matter or evidence to the appellate review body and the other party at least three (3) days prior to the scheduled date of the review.

### **6. Powers:**

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<sup>366</sup> The appellate process should not be closed to oral arguments to promote the opportunity to adequately explain the case, and thus ward off challenges of unfairness at the appellate level.

The appellate review body has all the powers granted to the Hearing Committee, and any additional powers that are reasonably appropriate to or necessary for the discharge of responsibilities.

**7. Presence of Members and Vote:**

A majority of the review body must be present throughout the review and deliberations. If a member is absent from any part of the proceedings, he shall not be permitted to participate in the deliberations or the decision.

**8. Recesses and Adjournments:**

The review body may recess and reconvene the proceedings without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. At the conclusion of the oral statements, if allowed, the appellate review shall be closed. The review body shall then, at a time convenient to itself, conduct its deliberations outside the presence of the parties. The appellate review shall be adjourned at the conclusion of those deliberations.

**9. Action Taken:**

The review body may affirm, modify or reverse the result or action or in its discretion, may refer the matter back to the Hearing Committee for further review and recommendation to be returned to it within twenty-one (21) days and in accordance with its instructions. Within ten (10) days after receipt of such recommendation after referral, the review body shall take action. The action is immediately effective if the review body is the board itself, or if the review body is a committee, the decision shall be directly referred to the Board for final action. The decision shall be in writing, shall specify the reasons for the action taken and shall be forwarded to the president, the Medical Executive and Credential Committees, the respondent,<sup>367</sup> and the administrator.

**G. General Provisions**

**1. Number of Hearings and Reviews:**

Notwithstanding any other provision of the Medical Staff bylaws, no respondent is entitled to request more than one (1) evidentiary hearing and appellate review with respect to the subject matter that is the basis of the adverse recommendation or action.

**2. Release:**

By requesting a hearing or appellate review under this plan, the respondent agrees to be bound by the provisions of the Medical Staff bylaws relating to immunity from liability.

**3. Challenges to Rules:**

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<sup>367</sup> The HCQIA calls for the physician or dentist to receive a copy of the written decision including a statement for the basis for the decision.

The Hearing Committee is not authorized to modify, limit, or overrule any rule or requirement, and shall not entertain challenges to such rules and requirements. Any Medical Staff member who wishes to challenge an established rule or requirement involving the subject matter of a hearing must first notify the Medical Executive Committee of the rule or requirement he/she wishes to challenge and of the basis for the challenge. If the Medical Executive Committee decides to reconsider the particular rule or requirement, the Medical Executive Committee may stay the action recommended against the member pending the outcome of the process of reconsidering the rule or requirement.

## **ARTICLE VII - ALLIED HEALTH PROFESSIONALS**

Each allied health professional (“AHP”) shall be assigned to the Medical Staff department [and section] [service] appropriate to his or her occupational or professional training and, unless otherwise specified in the Medical Staff bylaws, rules and regulations, shall be subject to terms and conditions paralleling those specified for Medical Staff members as they may logically be applied to AHPs, whether employed by the hospital or another health care entity or by licensed independent practitioners, to promote a uniform standard of quality patient care.

### **A. Sponsored AHPs**

In the event an AHP’s required sponsor, collaborating physician or supervisor loses or resigns clinical privileges or the legal right to sponsor and/or supervise the AHP, then the AHP’s privileges are automatically suspended. This shall not be deemed an adverse action, and shall not entitle the AHP to the procedural rights set forth in this Article. The AHP may be reinstated upon substitution, within ninety (90) days, of another qualified Medical Staff member sponsor or supervisor. If the sponsor or supervisor is not substituted within this period, the AHP privileges terminate.

