

**MAG MODEL MEDICAL STAFF BYLAWS
ANNOTATED**

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1 **INTRODUCTION TO THE MODEL BYLAWS**

2
3 Georgia medical staffs are large and small, in rural and urban settings, offering specialty and
4 tertiary general care, on a community and academic basis. To serve this diversity, the Medical
5 Association of Georgia (MAG) Model Medical Staff Bylaws includes options so that each
6 medical staff can use the Model as best suits the needs of that particular medical staff. Wording
7 in brackets [like this] are options from which the medical staff can choose the best solution for
8 its problems or circumstances.

9
10 **Sources**

11
12 Abbreviations for the following frequently referenced sources are used in annotations supporting
13 the provisions of the Model:

- 14
15 AMA Policy Compendium Policy of the American Medical Association
16
17 Georgia Regulations Regulations of the state of Georgia
18
19 O.C.G.A. Statutes of the state of Georgia
20
21 HCQIA Federal Health Care Quality Improvement Act of 1986
22
23 JC Standard 2013 Joint Commission Standards for
24 the Accreditation of Hospitals
25
26 MAG Policy Policy of the Medical Association of Georgia
27

28 *See the Table of Authorities immediately following the Model for full citations to cases, statutes*
29 *and other resources for physicians, medical staffs and their attorneys.*

30
31 **Disclaimer**

32
33 The model bylaws are provided for the information and education of Georgia physicians and
34 medical staffs regarding the requirements for medical staff organization documents and should
35 not be construed as legal advice. No medical staff should consider this document to be
36 mandatory for its adoption or use. Rather, the Model provides approaches for medical staffs to
37 consider when faced with the challenges of compliance with the many laws, regulations and
38 standards governing medical staff bylaws. Medical staffs are encouraged to consult with an
39 independent medical staff attorney when considering or developing medical staff bylaws, rules
40 and regulations and any amendments to any medical staff organization documents.

41
42 *Originally prepared by Elizabeth A. Snelson;*
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44

45
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1 **PREAMBLE**

2
3 Recognizing that the medical staff is responsible for the quality of patient care¹[, education and
4 research] in the [] hospital; and that the hospital has a duty to rely upon the judgment and
5 recommendations of the medical staff in such matters; and recognizing that mutually cooperative
6 efforts of the medical staff and the hospital Board of trustees are necessary to fulfill the standards
7 of quality patient care within the hospital set by the medical staff,² the physicians[,] [and] dentists
8 [and podiatrists] practicing in this hospital hereby organize themselves in conformity with these
9 bylaws to initiate and maintain self-government of the medical staff and thereby determine all
10 matters pertaining to medical care in the hospital; to act on all matters of professional ethics and
11 of patient care quality; and to determine all qualifications for medical staff membership and for
12 clinical privileges.

13
14 **ARTICLE I. TERMS & PURPOSES**

15
16 **A. Purposes³ of the Medical Staff Organization**

17
18 The purposes of this organization are:

- 19
20 1. To engage in performance improvement activities that promote quality care for all
21 patients admitted to or treated in any of the facilities, departments or services of the hospital;
22
23 2. To determine the mechanisms for establishing and enforcing criteria for delegating
24 oversight responsibilities to practitioners with independent privileges, for establishing and
25 maintaining patient care standards and for credentialing and delineation of clinical privileges to
26 promote a high level of professional performance of all practitioners;
27
28 3. To provide an appropriate educational setting that will maintain scientific standards and
29 that will lead to continuous advancement in professional knowledge and skill;
30

¹ Georgia Regulation 111-8-40-.11(b) states, “The medical staff shall be accountable to the governing body for the quality of medical care provided to all patients.”

² 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.”

³ The Overview to the JC Medical Staff chapter defines self-governance as follows: “Self-governance of the organized medical staff includes the following and is located in the medical staffs 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 and standards for medical staff membership
- Determining the mechanism for establishing and enforcing criteria for delegating oversight responsibilities to practitioners with independent privileges;
- Determining the mechanism for establishing and maintaining patient care standards and credentialing and delineation of clinical privileges; and
- Engaging in performance improvement activities.”

1 4. To provide for its self-governance by initiating, developing and approving all medical
2 staff bylaws and rules and regulations, approving or disapproving any amendments to the
3 medical staff bylaws and rules and regulations, and selecting and removing medical staff
4 officers;⁴ and

5
6 5. To provide a means whereby issues or disputes concerning the medical staff and the
7 hospital may be discussed and resolved by the medical staff and the governing body.
8

9 **B. Purposes of these Bylaws**

10
11 1. To establish the exclusive means of credentialing, granting or affecting medical staff
12 membership and privileges.⁵ No membership or clinical privileges criterion established by
13 these bylaws shall be waived by action of the medical staff, its executive committee, or the
14 Board.⁶ No member or privileges holder is exempt from corrective action or other provisions of
15 these bylaws because of employment by or contract with the hospital.⁷
16

17 2. To meet the legal requirements for the medical staff, the hospital and the professionals
18 practicing at hospitals.⁸
19

20 **C. Terms**

21
22 1. Administrator means the individual hired by the Board to act on its behalf in the overall
23 management of the hospital.
24

25 2. Board [of Directors] [of Trustees] means the governing body⁹ of the hospital.
26

⁴ “The medical staff of the hospital shall adopt and enforce bylaws and rules and regulations which provide for the self-governance of medical staff activities and accountability to the governing body for the quality of care provided to all patients.” Georgia Regulation 111-8-40-.11(c).

⁵ Implementing Georgia Regulation 111-8-40-.11(a)2, which states, “The medical staff shall be responsible for the examination of credentials of any candidate for medical staff membership and for any other individuals seeking clinical privileges and for the recommendations to the governing body concerning appointment of such candidates.” Further, as found by the Georgia Court of Appeals in *Whitaker v. Houston*, “a public hospital authority cannot refuse to follow its existing bylaws concerning staff privileges.”

⁶ JC Standard MS.06.01.05, Elements of Performance 1 and 2 require that each of the criteria for privileges is used and consistently evaluated for all practitioners. Element of Performance 5 for JC Standard MS.06.01.07 states, “The hospital’s privilege granting/denial criteria are consistently applied for each requesting practitioner.”

⁷ Preventing the employed members from circumventing peer review recommendations because of any financial relationship with the hospital.

⁸ Georgia Regulation 111-8-40-.11(c) requires that “the medical staff of the hospital shall adopt and enforce bylaws and rules and regulations which provide for the self-governance of medical staff activities and accountability to the governing body for the quality of care provided to all patients.” Also, JC Standard MS.01.01.01, Element of Performance 4 states, “[t]he 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.”

⁹ According to Georgia Regulation 111-8-40-.02(e), “Governing body means the hospital authority, Board of trustees or directors, partnership, corporation, entity, person, or group of persons who maintain and control the hospital.”

1 3. Clinical privileges or privileges means authorization to provide care, treatment and services
2 as delineated consistent with these bylaws and includes the right to exercise those privileges in
3 the hospital’s facilities unless specifically restricted by action of these bylaws.¹⁰
4

5 4. Day means a calendar day unless otherwise specified in a particular context as “working
6 day,” which is a non-weekend, non-holiday day.
7

8 5. Hospital means [_____ Hospital] [and its corporate ownership.]
9

10 6. In good standing means, at the time of the assessment of standing, neither his/her
11 membership nor his/her privileges are involuntarily limited, restricted, suspended, or otherwise
12 encumbered for disciplinary reasons.
13

14 7. Investigation means the process specifically initiated by action of the Medical Executive
15 Committee to formally determine whether corrective action against a member should be
16 recommended. An investigation does not include the usual activities of departments or of other
17 committees of the medical staff in compliance with the licensing and certification
18 requirements, or preliminary deliberations or inquiries of the Medical Executive Committee to
19 determine whether to order an investigation.¹¹
20

21 8. Medical staff¹² means the organization of physicians [,][and] dentists, [and podiatrists]
22 created and operated pursuant to the provisions of these bylaws to be responsible and
23 accountable for the quality of patient care provided at the hospital.¹³
24

25 9. Member means a professional holding current membership in the [] medical staff.
26

¹⁰ Implementing the bylaws language cited in and enforced by the court in *Satilla v. Bell*, at 19, to prevent the hospital from revoking existing privileges granted to medical staff member physicians by extending an exclusive contract to other physicians. Medical staff bylaws should include clear provisions on the effect of exclusive contracts, as the Georgia courts in *Alonso v. Hosp. Auth. of Henry County*, *Cobb County Kennestone Hosp. Auth. v. Prince* and *St. Mary’s v. Radiology Professional Corp.* have held that physicians can be protected by such provisions, and hospitals are obligated to follow medical staff bylaws regarding clinical privileges and termination of clinical privileges held by physicians with hospital contracts.

¹¹ 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. A definition of when an investigation begins and what it entails should avoid uncertainty as to when privileges surrenders must be reported, and could lessen the possibility of litigation involving reporting of investigations to the data bank, such as in the case of *Lee v. Hosp. Auth. of Colquitt County*.

¹² “Medical staff means the body of licensed physicians, dentists, and/or podiatrists, appointed or approved by the governing body, to which the governing body has assigned responsibility and accountability for the patient care provided at the hospital,” according to Georgia Regulation 111-8-40-.02(i).

¹³ Georgia Regulation 111-8-40-.11(b) states, “The medical staff shall be accountable to the governing body for the quality of medical care provided to all patients.”

1 **10.** Practitioner means any individual engaged in the practice of the profession for which he
2 or she is licensed, certified, or otherwise qualified or authorized to practice.¹⁴
3

4 **11.** Respondent means the applicant to or member of the medical staff, or applicant for or
5 holder of clinical privileges, who is the subject of a hearing or appeal.
6

7 **12.** Special notice means written notice mailed, return receipt requested, to a member,
8 respondent, applicant, or other person, at the address as last appears in the official records of
9 the medical staff or the hospital.¹⁵
10

11 **ARTICLE II. MEDICAL STAFF ORGANIZATION**¹⁶

12
13 The medical staff is organized into departments and committees under elected leadership to
14 fulfill its purposes.¹⁷
15

16 **A. Leadership**

17
18 The medical staff organization elects officers, representatives, [department chairs] and
19 committee chairs as stated in this Article.
20

21 **1. General**

22 **a) Qualifications**

23
24
25 Only [active] medical staff members in good standing at the time of nomination can be
26 nominated for and serve as officers, representatives, [department chairs] and committee
27 chairs. [A member elected to the office of president-elect shall not be eligible for election
28 to the office of president-elect again until the member has ceased to hold any office for at
29 least one year.] Failure to retain membership in good standing throughout the term of
30 office will create a vacancy in the position.
31

32 **b) Training Requirements**

33
34 Each member of the Medical Executive Committee [officer] [department chief]
35 [committee chair] shall fulfill annual leadership training requirements as established by
36 the Medical Executive Committee.
37

¹⁴ Georgia Regulation 111-8-40-.02(q) states, "Practitioner means any individual engaged in the practice of the profession for which they are licensed, certified, or otherwise qualified or authorized to practice."

¹⁵ "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

¹⁶ Under JC Standard MS.01.01.01, Element of Performance 12 the bylaws include "the structure of the medical staff."

¹⁷ Georgia Regulation 111-8-40-.11(c) states, "The bylaws and rules and regulations ... shall include at a minimum: A plan for administrative organization of the medical staff and committees thereof, which clearly delineates lines of authority, delegation, and responsibility for various tasks and functions..."

1 **c) Compensation**

2
3 Each officer [and] [the credentials committee chair] [and the quality improvement
4 committee chair] shall receive an annual stipend in honor of their services to the medical
5 staff in an amount set by the Medical Executive Committee and paid from medical staff
6 funds.

7
8 **d) Accountability**

9
10 **(1) To the medical staff**

11
12 Officers, representatives, [department chairs] and committee chairs are accountable
13 to the medical staff in fulfilling the responsibilities of their positions as defined in
14 this article. Medical staff members cannot be fired from their hospital employment
15 or be terminated from hospital contracts as a result of good-faith participation in
16 medical staff activities or fulfilling leadership duties consistent with these bylaws.

17
18 **(2) To the members**

19
20 No officer, representative, [department chair] or committee chair shall engage in
21 any punitive or retaliatory action against any medical staff member because that
22 member seeks to exercise any right established under these bylaws, including
23 petitioning for the revocation of any medical staff leader's position with the medical
24 staff.

25
26 **2. Nomination**

27
28 **a) By nominating committee.**

29
30 The nominating committee shall meet beginning in July of each [even numbered] year to
31 prepare one or more nominations meeting the qualifications for each leadership position
32 open in the next year, and as needed to prepare nominations for vacancies. It shall secure
33 its nominees consent to be nominated and serve. Prior to the 15th day of the month of
34 October of each [even numbered] year, and as needed as vacancies arise, the nominating
35 committee shall submit to the Medical Executive Committee one or more nominations for
36 each office to be filled. The medical staff office shall post the names of the nominees [in
37 the medical staff lounge] [on the medical staff bulletin Board] [on the medical staff
38 website] or otherwise provide written notice to the medical staff¹⁸ not less than 20 days
39 prior to the medical staff election.

40
41 **b) By Petition.**

42
43 Nominations may also be made by petition signed by at least [20 Members] [___%] of
44 the active staff and filed with the medical staff office at least 10 days prior to the election.

¹⁸ 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.

1 The medical staff office shall promptly report the names of additional nominees, if any,
2 to the medical staff, in the same manner as those nominated by the nominations
3 committee.
4

5 **c) Other nominations**
6

7 In the event that all nominees shall refuse, be disqualified from, or be unable to accept
8 nomination before the election:
9

10 (1) the nominating committee shall submit the names of one or more additional
11 nominees to the annual meeting of the medical staff and
12

13 (2) nominations shall be permitted from the floor.
14

15 **d) Nominations from the floor**
16

17 Elections at a meeting of the medical staff shall include nominations from the floor if the
18 nominee is present, qualified, and agrees to serve.
19

20 **3. Elections of Officers and Representatives**
21

22 **a) Schedule¹⁹**
23

24 [The president-elect and the secretary-treasurer shall be elected by majority vote in each
25 [even] [odd] numbered year at the annual meeting of the staff and at the end of this term
26 the president-elect shall automatically assume the office of the president.]
27

28 [Officers shall be elected at the annual meeting of the medical staff.]
29

30 **b) Number of Votes**
31

32 A nominee must receive a majority of all valid votes cast for an office to be elected. If no
33 nominee receives a majority vote, a run-off election shall be held promptly between the
34 two nominees receiving the highest number of votes cast for such office.
35

36 **c) Balloting²⁰**
37

38 [Balloting shall be by secret written [mailed] ballot at the annual medical staff meeting.]
39 [Voting shall take place at the annual meeting by voice or hand.] [Balloting shall take
40 place on the website or via email.]
41

¹⁹ The schedule of elections varies based on the medical staff's choice of a one-year term of office or a two-year term.

²⁰ 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.

1 **d) Terms of Office**

2
3 [All officers and representatives shall serve a one (1) year term beginning January 1.]

4
5 [All officers and representatives shall serve a two (2) year term beginning on the first day
6 of January in each odd numbered year.]

7
8 [All officers may be re-elected for a succeeding term.] [Officers [and representatives]
9 may be elected to [one] [additional] [consecutive] term(s).]

10
11 [Officers [and representatives] may not be elected to [additional] [consecutive] terms.]

12
13 **4. Officers**²¹

14
15 The medical staff officers are the president, the president-elect, the immediate past president,
16 the secretary, and the treasurer [the secretary-treasurer].

17
18 **a) President**

19
20 The medical staff president is elected by the [active] medical staff to represent the
21 medical staff as the chief medical officer at the hospital, and shall:

22
23 (1) call, preside at, and be responsible for the agenda of all meetings of the
24 medical staff organization;

25
26 (2) serve as chair of the Medical Executive Committee, and call, preside at, and
27 be responsible for the agenda of all Medical Executive Committee meetings;

28
29 (3) appoint medical staff members for [one-year] terms to all standing and special
30 medical staff committees except the Medical Executive Committee, and to any
31 hospital medical staff committees with medical staff representation, unless
32 otherwise provided by these bylaws;

33
34 (4) appoint chairs of medical staff committees to [one][two] year terms unless
35 otherwise stipulated in these bylaws;

36
37 (5) report the medical staff's recommendations and concerns and otherwise
38 represent the medical staff at each Board meeting and communicate reactions and
39 responses to the medical staff and Medical Executive Committee;²²

40

²¹ The overview to the JC Medical Staff chapter defines medical staff self-governance as including selecting and removing medical staff officers. JC Accreditation Manual for Hospitals

²² JC Standard LD.01.03.01, Element of Performance 9 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."

1 (6) serve as a member of the Board representing the Medical Staff, as a liaison
2 between the two; to assist in the development of hospital policy; to maintain open
3 communication; to participate in strategic planning; to contribute to oversight of
4 hospital operations; and to communicate reactions and responses to the medical
5 staff and Medical Executive Committee;²³
6

7 (7) serve as or appoint an appropriate medical staff member to serve as
8 spokesperson for the medical staff in its external professional and public relations;
9 and
10

11 (8) carry out other responsibilities as established in these bylaws or as are
12 appropriately delegated by the Medical Executive Committee or the medical staff.
13

14 **b) President-Elect**
15

16 The medical staff president-elect is elected by the [active] medical staff to assume the
17 president’s responsibilities in his/her absence, and shall
18

19 (1) serve as a member of the Medical Executive Committee;
20

21 (2) represent the medical staff at each Board meeting, along with the medical staff
22 president, and communicate reactions and responses to the medical staff and
23 Medical Executive Committee;²⁴
24

25 (3) [serve as a member of the Board representing the medical staff, as a liaison
26 between the two; to assist in the development of hospital policy²⁵; to maintain open
27 communication; to participate in strategic planning; to contribute to oversight of

²³ Serving as a member of the Board described here differs from serving as a representative before the Board as described immediately preceding this section. JC Standard LD.01.03.01, Element of Performance 10 states, “Organized medical staff members are eligible for full membership in the hospital’s governing body, 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 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 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-225.983 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.

²⁴ JC Standard LD.01.03.01, Element of Performance 9 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.” The president-elect can serve as a representative before the Board in addition to the president or other designated representatives.

²⁵ To implement in part the requirement of Georgia Regulation 111-8-40-.11(c)1 that medical staff bylaws include “a mechanism for participation of medical staff in policy decisions related to patient care in all areas of the hospital.”

1 hospital operations; and to communicate reactions and responses to the medical
2 staff and Medical Executive Committee;]²⁶

3
4 (4) [automatically assume the office of the presidency upon completion of the
5 president-elect term;]

6
7 (5) carry out other responsibilities as established in these bylaws or as are
8 appropriately delegated by the Medical Executive Committee or the medical staff.

9
10 **c) Secretary**

11 The medical staff secretary is elected by the [active] medical staff, and shall

12 (1) serve as a member of the Medical Executive Committee;

13
14 (2) oversee the accuracy of the minutes of all medical staff and Medical
15 Executive Committee meetings;²⁷

16
17 (3) call medical staff meetings on order of the President;

18
19 (4) attend to all medical staff correspondence unless otherwise delegated under
20 these medical staff bylaws;

21
22 (5) perform such other duties as ordinarily pertain to the office; and

23
24 (6) carry out other responsibilities as established in these bylaws or as are
25 appropriately delegated by the Medical Executive Committee or the medical staff.

26
27
28 **d) Treasurer**

29 The medical staff treasurer is elected by the [active] medical staff, and shall:

²⁶ Serving as a member of the Board described here differs from serving as a representative before the Board as described immediately preceding this section. JC Standard LD.01.03.01, Element of Performance 10 states, “Organized medical staff members are eligible for full membership in the hospital’s governing body, 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 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-225.983. 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.

²⁷ 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.

- (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;
- (6) carry out other responsibilities as established in these bylaws or as are appropriately delegated by the Medical Executive Committee or the medical staff.

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;²⁸
- (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:

²⁸ 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.

- 1 (1) serve as a member of the Medical Executive Committee;
2
3 (2) carry out other responsibilities as established in these bylaws or as are
4 appropriately delegated by the Medical Executive Committee or the medical staff.
5

6 **5. Representatives**
7

8 **a) Board Representatives²⁹**
9

10 The [two] Board representatives are elected by the [active] medical staff to serve as
11 voting Board members, and shall:
12

- 13 (1) attend all Board meetings;
14
15 (2) designate one representative to attend and report on Board issues to the
16 Medical Executive Committee;
17
18 (3) report on Board issues to the medical staff;
19
20 (4) carry out other responsibilities as established in these bylaws or as are
21 appropriately delegated by the Medical Executive Committee or the medical staff.
22

23 **b) Medical Executive Committee Members At-Large³⁰**
24

25 The [four] medical staff representatives are elected by the [active] medical staff to serve
26 as voting Medical Executive Committee members at large, and shall:
27

- 28 (1) attend all Medical Executive Committee meetings;
29

²⁹ Supported by AMA Policy Compendium H-225.983, 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 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. JC Standard LD.01.03.01, Element of Performance 10 states, “Organized medical staff members are eligible for full membership in the hospital’s governing body, unless legally prohibited.”