### **B. AHP Hearing and Appeal Process**

#### **1. Hearing Process:**

Whenever the Medical Executive Committee or the Board makes a recommendation or proposes to take an action to restrict or deny an AHP’s clinical privileges for more than thirty days or any application therefor, the administrator shall provide the AHP with written notice of the recommendation, the reasons therefor and the time period within which the AHP can request a hearing.<sup>368</sup> If a hearing is requested, the president shall name and administrator shall appoint a committee of three (3) unbiased Medical Staff members and allied health professionals with clinical

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<sup>368</sup> JC standard MS.06.01.07 Element of Performance 4 states, “The organization makes the practice aware of available due process or, when applicable, the option to implement the Fair Hearing and Appeal Process for Adverse Privileging Decisions as described in MS.10.01.01.”

privileges<sup>369</sup> to hear the AHP's objections to the proposed action or recommendation no sooner than thirty days from the date of the request. A record of the hearing shall be made. The committee's recommendation shall be in writing, shall reflect consideration of the information presented at the hearing, and shall be provided to the AHP, the Medical Executive Committee, and the Board.

## **2. Appeals:**

The AHP and the Medical Executive Committee each have the right to appeal the committee's recommendation by submitting written statements to the Board within thirty days of receipt of the recommendation. The Board, or a committee thereof, shall review the parties' written submissions. If the appeal is reviewed by a committee, it shall promptly provide the parties and the Board with its recommendation. Upon consideration of the Hearing Committee recommendation and the information presented at appeal, the Board shall take final action and shall thereupon provide all parties with its decision, and the reasons therefore, in writing.

## **3. Reporting:**

Final actions regarding allied health professionals' privileges shall not be reported to the National Practitioner Data Bank.<sup>370</sup>

## **ARTICLE VIII- INDEMNIFICATION<sup>371</sup>**

The hospital shall defend (or cover the costs incurred for defense by), and cover settlements, judgments and damages amounts on behalf of any Medical Staff leader or other member of the Medical Staff serving on or assisting any hospital or Medical Staff committee, or assisting in peer review or quality management activities involving care provided at the hospital, involved in claims arising out of such activities, so long as the member of the Medical Staff acted in good faith.

## **[ARTICLE IX-EFFECT OF HOSPITAL EMPLOYMENT<sup>372</sup>**

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369 JC standard MS.10.01.01 Element of Performance 4 states, "he organized Medical Staff has developed a fair hearing and appeal process addressing quality of care issues hat has the following characteristics: identifies the composition of the Hearing Committee as a committee that includes impartial peers."

370 Adverse actions against allied health professionals are optional under the National Practitioner Data Bank reporting regulations. Since there is no protection for review of allied health professionals under the HCQIA, not reporting the outcome of such reviews may lessen the liability exposure resulting from the adverse action.

371 If the members of the Medical Staff did not conduct peer review, the hospital would not be eligible for JC accreditation or state licensure. While the Medical Staff members are protected to some degree by immunity statutes, they will incur costs in establishing that immunity. The statutory immunity will not completely protect against the costs and liabilities faced by those conducting peer review; for example, the federal immunity does not apply at all to review of any practitioners other than physicians and dentists. To encourage the conduct of peer review, the hospital should indemnify Medical Staff members against these liabilities.

<sup>372</sup> This Article is useful where physician employment by the hospital is anticipated or on-going.

Physicians and other medical staff members who are employed or otherwise under contract <sup>373</sup>with the hospital [to render professional services to patients pursuant to privileges granted]<sup>374</sup> full-time or part-time, are subject to the bylaws, rules and regulations and policies of the medical staff.

#### **A. Standards**

##### **1. Membership**

All those holding an MD, DDS, OD or a DPM degree engaged by the hospital [to render professional services to patients pursuant to privileges granted] <sup>375</sup> in a full-time or part-time capacity, must apply, qualify for, obtain and maintain Medical Staff membership, subject to the same processes and standards that apply to Medical Staff members who have no financial relationship with the hospital.

##### **2. Incentives**

Any incentive offered by the hospital to any medical staff member is subject to review and authorization by the Medical Executive Committee to assure that it will not conflict with Medical Staff standards or otherwise adversely affect patient care. <sup>376</sup>

#### **B. Participation<sup>377</sup>**

Members otherwise under contract <sup>378</sup>with the hospital are [not] eligible for election to medical staff office or appointment to medical staff committees. <sup>379</sup> Selection of peer reviewers, including hearing committee membership, cannot be limited to members who are either employed by or under contract to the hospital.