³⁰ At-large representatives may assist the medical staff to comply with JC Standard MS.02.01.01, Element of Performance 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 JC 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 JC, but is not mandated. This model limits medical executive committee members to members of the medical staff.

- 1 (2) report on Medical Executive Committee issues to the medical staff;
2
3 (3) carry out other responsibilities as established in these bylaws or as are
4 appropriately delegated by the Medical Executive Committee or the medical staff.
5

6 **c) AMA OMSS Representative³¹**
7

8 The medical staff representative and alternate representative to the American Medical
9 Association (AMA) Organized Medical Staff Section (OMSS) are elected by the [active]
10 medical staff to represent the medical staff to organized medicine. The OMSS
11 representative and alternative representative must be members of MAG and AMA, and
12 shall
13

- 14 (1) serve as a member of and attend all Medical Executive Committee meetings;
15
16 (2) represent the medical staff at all meetings of the AMA OMSS;
17
18 (3) report on AMA OMSS issues and actions to the Medical Executive
19 Committee and the medical staff;
20
21 (4) carry out other responsibilities as established in these bylaws or as are
22 appropriately delegated by the Medical Executive Committee or the medical staff.
23

24 **6. Committee Chairs**
25

26 Committee chairs shall be appointed by the president to serve [one][two] year terms unless
27 otherwise stipulated in these bylaws and shall
28

- 29 **a)** call meetings as set by these bylaws or as necessary to fulfill committee
30 responsibilities;
31
32 **b)** preside at, and be responsible for the agenda of all meetings;
33
34 **c)** carry out other responsibilities as established in these bylaws or as are appropriately
35 delegated by the Medical Executive Committee or the medical staff.
36

37 **7. Department Chairs**
38

39 Department Chairs shall be elected by the [active] medical staff members of the department to
40 [one][two] year terms unless otherwise stipulated in these bylaws and shall:
41

³¹ 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 www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/organized-medical-staff-section.page or by calling AMA OMSS staff at 800.621.8335.

- 1 **a)** Maintain appropriate specialty Board certification or establish comparable
2 competence through the medical staff credentialing process;³²
3
4 **b)** Oversee department administration;³³
5
6 **c)** Continuously review the professional performance of all privileges holders in the
7 department;³⁴
8
9 **d)** Recommend to the Medical Executive Committee all criteria for clinical privileges
10 relevant to the care provided in the department;³⁵
11
12 **e)** Make recommendations to the Medical Executive Committee regarding all requests
13 for privileges within the department;³⁶
14
15 **f)** Assess and recommend to the Medical Executive Committee any off-site sources
16 for needed patient care, treatment, and services not provided by the department or the
17 hospital;³⁷
18
19 **g)** Oversee integration of the department into the hospital’s primary functions;³⁸
20
21 **h)** Oversee the coordination and integration of interdepartmental and intradepartmental
22 services;³⁹
23
24 **i)** [Serve as members of the Medical Executive Committee;]
25
26 **j)** Oversee the development and implementation of policies and procedures that guide
27 and support the provision of care, treatment, and services;⁴⁰
28
29 **k)** Recommend the number of qualified and competent persons and the space and
30 other resources needed to provide care, treatment, and services in the department;⁴¹
31
32 **l)** Determine the qualifications and competence of department personnel who are not
33 licensed independent practitioners and who provide patient care, treatment, and
34 services;⁴²
35

³² Medical staff bylaws are to define the qualifications under JC Standard MS.01.01.01.

³³ As called for by JC Standard MS.01.01.01.

³⁴ As called for by JC Standard MS.01.01.01.

³⁵ As called for by JC Standard MS.01.01.01.

³⁶ As called for by JC Standard MS.01.01.01.

³⁷ As called for by JC Standard MS.01.01.01.

³⁸ As called for by JC Standard MS.01.01.01.

³⁹ As called for by JC Standard MS.01.01.01.

⁴⁰ As called for by JC Standard MS.01.01.01.

⁴¹ As called for by JC Standard MS.01.01.01.

⁴² As called for by JC Standard MS.01.01.01.

- 1 **m)** Continuously assess and work toward improvement of the quality of care,
2 treatment, and services through maintenance of quality control programs, as
3 appropriate;⁴³
4
5 **n)** Oversee orientation and continuing education of all persons in the department;⁴⁴
6
7 **o)** [Appoint a vice chair from among the qualified active staff members in the
8 department to assume the responsibilities and authority of the chair in his/her temporary
9 absence;]
10
11 **p)** Carry out other responsibilities as established in these bylaws or as are
12 appropriately delegated by the Medical Executive Committee or the medical staff.
13

14 **8. [Sections Heads]**

15
16 Section heads shall be elected by the [active] medical staff members of the section to
17 [one][two] year terms and shall
18

- 19 **a)** Oversee section administration;
20
21 **b)** Continuously review the professional performance of all privileges holders in the
22 section;
23
24 **c)** Recommend to the department chief all criteria for clinical privileges relevant to the
25 care provided in the section;
26
27 **d)** Make recommendations to the department chief regarding all requests for privileges
28 within the section;⁴⁵
29
30 **e)** Assess and recommend to the Medical Executive Committee any off-site sources
31 for needed patient care, treatment, and services not provided by the section or the
32 hospital;⁴⁶
33
34 **f)** Oversee integration of the section into the hospital's primary functions;
35
36 **g)** Oversee the development and implementation of policies and procedures that guide
37 and support the provision of care, treatment, and services;
38
39 **h)** Recommend to the department chief the number of qualified and competent persons
40 and the space and other resources needed to provide care, treatment, and services in the
41 section;
42

⁴³ As called for by JC Standard MS.01.01.01.

⁴⁴ As called for by JC Standard MS.01.01.01.

⁴⁵ As called for by JC Standard MS.01.01.01.

⁴⁶ As called for by JC Standard MS.01.01.01.

1 i) Make recommendations to the department chief on the qualifications and
2 competence of section personnel who are not licensed independent practitioners and who
3 provide patient care, treatment, and services;

4
5 j) Continuously assess and work toward improvement of the quality of care,
6 treatment, and services through maintenance of quality control programs, as appropriate;

7
8 k) Carry out other responsibilities as established in these bylaws or as are
9 appropriately delegated by the Medical Executive Committee or the medical staff.

10
11 **9. Disclosure of Conflicts of Interest⁴⁷**

12
13 In order to protect the interests of the medical staff in improving patient care and conducting
14 fair peer review, all medical staff leaders, including officers, department chairs, section heads,
15 medical staff representatives, and medical staff members serving on committees shall disclose
16 potential conflicts of interest as relevant to the position held and the circumstances, consistent
17 with these bylaws. Disclosure of conflicts shall have no bearing on a member's medical staff
18 membership or clinical privileges. No member may exercise any leadership or committee role
19 unless and until the member completes the conflict of interest disclosure form approved by the
20 Medical Executive Committee as consistent with these bylaws. This section shall be the unique
21 and exclusive mechanism for discerning and acting upon conflicts of interest applicable to
22 medical staff members.⁴⁸

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

26
27 **a) Who Discloses**

28
29 Disclosure is required:

30
31 (1) By members interested in medical staff leadership positions, prior to
32 nomination, to the nominating committee or member who will be submitting the
33 nomination, and, prior to election, to those eligible to vote;

34
35 (2) By committee chairs and committee members, prior to the date the committee
36 appointment begins, to the president;

37
38 (3) Annually by members of the following committees to their chairs:

39

⁴⁷ "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

⁴⁸ Clarifying those hospital conflicts of interests policies do not apply to medical staff members.

1 (a) Medical Executive Committee; infection control; pharmacy & therapeutics
2 committee; credentials committee, bylaws committee, institutional review
3 Board (or other research-related committees), budget committee;

4
5 (b) in committees, including ad hoc committees, and in meetings pursuant to
6 the parameters below.

7
8 **b) Potential Conflicts to Be Disclosed**

9
10 Potential conflicts include:

11
12 (1) Competitive or personal relationships, activities, or interests that may
13 inappropriately influence a member's decisions or actions;⁴⁹

14
15 (2) Grants or other financial, academic or professional relationships involving
16 research relating to decisions under review;⁵⁰

17
18 (3) Ownership held by a member or his/her immediate family in the hospital or
19 the system of which the hospital is a part or affiliated;⁵¹

20
21 (4) Ownership of material financial interests in any company that furnishes goods
22 or services to the hospital or is seeking to provide goods or services to the
23 hospital;⁵²

24 (5) Current or imminent personal compensation arrangements with the hospital
25 under the terms of a contract or employment;⁵³

26
27 (6) Ownership in or directorship or other leadership or employment by a managed
28 care company that contracts with or could contract with the hospital;⁵⁴

29
30 (7) Receipt of gifts including goods, services, or honoraria from the hospital or
31 any company or person who contracts with or otherwise sells to the hospital.

32
33 **c) Conflict Resolution**

34
35 (1) A member shall recuse himself/herself if the member reasonably believes that
36 his/her ability to render a fair and independent decision is or may be affected by a
37 conflict of interest;

⁴⁹ To make known matters that could prejudice a member for or against another professional in peer review.

⁵⁰ To address bias by members involved in research.

⁵¹ To make known a financial bias that favors the hospital that might influence a member's position on matters in which the hospital and medical staff have differing views.

⁵² To make known a financial bias that favors the hospital that might influence a member's position on matters in which the hospital and medical staff have differing views.

⁵³ To make known the possibility that the hospital has extraordinary influence over the member.

⁵⁴ To make known a financial bias that favors the hospital that might influence a member's position on matters in which the hospital and medical staff have differing views.

1
2 (2) If a majority of voting members of the committee or in the staff meeting vote
3 that the member should be excused from discussion or voting, due to conflict of
4 interest, the chair shall excuse the member;

5
6 (3) If a member discloses a potential conflict of interest and requests a vote
7 regarding excusing the member, the member shall leave the room while the issue is
8 being discussed and voted upon;

9
10 (4) The minutes of the meeting shall include the names of those excused for
11 conflicts and the nature of the conflicts involved.