#### **C. Corrective Action**

Members who are employed by or under contract with the hospital are not exempt from corrective action processes set forth in these bylaws. Members employed by the hospital may be subject to those provisions of the hospital's code of conduct that are not inconsistent with those established in these bylaws,

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<sup>373</sup> See section VI.B.2 regarding the Medical Executive Committee review of proposed contracts.

<sup>374</sup> Retain this bracketed phrase to exempt physicians and other professionals from medical staff membership if they are serving in an administrative capacity only, such as medical directors or vice presidents of medical affairs.

<sup>375</sup> Retain this bracketed phrase to exempt physicians and other professionals from medical staff membership if they are serving in an administrative capacity only, such as medical directors or vice presidents of medical affairs.

<sup>376</sup> See section II.C.12.b.2 regarding Medical Staff standard setting.

<sup>377</sup> See section II.A.10 requiring disclosure of employment or contractual relationships as conflicts of interest.

<sup>378</sup> See section VI.B.2 regarding the Medical Executive Committee review of proposed contracts.

<sup>379</sup> See section II.A.1.d.1, "Medical staff members cannot be fired from their hospital employment or be terminated from hospital contracts because they fulfill Medical Staff assignments in good faith consistent with these bylaws."

#### **D. Hearing and Appeal Processes**

All members have rights to the hearing and appeal processes established in these bylaws, the terms of the member's hospital contract notwithstanding.

### **ARTICLE X - BYLAWS, RULES AND REGULATIONS AND POLICY AMENDMENT AND EFFECT**

Medical Staff organization documents shall be adopted and amended strictly and exclusively according to the process established in these bylaws.

#### **A. Policy**

The Medical Executive Committee, or the Medical Staff, after communicating with the members of its Medical Executive Committee present,<sup>380</sup> shall review, develop and adopt policies that are binding upon the Medical Staff and its members and those otherwise holding clinical privileges.<sup>381</sup> Such policies must be consistent with the Medical Staff bylaws, rules and regulations. Only policies adopted consistent with this section are binding upon the Medical Staff and its members. Any medical staff policies approved by the board are upheld by the board.<sup>382</sup> Amendments to Medical Staff policies are to be distributed in writing to Medical Staff members and those otherwise holding clinical privileges in a timely and effective manner.<sup>383</sup>

#### **B. Rules and Regulations**

The Medical Staff shall initiate and adopt such rules and regulations as may be necessary to implement more specifically the general principles found within these Bylaws and to delineate the level of practice that is to be required of each practitioner in the hospital.<sup>384</sup> Suggestions for changes in the rules and regulations shall be referred to

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<sup>380</sup> Implementing Joint Commission standard MS 01.01.01, Element of Performance 9, which states, "If the voting members of the organized medical staff propose to adopt a rule, regulation, or policy, or an amendment thereto, they first communicate the proposal to the medical executive committee. ..."

<sup>381</sup> Consistent with Joint Commission standard MS 01.01.01, Element of Performance 1, which states that "The organized medical staff develops medical staff bylaws, rules and regulations, and policies."

<sup>382</sup> Joint Commission standard MS 01.01.01 Element of Performance 7 states, "The governing body upholds the medical staff bylaws, rules and regulations, and policies that have been approved by the governing body."

<sup>383</sup> Consistent with Joint Commission standard MS 01.01.01 Element of Performance 9, which requires that if the organized medical staff, with the approval of the governing body, has delegated to the medical executive committee the authority to adopt policy or amendment thereto, the medical executive committee communicates this to the medical staff.

<sup>384</sup> Rules and regulations typically detail requirements for specific clinical practices, particularly for issues that tend to be subject to frequent changes since rules and regulations are typically more easily amended. Issues that are not addressed in this Model but that should be addressed in a Medical Staff's rules and regulations include mechanisms for ensuring physician response to inpatient emergencies twenty-four (24) hours per day, called for in North Carolina Rule 10A NCAC 13B .4202(c) designation of who is qualified to conduct an emergency medical screening examination where emergency services are provided, called for in North Carolina Rule 10A NCAC 13B .4106; requirements for the patient's history and physical

the Bylaws Committee, which shall present its recommendations in timely fashion to the Medical Executive Committee for review and comment and referral to the Medical Staff. The rules and regulations shall only be amended, added to, or repealed at a regular or special meeting of the Medical Staff at which a quorum is present by a majority vote of those active staff members present. All amendments, additions, or recommendations for rule and regulations repeal must be presented to the Medical Staff at least [fifteen (15)] days prior to the meeting at which they are to be acted upon. Rules and regulations changes shall become effective when approved by the Board, which shall not be unreasonably withheld.<sup>385</sup>

### C. Bylaws Amendment<sup>386</sup>

The Medical Staff shall initiate and adopt such Medical Staff bylaws as may be appropriate for operation of the Medical Staff.<sup>387</sup> Suggestions for changes in the Bylaws shall be referred to the Bylaws Committee, which shall present its recommendations in timely fashion to the Medical Executive Committee for review and comment and referral to the staff. In addition, Medical Staff bylaws amendments can be proposed for adoption at the next Medical Staff meeting without any committee review by a petition to the Medical Executive Committee, signed by [[10 ]% of the] [20] members in good standing.<sup>388</sup> All amendments, additions, or recommendations for Medical Staff amendment and related Bylaws Committee and Medical Executive Committee comments must be circulated to the Medical Staff at least [fifteen (15)] days prior to the meeting at which they are to be acted upon. Amendments can be made at a regular or special meeting of the Medical Staff at which a quorum is present, by a majority vote of those active staff members present. Bylaws amendments shall become effective when approved by the Board,<sup>389</sup> which shall not be unreasonably withheld.<sup>390</sup>

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examination, called for in NC Rule10A NCAC 13B .4204; requirements for medical records completion, called for in North Carolina Rule 10A NCAC 13B .3905; requirements for medical orders, called for in North Carolina Rule 10A NCAC 13B .3707; and autopsy requirements, called for in North Carolina Rule 10A NCAC 13B .4907.

385 The AMA believes that (1) the Medical Staff bylaws, rules and regulations should be initiated and adopted by the Medical Staff and should establish a framework of self-government; (2) the Medical Staff should govern itself by these bylaws, rules and regulations which should: (a) be approved by the governing body, whose approval should not be unreasonably withheld; (b) be reviewed and revised as necessary to reflect current Medical Staff practices, and (c) define the Medical Executive Committee of the Medical Staff, whose members are selected in accordance with criteria and standards established by the Medical Staff; and (3) the Medical Staff should have authority to approve or disapprove all amendments to Medical Staff bylaws, rules and regulations.” AMA Policy Compendium H-235.989.

386 JC standard MS 01.01.01, Element of Performance 2, states “The organized medical staff adopts and amends medical staff bylaws. Adoption or amendment of medical staff bylaws cannot be delegated.”

387 JC standard MS 01.01.01, Element of Performance 1, states “The organized medical staff develops medical staff bylaws, rules and regulations, and policies.”

388 Joint Commission standard MS 01.01.01, Element of Performance 8 states, “The organized medical staff has the ability to adopt medical staff bylaws, rules and regulations, and policies, and amendments thereto, and to propose them directly to the governing body.”

389 NC Rule10A NCAC 13B .3705(a) states, “The active Medical Staff shall develop and adopt, subject to the approval of the governing body, a set of bylaws, rules or regulations, to establish a framework for self

## **D. Technical Amendments**

The Medical Executive Committee has the authority to adopt such amendments to the policies, rules and regulations, and bylaws as are, in its judgment, strictly technical clarifications, or renumbering of the Bylaws or amendments made necessary because of punctuation, spelling or other errors of grammar or expression. After adoption, such amendments shall be communicated in writing to the Medical Staff and to the Board. Such amendments shall be effective immediately but are subject to reversal by vote of the Medical Staff or the Board within ninety (90) days of adoption by the Medical Executive Committee. The action to amend may be taken by motion acted upon in the same manner as any other motion before the Medical Executive Committee.