12
13 **10. Absence, Resignation and Removal**

14
15 **a) Absence**

16
17 **(1) Temporary Absence of Officers**

18
19 In case of temporary absence [of less than three weeks], the following officer
20 coverage shall facilitate medical staff operation:

21
22 (a) in the president's absence, the president-elect shall assume all duties of the
23 president.

24
25 (b) in the absence of both the president and the president-elect, the secretary
26 [secretary-treasurer] shall assume all the duties of the president.

27
28 (c) in the absence of the president, the president-elect, and the secretary, the
29 treasurer shall assume all the authority and responsibilities of the president and
30 the secretary.

31
32 (d) in the absence of the president, the vice president, the secretary and the
33 treasurer [secretary-treasurer], the immediate past president shall assume all the
34 duties of the president, the secretary and the treasurer.

35
36 (e) in the absence of the president, the vice president, the secretary and the
37 treasurer [the secretary-treasurer] and the immediate past president, the
38 executive committee shall elect a presiding chair, and shall as a committee carry
39 out all the duties and have the authority and responsibilities of the offices.

40
41 **(2) Temporary Absence of Department Chairs, [Section Heads] and**
42 **Committee Chairs**

43
44 In the absence of Department Chairs, [Section Heads] and Committee Chairs, the
45 vice-chief, assistant head or vice-chair shall assume all duties of the absent leader.

1 In the absence of a vice-chief, assistant head or vice-chair, the Medical Executive
2 Committee shall name a temporary leader to assume the duties of the position.
3

4 **b) Leave of Absence**
5

6 If a medical staff leader or committee members take a leave of absence from medical
7 staff membership for any reason, their medical staff leadership and committee position(s)
8 will be deemed resigned, and the position(s) will be filled consistent with these bylaws.
9

10 [If a medical staff leader takes a leave of absence from medical staff membership for any
11 reason, the leave of absence will be addressed as a temporary absence from leadership
12 under these bylaws.]
13

14 **c) Resignation**
15

16 **(1) Resignation of Leadership Position**
17

18 A medical staff leader may resign, effective immediately or upon a date specified,
19 in writing, or verbally stating, the resignation to a medical staff officer or
20 department chief. Any verbal resignation shall be immediately documented by the
21 officer or chief receiving the resignation, with a copy to the resigning leader.
22

23 **(2) Resignation of Committee Membership**
24

25 A member may resign committee membership for good cause, effective
26 immediately or upon a date specified, in writing to the committee chair. Failure to
27 meet committee membership requirements will be included in the evaluation for
28 any renewal of medical staff membership and may result in denial of medical staff
29 membership renewal.⁵⁵
30

31 **d) Removal of Officers,⁵⁶ Representatives, Department Chairs, Committee**
32 **Chairs, and Committee Members**
33

34 **(1) Removal of Officers and Representatives**
35

36 Any officer or representative may be removed from leadership without assigning
37 specific cause by the affirmative vote of 51 percent of Active Medical Staff
38 Members in a medical staff meeting attended by [mail or email balloting
39 participated in by] a majority of the active staff members.
40

41 **(2) Removal of Department Chief or Vice Chief [and Section Head or**
42 **Assistant Head]**

⁵⁵ To enforce membership duties to participate in medical staff organization activities.

⁵⁶ Under JC Standard 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.”

1
2 Any department [or section] leader may be removed from leadership without
3 assigning specific cause by the affirmative vote of 51 percent of Active Medical
4 Staff Members in a department [or section] meeting attended by [mail or email
5 balloting participated in by] a majority of the active staff members of the
6 department [or section].
7

8 **(3) Removal of Committee Member⁵⁷**
9

10 If a member of a committee fails to carry out the duties of committee membership,
11 or commits malfeasance as a committee member, or if any other good cause exists,
12 that member may be removed [by vote of the committee,] [or] [by the president,
13 subject to approval by the Medical Executive Committee] [or] [by the Medical
14 Executive Committee]. If the member at issue is a member of the Medical
15 Executive Committee, he/she shall not be involved in the discussion or vote on
16 his/her removal, but may make a statement in his/her defense to the Medical
17 Executive Committee prior to the discussion and vote.
18

19 **(4) Automatic Removal**
20

21 A leader, or committee members, shall be automatically removed from any and all
22 medical staff organization positions upon loss of medical staff membership.
23

24 **(5) Effect of Removal**
25

26 Removal itself shall not constitute a diminution of the member's medical staff
27 membership or privileges, or otherwise give rise to any right to hearing or appeal.
28

29 **B. Services⁵⁸**
30

31 The medical staff is organized into the following services:
32

33 **1. Medicine**
34

35 **2. Surgery**
36

37 **3. Obstetrics**
38

39 Medical staff members shall serve as Service Directors and fulfill the following responsibilities
40 [see responsibilities for department chairs above at section II.A.7.

⁵⁷ JC 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.

⁵⁸ For non-departmentalized hospital medical staffs.

1 Service Director recommendations shall become effective only when acted upon by a designated
2 medical staff committee.]

3
4 **C. Departments [and Sections]**

5
6 **1. Medicine and Surgery⁵⁹**

7
8 All members will be members of either the Department of Surgery or the Department of
9 Medicine as determined by the Medical Executive Committee. The Medical and Surgical
10 Departments may be divided into clinical sections subject to the approval of the Medical
11 Executive Committee.

12
13 **2. Roster of Departments**

14
15 Members may have privileges in more than one department but shall be granted membership in
16 only one medical staff department.

17 [The roster of current medical staff departments and sections is available in the medical staff
18 office.]⁶⁰

19
20 **a)** Anesthesiology

21
22 **b)** [Clinical Services, comprised of hospital-based specialties under hospital contract:
23 Anesthesiology, Emergency, ICU, Pathology, Physical Medicine, Radiology, Radiation
24 Therapy]

25
26 **c)** Emergency

27
28 **d)** Family Medicine

29
30 **e)** Intensive Care

31
32 **f)** Internal Medicine

33
34 **g)** Neurosurgery

35
36 **h)** Obstetrics & Gynecology

37
38 **i)** Orthopaedic Surgery

39
40 **j)** Pathology

41
42 **k)** Pediatrics

43

⁵⁹ To allow for a simple departmentalization.

⁶⁰ No law or standard 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.

1 l) Physical Medicine

2
3 m) Psychiatry

4
5 n) Radiation Therapy

6
7 o) Radiology

8
9 p) Surgery

10
11 **3. Changes in Departments**

12
13 Recommendations to add, eliminate or consolidate departments shall be submitted by medical
14 staff members to the Medical Executive Committee with documentation supporting the
15 recommendation. The Medical Executive Committee shall study the recommendation, and if
16 adopted, shall refer the action to the medical staff bylaws committee and credentials committee
17 for recommendations as to implementation of the recommendation.

18
19 **4. Department Functions**

20
21 As appropriately determined by the department and consistent with these bylaws, department
22 functions shall be discharged under the leadership of the department chair.

23
24 Each department:

25
26 a) Develops and recommends to the chair for further recommendation to the Medical
27 Executive Committee the criteria for clinical privileges in the department,⁶¹ specifying
28 minimum training, experience and qualifications for each privilege.⁶²

29
30 b) Reviews and develops recommendations for action on applicants seeking
31 membership and privileges within the department;

32
33 c) Develops and recommends changes in staffing, space and other hospital resources
34 as needed to support privileges being requested or exercised in the department;⁶³

35
36 d) Develops recommendations for the establishment of standards for measuring the
37 quality, appropriateness and improvement of patient care furnished in the department;

⁶¹ JC Standard MS.01.01.01, Element of Performance 36, calls for the department chair to recommend privilege criteria to the medical staff.

⁶² Mandated by Georgia Regulation 111-8-40-.11(a) 2(vii), which states, "...Minimum requirements for medical staff appointments and clinical privileges shall include:... [c]ongruity of the qualifications and/or training requirements with the privilege requested. ..."

⁶³ JC Standard MS.06.01.01, Element of Performance 1, 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."

- 1 e) Establishes focused evaluation processes⁶⁴ for care in the department consistent
2 with these bylaws, including chart review, practice pattern monitoring, proctoring,
3 external peer review, and discussion with other professionals involved in the care of the
4 same patients,⁶⁵ for new members and members with new privileges,⁶⁶ and for focused
5 review or investigation.⁶⁷
6
- 7 f) Develops standards and recommendations for implantable devices and other
8 medical equipment and devices used in the exercise of privileges in the department;
9
- 10 g) Establishes surgical and other procedural schedules for procedures performed under
11 privileges exercised in the department;
12
- 13 h) Adopts, repeals, or revises departmental rules and regulations by a majority vote of
14 [active staff] members of the department [present at] [participating electronically or
15 otherwise in] any meeting at which a quorum exists. Such rules and regulations may
16 include criteria for department members to hold departmental office, which may be
17 developed by the individual departments as appropriate. All departmental rules and
18 regulations shall be submitted to the medical staff executive committee for final review
19 and approval prior to their implementation;
20
- 21 i) Carries out functions delegated to the department by the medical staff, the Medical
22 Executive Committee or otherwise by operation of these bylaws.
23

24 5. [Sections]

25
26 [Sections of clinical subspecialties and specialties may be organized within a department
27 for purposes of education, peer review, and self-government with approval of the Medical
28 Executive Committee. Five or more members of a department with similar clinical
29 interests shall submit to the chief a written proposal of rationale, organization structure,
30 rules and regulations for a section consistent with the overall department and medical
31 staff policies, including commitments to serve as a section leader until the next election.
32 If approved by the department, the petition and proposed organizational structure and
33 rules and regulations shall be submitted to the Executive Committee for approval. If
34 approved, sections shall carry out for the section the duties stipulated for departments in
35 this article but shall direct recommendations to the department chair.]
36

⁶⁴ JC Standard MS.08.01.01 states “[t]he organized medical staff defines the circumstances requiring monitoring and evaluation of a practitioner’s professional performance.”

⁶⁵ As described in the rationale for JC Standard MS.08.01.01.

⁶⁶ JC Standard MS.08.01.01, Element of Performance 1, states that “[a] period of focused professional practice evaluation is implemented for all initially requested privileges.”

⁶⁷ JC Standard MS.08.01.0, Element of Performance 2, states that “[t]he 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.”