## **E. Effect of the Policies, Rules and Regulations and Bylaws**

### **1. Effect of Conflicts:**

- a) Among Medical Staff Documents. If there is a conflict between the policies and the rules and regulations, the rules and regulations prevail. If there is a conflict between the bylaws and rules and regulations, the bylaws shall prevail.
- b) Between Medical Staff Bylaws and Hospital Documents. If there is a conflict between the Medical Staff bylaws and the hospital bylaw or policies, the Medical Staff bylaws shall prevail as the only mutually adopted document.<sup>391</sup>

### **2. Exclusivity:**

The mechanisms described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff rules and regulations

### **3. Effect of the Bylaws:**

Upon adoption and approval of these bylaws, the hospital and the Medical Staff agree that these bylaws shall be binding upon the Medical Staff,<sup>392</sup> its

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governance of Medical Staff activities and accountability to the governing body.” Joint Commission standard MS 01.01.01, Element of Performance 2 states, “(medical staff) Bylaws become effective only upon governing body approval.”

390 “The AMA believes that (1) the Medical Staff bylaws, rules and regulations should be initiated and adopted by the Medical Staff and should establish a framework of self-government; (2) the Medical Staff should govern itself by these bylaws, rules and regulations which should: (a) be approved by the governing body, whose approval should not be unreasonably withheld; (b) be reviewed and revised as necessary to reflect current Medical Staff practices, and (c) define the Medical Executive Committee of the Medical Staff, whose members are selected in accordance with criteria and standards established by the Medical Staff; and (3) the Medical Staff should have authority to approve or disapprove all amendments to Medical Staff bylaws, rules and regulations.” AMA Policy Compendium H-235.989 DNV Standard MS 7, Standard Requirement 2 states, “Changes to the medical staff bylaws, rules and regulations shall require approval of the medical staff and the governing body.”

391 Under Joint Commission standard MS 01.01.01, Element of Performance 4, “The Medical Staff bylaws, rules and regulations, and policies, the governing body bylaws, and the hospital policies are compatible with each other and are compliant with law and regulation.” In case of an incompatible bylaw or policy being adopted by the hospital, the Medical Staff bylaws, as adopted by the Medical Staff and the hospital together, should override incompatible terms in the hospital’s documents.

members,<sup>393</sup> and upon the hospital,<sup>394</sup> and upon any successor in interest in this hospital. Affiliations between the hospital and other hospitals, healthcare systems or other entities shall not, of themselves, affect these bylaws.<sup>395</sup>

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392 AMA Principle for Strengthening the Physician-Hospital Relationship #7 states, "Organized Medical Staff bylaws are a binding, mutually enforceable agreement between the organized Medical Staff and the hospital governing body, as well as between those two entities and the individual members of the organized Medical Staff." AMA Policy Compendium H-225.957

393 "All applicants or individuals who have privileges shall comply with all applicable Medical Staff bylaws, rules and regulations..." under N.C.G.S. 131E-85(d.)

394 North Carolina courts have held that the Medical Staff bylaws are part of an enforceable contract between the physician and the hospital. *Virmani v Presbyterian Health Services Corp.*; *Lorhmann v. Iredell Memorial Hospital*. In *Virmani* the court stated that since "[t]he application process was in accordance with the [Medical Staff bylaws] as adopted by Virmani and Virmani agreed 'to be bound by the terms' of the bylaws in the event he was granted hospital privileges...supports the determination that a valid and enforceable contract existed between Presbyterian and Virmani and that the [Medical Staff] [b]ylaws were an integral part of that contract." This section implements Joint Commission standard MS 01.01.01, Element of Performance 7, which states that "The governing body upholds the medical staff bylaws, rules and regulations, and policies that have been approved by the governing body."

395 "Our AMA encourages individual hospital Medical Staffs to develop bylaw provisions affirming the binding effect of the bylaw provisions on both the governing body and the Medical Staff, where consistent with applicable state law. The Medical Staff bylaws also should contain a successor-in-interest provision to protect Medical Staffs from a hospital ignoring the Medical Staff bylaws, and establishing new Medical Staff bylaws to apply post-merger, acquisition, affiliation, or consolidation." AMA Policy Compendium H-235.991.