1 **D. Committees**⁶⁸
2

3 Unless otherwise provided by these bylaws, all medical staff committees report to the Medical
4 Executive Committee. Members shall be appointed by the president from among the medical
5 staff membership, taking into consideration financial relationships with the hospital and other
6 potential conflicts of interest, and may be removed by the president for cause, which must be
7 disclosed in the notice of removal. Subcommittees of any medical staff committee may be
8 established by the committee chair to carry out such functions of the committee as the chair
9 assigns and to report to the parent committee. Subcommittees may include members other than
10 those on the parent committee, but each subcommittee shall be chaired by a member of the
11 parent committee[, except as otherwise provided in these bylaws.]
12

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

⁶⁸ According to Georgia Regulation 111-8-40-.11, "...The bylaws may provide for the exercise of the medical staff's authority through committees..."

1 **1. Bioethics Committee**⁶⁹

2
3 **a) Composition**

4
5 The bioethics committee shall be composed of [five] members selected on basis of
6 interest and diversity of expertise and experience; [an ethicist];⁷⁰ a representative of the
7 religious community appointed by the executive committee; a representative appointed
8 by hospital administration, and a representative appointed by the nursing staff. An active
9 staff member shall chair the Committee.

10
11 **b) Duties**

12
13 The bioethics committee:

- 14
15 **(1)** develops for adoption by the executive committee, and approval as
16 appropriate by the Board, any medical staff and hospital policies regarding the
17 bioethics of patient care and treatment at this hospital, including the “Do Not
18 Resuscitate” policy;⁷¹

⁶⁹ Following AMA Code of Ethics E-9.11, “Ethics Committees in Health Care Institutions,” which provides, “The 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 would 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 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 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.”

⁷⁰ If available from a university, college or otherwise from the local community.

⁷¹ Consistent with MAG Policy 140.977, “MAG encourages hospital medical staff and governing bodies to develop

- 1
2 (2) provides consultation upon referral by the executive committee or the Board;
3
4 (3) provides consultation upon appropriate request from patients, patient families,
5 and other hospital community members;
6
7 (4) supports or provides educational opportunities for medical and hospital staff
8 regarding bioethics;
9
10 (5) maintains confidentiality of all patient and peer review information;⁷²
11
12 (6) meets [at least monthly and] at the call of the chair as necessary to fulfill its
13 duties in a timely manner.
14

15 The consultations and recommendations of the bioethics committee are not binding, but
16 rather are consultative in nature.
17

18 2. Budget Committee

19 a) Composition

20 The budget committee consists of [two] members of the medical staff and the medical
21 staff treasurer [secretary-treasurer] who will serve as committee chair. Members shall
22 serve three (3) year terms on a staggered basis, subject to re-appointment.
23
24
25

26 b) Duties

27 The budget committee:

- 28 (1) determines the hospital resources and financial support the medical staff
29 requires for the administrative activities involved to fulfill its duties as established
30 under these bylaws, and works with the Board to develop related parts of the
31 medical staff budget;⁷³
32

and implement their own "Do Not Resuscitate" policies consistent with Georgia law and their respective bylaws, rules and regulations."

⁷² Georgia state protections for peer review confidentiality are strong and should be maximized in medical staff bylaws. The court in *Patton v. St Francis* identified as the basis for its decision to affirm immunity for the hospital in Dr. Patton's challenge of a peer review action against him the "clear legislative intent to protect review proceedings from discovery while granting immunity from civil liability to review participants. The Georgia 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. O.C.G.A. §§ 31-7-130 ("It is the intent of the General Assembly to provide protection for those individuals who are members of peer review groups which evaluate the quality and efficiency of professional health care providers and to protect the confidentiality of their records."); 31-7-132 (a) (immunity from liability for peer review); 31-7-133 (a); 31-7-141 (immunity for medical review committee members from claims for damages filed by health care providers); 31-7-143; *Baldwin County Hosp. Authority v. Wright* (peer review and medical review proceedings are both absolutely privileged)."

⁷³ AMA Principles 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

- 1
2 (2) recommends the annual medical staff budget to the Medical Executive
3 Committee;
4
5 (3) recommends the amount of annual dues and, if appropriate, assessments to the
6 Medical Executive Committee;
7
8 (4) meets at the call of the chair but no less frequently than monthly;
9
10 (5) fulfills other responsibilities as established in these bylaws or as are
11 appropriately delegated by the Medical Executive Committee or the medical staff.
12

13 3. Bylaws Committee

14 a) Composition

15
16
17 The bylaws committee consists of [two] members of the medical staff and the medical
18 staff secretary [secretary-treasurer] who will serve as committee chair.
19

20 b) Duties

21
22 The bylaws committee:

- 23
24 (1) reviews medical staff bylaws, rules and regulations and policies on an annual
25 basis and propose amendments as appropriate to the Medical Executive
26 Committee;⁷⁴
27
28 (2) reviews hospital bylaws and related policies on an annual basis and alerts the
29 Medical Executive Committee of conflicts with medical staff bylaws, rules and
30 regulations and policies;⁷⁵
31 (3) reviews medical staff application forms and other forms for consistency with
32 the medical staff bylaws, rules and regulations and policies, and proposes
33 amendments as appropriate to the Medical Executive Committee;

administrative activities, which the hospital shall fund, based upon the financial resources available to the hospital.”
AMA Policy Compendium H-225.957

⁷⁴ Georgia Regulation 111-8-40-.11(c) states, “The medical staff of the hospital shall adopt and enforce bylaws and rules and regulations which provide for the self-governance of medical staff activities and accountability to the governing body for the quality of care provided to all patients. The bylaws and rules and regulations shall become effective when approved by the governing body and shall include at a minimum: “...A procedure for review and/or update of the bylaws and rules and regulations as necessary, but at least once every three (3) years.”

⁷⁵ 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 4, “[t]he 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.”

1
2 (4) oversees compliance with the medical staff bylaws, rules and regulations, and
3 policies;⁷⁶
4

5 (5) fulfills other responsibilities as established in these bylaws or as are
6 appropriately delegated by the Medical Executive Committee or the medical staff.
7

8 **4. Cancer Committee**⁷⁷
9

10 **a) Composition**
11

12 The cancer committee consists of at least six Board-certified physicians, one each from
13 these specialties: general surgery, medical oncology, radiation oncology, diagnostic
14 radiology, pathology, and the cancer liaison physician,⁷⁸ and including at least one
15 physician representing each of the diagnostic and treatment services.⁷⁹ The cancer
16 committee chair is a physician who may also fulfill the role of one of the required
17 physician specialties.⁸⁰ The cancer committee shall also include an individual from each
18 of the following areas of the hospital: cancer program administration, oncology nursing,
19 social services, certified tumor registrar to carry out case abstracting, and quality
20 improvement professional. Additional physician or non-physician members include at a
21 minimum representatives of hospice/home care nursing or administration; pain
22 control/palliative care specialist, clinical research data manager or nurse; and may include
23 a nutrition specialist, pharmacists, mental health professional or psychiatrist, pastoral care
24 representative, American Cancer Society cancer control representative, and a public
25 member of the community served. Other physician and non-physician members may also
26 be on the committee as needed.⁸¹ All non-medical staff members will be eligible to vote,
27 except on matters relating exclusively to the medical staff.
28

29 **b) Duties**
30

31 The cancer committee:
32

⁷⁶ Implementing Georgia Regulations 111-8-40-.11(b)2, “The medical staff shall implement measures, including peer review, to monitor the on-going performance of the delivery of patient care by those granted clinical privileges, including monitoring of compliance with the medical staff bylaws, rules and regulations...” Under JC Standard MS.01.01.01, Element of Performance 6, “[t]he organized medical staff enforces the medical staff bylaws, rules and regulations, and policies...”

⁷⁷ This section is designed to help the medical staff and hospital meet the standards of the American College of Surgeons Commission on Cancer. “Cancer committee authority is established and documented by the facility. The program provides the bylaws, policy or procedure, or other sources that set forth the cancer committee’s authority for the cancer program.” Cancer Program Eligibility Requirement E2

⁷⁸ Called for by American College of Surgeons Commission on Cancer, Cancer Program Standard 1.2, Cancer Committee Membership.

⁷⁹ Specified under the definitions and requirements under American College of Surgeons Commission on Cancer, Cancer Program Standard 1.2, Cancer Committee Membership.

⁸⁰ Called for by American College of Surgeons Commission on Cancer, Cancer Program Standard 1.2.

⁸¹ 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 1.2.

- 1 (1) develops and evaluates annual goals and objectives for clinical, community
2 outreach, quality improvement, and programmatic endeavors related to cancer care;
3
- 4 (2) is accountable, through the Medical Executive Committee, to the Board, for
5 all clinical cancer activities at the hospital;⁸²
6
- 7 (3) reviews and makes recommendations on all policies and procedures related to
8 care of cancer patients;
9
- 10 (4) works towards complete compliance with all standards required to maintain
11 accreditation by the American College of Surgeons Commission on Cancer;
12
- 13 (5) establishes, as appropriate, subcommittees or workgroups to fulfill cancer
14 program goals;
15
- 16 (6) monitors cancer-related quality management and improvement through
17 completion of quality management studies that focus on quality, access to care, and
18 outcomes;
19
- 20 (7) promotes clinical research;
21
- 22 (8) supervises the cancer registry and encourages accurate and timely abstracting,
23 staging, and follow-up reporting;⁸³
24
- 25 (9) performs quality control for registry data;
26 (10) encourages data usage and regular reporting;
27
- 28 (11) designates one coordinator for each of the following areas of cancer
29 committee activity: cancer conference, quality control of cancer registry data,
30 quality improvement, community outreach, clinical research and psychosocial
31 services. The cancer liaison physician can fulfill the role of community outreach
32 coordinator;⁸⁴
33
- 34 (12) establishes cancer conference frequency, format and multidisciplinary
35 attendance requirements for cancer conferences on an annual basis and monitors
36 attendance and compliance;⁸⁵
37
- 38 (13) ensures the required numbers of cases are discussed at cancer conference and
39 that at least 80 percent of the cases discussed are prospective;⁸⁶

⁸² American College of Surgeons Commission on Cancer, Cancer Program Eligibility Requirement E2: Cancer Committee Authority states, “Cancer committee authority is established and documented by the facility.”

⁸³ Georgia hospitals are required to report certain information on patients receiving hospital services to the Georgia Comprehensive Cancer Registry pursuant to O.C.G.A. § 31-12-2(a) and 42 U.S.C.S. § 280e (6/13/13).

⁸⁴ American College of Surgeons Commission on Cancer, Cancer Program Standard 4.3.

⁸⁵ Based on American College of Surgeons Commission on Cancer, Eligibility Requirement E3.

⁸⁶Based on American College of Surgeons Commission on Cancer, Eligibility Requirement E3.

- 1 (14) establishes and implements a plan to evaluate the quality of cancer registry
2 data and activity on an annual basis;⁸⁷
3
4 (15) completes an annual analysis that includes outcome data and disseminates the
5 results of the analysis to the public;⁸⁸
6
7 (16) reviews at minimum 10 percent of the eligible analytic caseload to ensure that
8 90 percent follow College of American Pathologists (CAP) protocols for reporting
9 required data elements in cancer pathology reports;⁸⁹
10
11 (17) analyzes patient outcomes and disseminates the results of the analysis
12 annually;
13
14 (18) provides a formal mechanism for educating patients about cancer-related
15 clinical trials and offers at least one cancer-related educational activity each year;⁹⁰
16
17 (19) reviews the percentage of cases accrued to cancer-related clinical trials each
18 year;
19
20 (20) monitors community outreach activities on an annual basis;
21 (21) completes and documents annually the required studies that measure quality
22 and outcomes;⁹¹
23
24 (22) meets at the call of the chair at least quarterly, for a minimum of four times
25 each year;⁹²
26
27 (23) fulfills other responsibilities as established in these bylaws or as are
28 appropriately delegated by the Medical Executive Committee or the medical staff.
29

30 5. Credentials Committee

31 a) Composition

32 The credentials committee shall be composed of [five] members representing different
33 specialties.
34

35 b) Duties

36
37
38

⁸⁷ Based on American College of Surgeons Commission on Cancer, Cancer Program Standard 1.6.

⁸⁸ Based on American College of Surgeons Commission on Cancer, Cancer Program Standard 1.12.

⁸⁹ To meet American College of Surgeons Commission on Cancer, Cancer Program Standard 2.1.

⁹⁰ To meet American College of Surgeons Commission on Cancer, Eligibility Requirement E9 and Cancer Program Standard 1.10.

⁹¹ American College of Surgeons Commission on Cancer, Cancer Program Standard 4.7.

⁹² Suggested by the definition and requirements for American College of Surgeons Commission on Cancer, Cancer Program Standard 1.4.

1 The credentials committee:
2

3 (1) reviews [section and] department recommendations and evaluates the
4 information supporting all medical staff membership and clinical privileges
5 applications, and makes recommendations regarding membership, staff category,
6 privileges, restrictions and changes in privileges to the Medical Executive
7 Committee (MEC);
8

9 (2) reviews [section and] department recommendations and evaluates the
10 information supporting all applications for renewed membership and all available
11 information and makes recommendations to the MEC concerning membership
12 renewals and clinical privileges for the ensuing membership period;
13

14 (3) periodically reviews the forms, procedures and policies involved in the
15 credentialing process and recommends changes to the Medical Executive
16 Committee.
17

18 In carrying out these duties, credentials committee members shall comply with the
19 conflict of interest requirements of these bylaws.
20

21 **6. Infection Control Committee**⁹³
22

23 **a) Composition**
24

25 The infection control committee shall consist of at least one representative of the
26 departments of medicine, surgery, obstetrics-gynecology, pediatrics, anesthesiology,
27 [infectious diseases], pathology, [the infection control officer],⁹⁴ and the lead nurse for
28 infection control.
29

30 **b) Duties**
31

32 The infection control committee:
33

34 (1) recommends to the Medical Executive Committee preventive programs
35 designed to minimize infection;
36

37 (2) oversees infection control throughout the hospital including without limitation
38 operating rooms, delivery rooms, recovery rooms and special care units;

⁹³ AMA policy states that: “(1) the hospital medical staff should have a multidisciplinary committee to oversee the surveillance, prevention and control of infection; (2) the infection control committee should report to the hospital medical staff executive committee; and (3) the medical staff’s role, responsibility and authority in the infection control activities should be included in the medical staff bylaws.” AMA Policy Compendium H-235.969.

⁹⁴ 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.

1 sterilization procedures; isolation procedures; provider testing; and procurement,
2 storage, and transfusion procedures of blood or blood products;

3
4 (3) meets at the call of the chair but no less frequently than monthly;

5
6 (4) fulfills other responsibilities as established in these bylaws or as are
7 appropriately delegated by the Medical Executive Committee or the medical staff.
8

9 **7. Joint Conference Committee⁹⁵**

10
11 **a) Composition**

12
13 The joint conference committee consists of the medical staff officers and hospital Board
14 members in equal number,⁹⁶ selected by the Board chair from its members. The chair will
15 alternate at each meeting between Board and medical staff representatives.
16

17 **b) Duties**

18
19 The committee serves as the primary locus for management and resolves disputes
20 between medical staff and Board, and may accept requests to resolve differences between
21 or among other medical staff and/or hospital leaders.⁹⁷ Disputes shall be managed, and
22 where possible resolved by consensus, after sufficient opportunity for the committee to
23 receive and review any documentation or other appropriate input, including meeting and
24 working with any involved parties.⁹⁸ The joint conference committee reviews all hospital
25 strategic plans prior to implementation.⁹⁹ The joint conference committee may request
26 any additional information from the medical staff or administration before acting to
27 approve or disapprove such plan.
28

⁹⁵ The Committee provides a forum for conflict resolution as called for under JC Standard LD.02.04.01

⁹⁶ 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

⁹⁷ JC Standard 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.”

⁹⁸ JC Standard LD.02.04.01, Element of Performance 4, provides:

“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.”

⁹⁹ 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

1 **8. Medical Executive Committee**¹⁰⁰

2
3 [The medical staff as a whole serves as the executive committee.]¹⁰¹

4
5 **a) Composition**

6
7 The Medical Executive Committee consists of the medical staff officers, the elected
8 department chairs or, in any departments under exclusive contract, the elected
9 representative of the department,¹⁰² the AMA OMSS Representative,¹⁰³ and [four] at-
10 large member representatives.¹⁰⁴ The president will chair the committee. The
11 administrator may be invited by the president to attend the Medical Executive Committee
12 meetings as needed and appropriate.¹⁰⁵

13
14 **b) Duties**

15
16 The Medical Executive Committee:

17
18 (1) reviews the recommendations of the medical staff departments and
19 committees regarding the clinical competence of applicants and medical staff
20 members and other practitioners with or applying for clinical privileges and make
21 recommendations to the Board regarding membership, membership renewal,¹⁰⁶ staff
22 categorization, and department assignments, and renewal, termination or changes in
23 clinical privileges;¹⁰⁷

24
25 (2) is authorized to act for the organized medical staff between meetings of the
26 organized medical staff,¹⁰⁸ with the exception of election of officers and amendment

¹⁰⁰ JC Standard MS.01.01.01, Element of Performance 20, states that the medical staff bylaws must also include "...the medical executive committee's function, size, and composition..."

¹⁰¹ As noted in the note for JC Standard MS.02.01.01, "[t]he medical staff as a whole may serve as the executive committee. In smaller, less complex hospitals where the entire medical staff functions as the executive committee, it is often designated as a committee of the whole."

¹⁰² To permit the department rather than the hospital to name the department's representative to the medical executive committee.

¹⁰³ Including the AMA OMSS representative will promote communication between the medical staff and AMA.

¹⁰⁴ Allowing at large representatives may assist the medical staff to comply with JC Standard MS.02.01.01, Element of Performance 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."

¹⁰⁵ 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 executive committee meeting on an ex-officio basis, with or without a vote."

¹⁰⁶ According to JC Standard MS.02.01.01, Element of Performance 6, "the medical staff executive committee has a mechanism to recommend medical staff membership termination."

¹⁰⁷ Consistent with JC Standard MS.02.01.01, Element of Performance 11, states that the medical staff executive committee makes recommendations, as defined in the medical staff bylaws, directly to the governing body on, at least... "[t]he delineation of privileges for each practitioner privileged through the medical staff process."

¹⁰⁸ JC Standard MS.01.01.01, Element of Performance 23, states that the medical staff bylaws must also include "[t]hat the medical executive committee acts on the 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."

1 of these bylaws,¹⁰⁹ and subject to any other limitations imposed by the medical staff
2 bylaws, which authority can be further limited or removed by a vote of two-thirds
3 of the medical staff eligible to vote.¹¹⁰ The Medical Executive Committee
4 represents and is accountable to the medical staff, and, except for recommendations
5 regarding membership, privileges and corrective actions, subject to reversal of its
6 decisions by a majority vote of the active staff;¹¹¹

7
8 (3) oversees and coordinates the activities of medical staff departments and
9 committees including resolving conflicts among them or among members;¹¹²

10
11 (4) receives and, when requested or appropriate, acts upon committee and
12 departmental minutes, reports and recommendations;¹¹³

13
14 (5) adopts and implements policies of the medical staff;

15
16 (6) is kept informed of any hospital activities, business developments and
17 projects, pending decisions, policies, plans or proposals related to patient care at the
18 earliest possible juncture and in all cases in advance of their implementation, by
19 hospital administration or Board members, to permit the Medical Executive
20 Committee to provide clinical input and recommendations to the Board;¹¹⁴

21
22 (7) recommends action to the Board of Directors as appropriate on matters of a
23 medical administrative nature including the medical staff structure;¹¹⁵

24
25 (8) develops organ and tissue donation protocols for the medical staff, or adopts
26 those developed by a committee, department or task force appointed by the
27 president for this purpose;¹¹⁶

¹⁰⁹ Under JC 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;..."

¹¹⁰ Under JC 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." 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...."

¹¹¹ Under JC 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. . ."

¹¹² "The hospital manages conflict between leadership groups to protect the quality and safety of care." JC Standard LD.02.04.01.

¹¹³ According to JC Standard MS.02.01.01, Element of Performance 12, "the medical staff executive committee makes recommendations, as defined in the medical staff bylaws, directly to the governing body on...the executive committee's review of and actions on reports of medical staff committees, departments, and other assigned activity groups."

¹¹⁴ Under Georgia Regulation 111-8-40-.11(c)1, the bylaws must include "a mechanism for participation of medical staff in policy decisions related to patient care in all areas of the hospital; ..."

¹¹⁵ JC Standard MS.02.01.01, Element of Performance 9, states that the medical staff 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."