**NCMS MODEL MEDICAL STAFF BYLAWS  
TABLE OF AUTHORITIES**

**CASES**

<b>Abbreviation Used in Model Bylaws</b>	<b>Complete Title</b>	<b>Citation</b>	<b>Summary</b>
Virmani v. Presbyterian Health Services Corp.	Virmani, M.D. vs. Presbyterian Health Services Corp.	127 N.C.App. 71 (488 S.E.2d 284)(N.C.App. 1998)	Physician brought action against the hospital for suspending his staff privileges. The court held that the Medical Staff bylaws and hospital bylaws become part of the contract between physician and the hospital when physician was granted clinical privileges. Second, the court held that the hospitals bylaws did not protect the hospital from liability when the hospital failed to follow their peer review procedures.
Lohnmann v. Iredell Memorial Hospital.	Wolfgang E. Lohmann, M.D. v Iredell Memorial Hospital Incorporated	174 N.C. App. 63 (620 S.E.2d 258) (N.C.App., 2005)	Dr. Lohnmann brought action against the hospital for suspending his Medical Staff privileges. First, court cited <i>Virmani</i> for proposition that contract exists between physician and hospital. On the question of the appropriateness of the decision to

Abbreviation Used in Model Bylaws	Complete Title	Citation	Summary
			suspend Dr. Lohnmann's privileges, the Court also noted that the authority to make correction action decisions rests with the governing body of the hospital and as long as the suspension of privileges is "administered with fairness, geared by a rationale compatible with hospital responsibility and unencumbered with irrelevant considerations" the court would not interfere.
Plummer v. Community General Hospital	Charles W. Plummer, M.D. v. Community General Hospital of Thomasville, Inc.	155 N.C.App. 574 (573 S.E.2d 596) (N.C.App. 2002)	An anesthesiologist brought an action for breach of contract when hospital entered exclusive contract with another company for anesthesiology services. The court held that the hospital's entering into an exclusive contract did not effectively terminate the anesthesiologist's Medical Staff privileges and therefore the plaintiff wasn't entitled to

Abbreviation Used in Model Bylaws	Complete Title	Citation	Summary
			notice and hearing procedures. Court followed the conclusion of courts outside of North Carolina that the granting of clinical staff privileges is separate from the right to exercise those privileges.
Woods v. Moses Cone Health System.	Woods v. Moses Cone Health System	678 S.E.2d 787 (2009)	Held that a letter from the plaintiff neurosurgeon to the chairperson of the medical review committee was privileged under statutory peer review protections even though letter was made available to more than one reviewing expert and to hospital's Chief Operating Officer.
Cunningham v. Cannon	George G. Cunningham v. Charles A. Cannon, Jr. Memorial Hospital Incorporated.	187 N.C.App. 732 (654 S.E.2d 24)(N.C.App. 2007)	Court held that peer review protections do not extend to material disclosed in physician's application for clinical privileges.

**FEDERAL REGULATIONS & STATUTES**

Abbreviation Used in Model Bylaws	Complete Title	Citation	Summary
EMTALA	Emergency Medical Transfer and Active Labor Act of 1986	42 U.S.C. §1395dd  see also: EMTALA INTERP GUIDELINES §489.24(j)(2)(i)  CMS Memorandum Ref #S&C-02-34, "On-Call Requirements-EMTALA"(June 13, 2002).	Intended to prohibit patient dumping, EMTALA requires hospitals to provide evaluation for emergency medical conditions without consideration of the patients' ability to pay. To provide stabilization, hospitals must post a list of physicians on call. EMTALA does not require physicians to serve on call.
HCQIA	Health Care Quality Improvement Act of 1986	42 U.S.C.A. § 11101 et seq.	Federal statute granting immunity for good faith peer review and establishing the National Practitioner Data Bank.
Medicare COP 42 C.F.R. §482xx	Medicare Conditions of Participation	42 C.F.R. §482et seq	Federal regulations setting forth the requirements for Medicare participation, .
Medicare exclusion	OIG Exclusion from Federal Health Care Programs	42 CFR §1001.1901	Federal regulation prohibiting payment by Medicare or any other federal health care programs for any services ordered or furnished by any excluded physician.
National Practitioner Data Bank reporting	National Practitioner Data Bank for Adverse Information	45 CFR 60.1 et seq.	Regulations detailing what licensure actions, credentialing

Abbreviation Used in Model Bylaws	Complete Title	Citation	Summary
regulations	on Physicians and Other Health Care Practitioners		action and malpractice payments must be reported federally.