1 (9) recommends to the Board of Directors or a committee thereof, all matters
2 relating to membership determinations, staff categorization, department
3 assignments and corrective action, except when such is a function of the medical
4 staff;

5
6 (10) reports at each general staff meeting;

7
8 (11) oversees the medical staff accounts and, when appropriate, votes to disperse
9 funds for medical staff activities, including for services rendered to the medical
10 staff by legal counsel and by other independent professional assistance retained by
11 the Medical Executive Committee to protect and promote the interests of the
12 medical staff;¹¹⁷

13
14 (12) discharges such other duties as may be assigned to it by the medical staff;

15
16 (13) meets at the call of the chair, but at least monthly;

17
18 (14) fulfills other responsibilities as established in these bylaws or as are
19 appropriately delegated by the Medical Executive Committee or the medical staff.
20

21 9. Medical Staff Wellness Committee¹¹⁸

22 a) Composition

23
24 The medical staff wellness committee consists of no fewer than three active medical staff
25 members, a majority of whom, including the chair, shall be physicians, where possible,
26 with experience in psychiatry and addiction medicine. Except for initial appointments,
27 each member shall serve a term of three years, and the terms shall be staggered to achieve
28 continuity. Members of this committee shall not serve on peer review committees or in
29 department or Medical Executive Committee leadership.¹¹⁹

30 b) Duties

31
32 The medical staff wellness committee:
33
34

¹¹⁶ MAG Policy #370.997 Organ Donation Protocols states, “MAG recognizes the importance of physician participation in the organ donation process and acknowledges organ donation as a specialized form of end-of-life care,” consistent with JC Standard TS.01.01.01, “The hospital, with the medical staff’s participation, develops and implements written policies and procedures for donating and procuring organs and tissues.”

¹¹⁷ Consistent with AMA policy, “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

¹¹⁸ 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 Georgia peer review laws.

¹¹⁹ Under JC Standard MS.11.01.01, the identification process “...is separate from actions taken for disciplinary purposes.”

- 1 (1) receives reports and self-referrals¹²⁰ related to the physical, mental and
2 emotional health and well-being of medical staff members, to improve patient care
3 by assisting those members who might be impaired;
- 4
5 (2) determines whether reports are reliable,¹²¹ and takes in additional data and
6 makes recommendations regarding such reports;
- 7
8 (3) refers the member to appropriate sources of treatment and assistance;¹²²
9
- 10 (4) provides advice, counseling, or monitoring, or coordinates services with
11 outside treatment and assistance sources;
- 12
13 (5) maintains all committee information, including as appropriate informants'
14 identity,¹²³ as confidential with the exception of a member whose condition or non-
15 compliance¹²⁴ presents unreasonable risk of harm to patients,¹²⁵ in such a case the
16 committee shall refer the member for corrective action;
- 17
18 (6) develops educational programs to instruct medical staff to recognize
19 behavioral problems, illness and impairment in health care professionals;¹²⁶
20
- 21 (7) reports to the Medical Executive Committee on the activities of the committee
22 without violating confidentiality of the members involved;
- 23
24 (8) fulfills other responsibilities as established in these bylaws or as are
25 appropriately delegated by the Medical Executive Committee or the medical staff;
- 26
27 (9) meets at the call of the chair, but at least quarterly.
28

¹²⁰ JC Standard MS.11.01.01, Element of Performance 2, states that the process design should address “self-referral by a licensed independent practitioner.”

¹²¹ JC Standard MS.11.01.01, Element of Performance 6, states that process design should address “[e]valuation of the credibility of a complaint, allegation, or concern.”

¹²² JC Standard MS.11.01.01, Element of Performance 4, calls for addressing the “[r]eferral of the licensed independent practitioner to appropriate professional internal or external resources for evaluation, diagnosis and treatment of the condition or concern.”

¹²³ JC Standard MS.11.01.01, Element of Performance 3, states that the process design should address the “[r]eferral by others and maintaining informant confidentiality.”

¹²⁴ 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.

¹²⁵ JC Standard MS.11.01.01, Element of Performance 5, states that the process design should address “[m]aintenance of confidentiality of the licensed independent practitioner seeking referral or referred for assistance, except as limited by applicable law, ethical obligation, or when the health and safety of a patient is threatened.” and under Element of Performance 8, “Reporting to the organized medical staff leadership instances in which a licensed independent practitioners is providing unsafe treatment.”

¹²⁶ JC Standard MS.11.01.01, Element of Performance 1, states that the process design should address “[e]ducation of licensed independent practitioners and other organization staff about illness and impairment recognition issues specific to licensed independent practitioners [at-risk criteria].”

1 **10. Peer Review Committee**¹²⁷

2
3 **a) Composition**

4
5 **b)** The peer review committee consists of [two] surgeons and [two] family physicians
6 or internists.¹²⁸ Under no circumstances is peer review committee membership limited to
7 members who are employed by or under contract with or otherwise practice exclusively
8 at the hospital.¹²⁹

9
10 **c) Duties**¹³⁰

11
12 The peer review committee:

13
14 **(1)** initiates review based on information referred by the performance
15 improvement process, or by the Medical Executive Committee. Sources for
16 identifying cases for peer review include, but are not limited to, chart reviews,
17 quality indicators, data from medical staff committees, patient or family complaints,
18 and event trending reports. All review will be conducted according to the medical
19 staff peer review policy;¹³¹

20
21 **(2)** requests the Medical Executive Committee to refer a matter for external peer
22 review when warranted, consistent with these bylaws;

23
24 **(3)** routinely recommends updates and other improvements in the medical staff
25 peer review policy for adoption by the Medical Executive Committee;

26 **(4)** meets at the call of the chair, but at least quarterly;

27

¹²⁷ For non-departmentalized medical staffs, a peer review committee may be a useful structure for conducting review. Medical review committees such as this are protected under Georgia state immunity and confidentiality statutes, specifically, O.C.G.A. § 31-7-130, 31-7-132 (a), 31-7-133 (a); 31-7-141; 31-7-143, enforced in numerous cases before Georgia courts such as *Baldwin County Hosp. Authority v. Wright*. The confidentiality protections are described by the court in *Emory Clinic v. Houston*, as “an absolute embargo upon the discovery and use of all proceedings, records, findings and recommendations of peer review groups and medical review committees in civil litigation.” Providing confidentiality is intended “to foster the delivery of quality medical services by preserving the candor necessary for the effective functioning of hospital medical review committees...” according to the decision in *Hollowell v. Jove*.

¹²⁸ Peer review committee membership should at least balance proceduralists and non-proceduralists, or provide representation of individual specialties.

¹²⁹ Based on “Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations,” AMA Policy Compendium D-375.992

¹³⁰ To meet Georgia Regulation 111-8-40-.11(b)2 requirement that “[t]he medical staff shall implement measures, including peer review, to monitor the on-going performance of the delivery of patient care by those granted clinical privileges, including monitoring of compliance with the medical staff bylaws, rules and regulations, and hospital policies and procedures.”

¹³¹ Georgia Regulation 111-8-40-.11(b)2 requires that “[t]he medical staff shall implement measures, including peer review, to monitor the on-going performance of the delivery of patient care by those granted clinical privileges...” Policy governing peer review processes can be continuously tailored and updated to improve quality.

1 (5) fulfills other responsibilities as established in these bylaws or as are
2 appropriately delegated by the Medical Executive Committee or the medical staff.
3

4 **11. The Pharmacy & Therapeutics Committee**¹³²
5

6 **a) Composition**
7

8 The pharmacy & therapeutics committee consists of a physician from each department, a
9 pharmacist from the hospital pharmacy and a representative from nursing. The chair
10 shall appoint appropriate physician members of the pharmacy & therapeutics committee
11 and hospital personnel to serve on a nutrition subcommittee.
12

13 **b) Duties**
14

15 The pharmacy & therapeutics committee:
16

- 17 (1) develops drug utilization policies; policies regarding drug inventory and floor
18 stock; and the hospital formulary;
19
20 (2) assesses the technical quality of diagnosis and therapeutic services performed
21 at the hospital;
22
23 (3) reviews adverse drug reaction reports, clinical antibiotic usages and other drug
24 usage practices;
25
26 (4) recommends medical equipment needs;
27
28 (5) oversees the activities of the nutrition subcommittee, which:
29
30 (a) on request, evaluates patients to provide for appropriate feeding;
31
32 (b) develops procedures for monitoring enteral and TPN feeding;
33
34 (c) makes recommendations on nutritionally high-risk patients upon
35 admission;
36
37 (d) provides updates on nutrition information to the medical staff;
38
39 (e) makes recommendations on outpatient nutritional programs;
40
41 (f) coordinates of nutritional services in the hospital and home care setting;
42
43 (6) meets at the call of the chair, but no less frequently than quarterly;

¹³² Implementing Georgia Regulation 111-8-40-.11(c) which states, "...The bylaws and rules and regulations shall become effective when approved by the governing body and shall include at a minimum: ...11. Establishment of procedures for the choice and control of all drugs in the hospital..."

1
2 (7) fulfills other responsibilities as established in these bylaws or as are
3 appropriately delegated by the Medical Executive Committee or the medical staff.
4

5 **12. Quality Improvement Committee**
6

7 **a) Composition**
8

9 The committee consists of representatives of each medical staff department [and section]
10 and shall be chaired by the president-elect.
11

12 **b) Duties**
13

14 The quality improvement committee:
15

16 (1) maintains and implements the written hospital-wide quality improvement
17 plan, recommending updates and improvements, as needed, to the Medical
18 Executive Committee;
19

20 (2) prioritizes and monitors the results of quality improvement activities
21 throughout the hospital;
22

23 (3) develops and maintains systems for monitoring the quality of hospital services
24 ordered by medical staff members;¹³³
25

26 (4) develops and implements continuing medical education activities based on
27 quality improvement data specific to this medical staff;¹³⁴
28

29 (5) meets at the call of the chair, but no less frequently than monthly;
30

31 (6) fulfills other responsibilities as established in these bylaws or as are
32 appropriately delegated by the Medical Executive Committee or the medical staff.

¹³³ Implementing Georgia Regulation 111-8-40-.11(b)3, which states, “[t]he medical staff shall establish effective systems of accountability for any hospital services ordered by physicians and other practitioners.”

¹³⁴ MAG Policy # 300.988 states that, “...MAG believes that each institution's medical staff should decide the types of CME activities that are appropriate for itself...”

1 **13. Utilization Review Committee**¹³⁵

2
3 **a) Composition**¹³⁶

4
5 The utilization review committee consists of physician representatives of each medical
6 staff department [and section] and shall be chaired by the Secretary [Secretary-
7 Treasurer].