#### STATE REGULATIONS & STATUTES

Abbreviation Used in Model Bylaws	Complete Title	Sections Cited	Summary
NCRule(s)	North Carolina Administrative Code Title 10A Chapter 13 North Carolina Medical Care Commission (2009)	10A NCAC 13B 3001 et seq.	North Carolina Medical Care Commission rules and regulations setting out the minimum requirements for hospital licensure.
NCGen Stat 131E - x	Chapter 131E: Health Care Facilities and Services Article 5 Hospital Licensure Act (2009)	N.C.G.S. 131E-75 et. seq.	North Carolina statutes including peer review and confidentiality protections for Medical Staffs.
NCGen Stat 130A-208	Chapter 130A Chapter 12 Control of Hazardous Conditions, Preventable Diseases, And Metabolic Disorders (2006)	N.C.G.S. 130A-208	Authorized by the Department to require hospital reporting of hospital services for cancer treatments to the North Carolina Central Cancer Registry.

#### OTHER RESOURCES

Abbreviation Used in Model Bylaws	Complete Title	Citation	Summary
American College of Surgeons Commission on Cancer, Cancer	American College of Surgeons Commission on Cancer,	<a href="http://www.facs.org/cancer/coc/programstandards.html">http://www.facs.org/cancer/coc/programstandards.html</a>	The multi-disciplinary Commission on Cancer of the American College of Surgeons establishes

Abbreviation Used in Model Bylaws	Complete Title	Citation	Summary
Program Standards	☒Cancer Program Standards 2004 (Revised Edition)		standards for cancer care delivered primarily in hospital settings; assesses compliance with those standards through hospital surveys; collects standardized and quality data from approved hospitals to measure treatment patterns and outcomes; uses the data to evaluate hospital performance; and develops educational interventions to improve cancer care outcomes.
AMA Policy Compendium	Policies of the American Medical Association House of Delegates	<a href="http://www.ama-assn.org/apps/pf">http://www.ama-assn.org/apps/pf</a>	Policy statements adopted by the AMA House of Delegates based on professional principles, scientific standards, and the experience of practicing physicians.
AMA Code of Ethics	American Medical Association's Code of Medical Ethics: the AMA Principles of Medical Ethics, and current Opinions of	<a href="http://www.ama-assn.org/apps/pf_new/pf_online?category=CEJA&amp;assn=AMA&amp;fn=mSearch&amp;st=&amp;st_p=&amp;nth=1&amp;">http://www.ama-assn.org/apps/pf_new/pf_online?category=CEJA&amp;assn=AMA&amp;fn=mSearch&amp;st=&amp;st_p=&amp;nth=1&amp;</a>	The Current Opinions of the AMA Council on Ethical and Judicial Affairs are CEJA's application of the AMA Principles of Medical Ethics to specific ethical issues.

Abbreviation Used in Model Bylaws	Complete Title	Citation	Summary
	the AMA Council on Ethical and Judicial Affairs (CEJA)		
DNV Standard	Det Norske Veritas (DNV) Health Care Inc. Standards	<a href="http://www.dnv.com/industry/healthcare/">http://www.dnv.com/industry/healthcare/</a>	DNV is a Norwegian risk assessment foundation with Medicare deemed status as an accreditor of American hospitals.
JC Standard	Joint Commission Hospital Accreditation Standards	Joint Commission Comprehensive Accreditation Manual For Hospitals: The Official Handbook (2012)	The Joint Commission is the primary hospital standards – setting and accreditation body, governed by a Board of Commissioners that includes AMA representatives.
NCMS Policy	North Carolina Medical Society	<a href="http://www.ncmedsoc.org">http://www.ncmedsoc.org</a>	Policy statements adopted by the NCMS House of Delegates based on professional principles, scientific standards, and the experience of North Carolina practicing physicians
Robert's Rules of Order (Tenth Edition)	Robert's Rules of Order (Tenth Edition)	Robert's Rules of Order Newly Revised, 10th ed. (Cambridge, Mass.: Perseus Publishing, 2000)	Long-standing code of parliamentary procedure to facilitate meetings and organization operations.