8
9 **b) Duties**¹³⁷

10
11 The utilization review committee:

- 12
13 (1) maintains and implements the hospital-wide utilization review plan which
14 shall be designed solely to promote quality care by promoting appropriate
15 utilization of hospital resources through reducing under-utilization and over-
16 utilization of services,¹³⁸ recommending updates and improvements, as needed, to
17 the Medical Executive Committee;

¹³⁵ 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 properly functioning staff committee, the UR committee must be established as specified in paragraph (b)(1)(ii) of this section.”

¹³⁶ Medicare Conditions of Participation require the Utilization Review Committee to consist of at least two doctors of medicine or osteopathy, under § 482.30, “Condition of participation: Utilization review.” The composition proposed here would meet the Medicare Condition of Participation and provide for diversity of professional specialties to structure and carry out utilization review.

¹³⁷ Consistent with MAG Policy #180.998, which states “MAG supports the concept that every hospital medical staff should have a viable, active and effective utilization review mechanism, recognizing that specific needs will vary from place to place, and that in some instances, combined or joint efforts by smaller facilities may be necessary in order to provide utilization review of an acceptable quality. MAG agrees strongly that true utilization review by physicians should be done only to determine the appropriateness and quality of care rendered. It should never be performed as fiscal review. MAG does not believe that physicians performing medical services should be required to perform utilization review simply to aid a facility insurer or other third party to reduce its operating costs.”

¹³⁸ 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.” O.C.G.A. § 31-7-7 authorizes hospitals to act on medical staff applications for clinical privileges based on the applicant's “demonstrated training, experience, competence, and availability and reasonable objectives, including, but not limited to, the appropriate utilization of hospital facilities...”

1 (2) consistent with the utilization plan, reviews hospital admissions with respect
2 to medical necessity of services and duration of hospital stay;

3
4 (3) meets at the call of the chair, but no less frequently than monthly;

5
6 (4) fulfills other responsibilities as established in these bylaws or as are
7 appropriately delegated by the Medical Executive Committee or the medical staff.
8

9 **E. Meetings**

10
11 Meetings of the medical staff are open to all medical staff members, regardless of category or
12 voting rights. Department [section] and committee meetings may be limited, in whole or in part,
13 to members only, by the chair for discussion of privileged and/or confidential information
14 regarding quality improvement or peer review information or unless and until executive session
15 is called.
16

17 **1. Attendance Obligation**

18 **a) Meeting attendance**

19
20
21 Except as stated below, each member of the [active] [medical] staff shall be required to
22 attend:
23

24 (1) The annual medical staff meeting;

25
26 (2) At least [50] percent of all other general staff meetings duly convened
27 pursuant to these bylaws; and
28

29 (3) At least [50] percent of all meetings of each department, division, and
30 committee to which the member is assigned.
31

32 Any member who is compelled to be absent from any medical staff, department, division, or
33 committee meeting shall promptly provide to the regular presiding officer thereof the reason
34 for such absence. Unless excused for good cause by the presiding officer of the department [,
35 section] or committee, or the secretary [secretary-treasurer] for medical staff meetings, failure
36 to meet the attendance requirements may be grounds for removal from such committee or for
37 non-renewal of medical staff membership.
38

39 **b) Special Attendance**

40
41 A practitioner whose case or care is scheduled for discussion at a department [section] or
42 committee meeting shall be provided special notice of the requirement to respond in the
43 manner determined by the department [, section] or committee. Failure by the
44 practitioner to attend such a meeting shall result in an automatic suspension of the
45 practitioner's privileges that shall remain in effect until the matter is resolved through any
46 mechanism that may be appropriate, including corrective action, unless the President, the

1 Chair of the applicable committee or department or the Executive Committee
2 subsequently determines that there was good cause for the failure to attend and terminates
3 the automatic suspension.
4

5 **2. Special Meeting**

6
7 A special meeting of the medical staff may be called by the president or the Medical Executive
8 Committee or shall be called by the president upon petition signed by not less than [one-fourth]
9 of the active medical staff members within 30 days after the petition is received. The
10 Executive Committee shall designate the time and place of any such special meeting in the
11 written notice delivered not less than seven or more than 15 days before the date of such
12 meeting. No business shall be transacted at any special meeting except that stated in the notice
13 calling the meeting.
14

15 **3. Notice**

16
17 Unless otherwise provided in these bylaws, notice of meetings may be established by
18 resolution of the meeting or by pronouncement of the chair at the previous meeting. Presence
19 at a meeting establishes receipt of notice. Notice of general and special meetings of the
20 medical staff shall be provided to all medical staff members, regardless of voting status.¹³⁹
21

22 **4. Quorum**

23
24 At any meeting of the medical staff, the presence of [50 percent of] the total membership of the
25 active medical staff at any regular or special meeting shall constitute a quorum for the purposes
26 of amendment to these bylaws and the rules and regulations. The presence of 25 percent of the
27 active medical staff shall constitute a quorum for all other actions. Except as otherwise
28 specified, the action of a majority of the members present and voting at a meeting at which a
29 quorum is present shall be the action of the group. A meeting at which a quorum is initially
30 present may continue to transact business notwithstanding the withdrawal of members, if any
31 action taken is approved by at least a majority of the required quorum for such meeting, or
32 such greater number as may be specifically required by these bylaws.
33

34 **5. Electronic Participation**

35
36 Attendance, meeting of a committee, department, [section,] or the medical staff organization,
37 actions including voting, notice other than special notice, and participation may be
38 accomplished by email or other electronic and/or telephonic means where permitted by the
39 chair of the meeting on either an individual or group basis.
40

41 **6. Agenda**

42
43 The agenda and order of business at all meetings of the medical staff shall be determined by
44 the president, subject to the approval of the Medical Executive Committee, and consistent with
45 the following:

¹³⁹ To encourage involvement and participation by all medical staff members.

1
2 a) The medical staff meeting agenda shall include acceptance of the minutes of the
3 last regular and all special meetings held since the last regular meeting, old business, new
4 business, reports by responsible officers, committees and departments, and election of
5 officers when required by these bylaws.
6

7 b) At any general medical staff meeting or any special medical staff meeting called for
8 that purpose, actions of the Medical Executive Committee, other than recommendations
9 regarding membership, privileges and corrective actions,¹⁴⁰ may, at the request of any
10 active member, be reviewed by the medical staff and revised by a majority of those
11 voting.¹⁴¹
12

13 c) The agenda of all other meetings shall be determined by the presiding officer of the
14 meeting.
15

16 7. Executive Session

17
18 The medical staff, its committees and departments [sections] are entitled to meet in executive
19 session, limited to voting members, administrative personnel needed to keep the record, and
20 those expressly invited by the presiding officer. Executive session may be called by the
21 presiding officer at the request of any member, and shall be called by the presiding officer
22 pursuant to a duly adopted motion.¹⁴² Actions can be taken in executive session, and have the
23 same force and effect of actions taken in open meetings.
24

25 8. Parliamentary Code

26
27 Unless otherwise specified, meetings shall be conducted according to Robert's Rule of Order
28 [Sturgis Standard Code of Parliamentary Procedure]; however, technical or not-substantive
29 departures from parliamentary codes shall not invalidate action taken at such a meeting.
30

31 F. Medical Staff Organization Support

32 1. Meeting Support

33
34
35 Hospital administration shall arrange for attendance of hospital administrative staff to attend, in
36 a non-voting capacity, at the request of the chair of the committee, department [section] or
37 medical staff meeting, to maintain the record of the meeting and otherwise provide support.
38

¹⁴⁰ Peer review actions should not be the subjects of popular vote.

¹⁴¹ 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.

¹⁴² "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

1 **2. Medical Staff Office**
2

3 The hospital shall provide the medical staff with appropriate office space, equipment, and
4 support staff necessary to carry out the managerial, secretarial and support work required by
5 the medical staff officers, departments, [sections] and committees. Confidentiality of medical
6 staff records¹⁴³ will be maintained by the medical staff office.
7

8 **a) Medical Staff Manager/Coordinator**
9

10 The hospital will hire administrative personnel to conduct verification of credentials,
11 maintain medical staff records, provide meeting management and facilitate other
12 functions needed for the medical staff organization to carry out its responsibilities as
13 detailed in these bylaws. Medical support staff shall be adequately trained and certified
14 in medical staff management.¹⁴⁴
15

16 **b) Medical Director [Vice President Of Medical Affairs]¹⁴⁵**
17

18 If a medical director [vice president of medical affairs] is hired by the hospital, the following
19 provisions shall apply.¹⁴⁶

¹⁴³ The medical staff office is typically the repository for medical staff information that Georgia 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 O.C.G.A. § 31-7-143, which states that “no person who was in attendance at a meeting of such committee shall be permitted or required to testify in any such civil action as to any evidence or other matters produced or presented during the proceedings of such committee or as to any findings, recommendations, evaluations, opinions, or other actions of such committee or any members thereof.” Georgia courts include in “records and proceedings” records pertaining to the care of the patient at issue in the case for which peer review information is being sought. *Hollowell v. Jove*. The statute continues, “however, information, documents, or records otherwise available from original sources shall not be construed as immune from discovery or use in any such civil action merely because they were presented during proceedings of such committee; nor shall any person who testifies before such committee or who is a member of such committee be prevented from testifying as to matters within his knowledge, provided that such witness may not be questioned regarding his testimony before such a committee or opinions formed by him as a result of such committee hearings.” Further, the Georgia Supreme Court has held in *Hosp. Auth. Of Valdosta And Lowndes County, D/B/A South Georgia Medical Center v. Meeks* that “Unless the credentialing information involves the evaluation of the quality and efficiency of actual medical services, it does not come within the peer review and medical review privileges of O.C.G.A. § 31-7-133 (a) and 31-7-143.” Because exceptions to confidentiality protections can be technical, and the ramifications of revealing confidential peer review information are significant, medical staffs should develop clear protocols for the release of information, including as appropriate access to medical staff counsel to assist in decision-making.

¹⁴⁴ Certification is available from the National Association Medical Staff Services at www.namss.org.

¹⁴⁵ “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

1 **(1) Qualifications**

2
3 The medical director [vice president of medical affairs] shall be a physician with
4 demonstrated administrative ability. The medical director [vice president of medical
5 affairs] shall be a member of the medical staff with clinical privileges if he/she will be
6 providing any clinical services at the hospital in addition to serving as the medical director
7 [vice president of medical affairs].
8

9 **(2) Selection**

10
11 The administrator shall coordinate any recruiting and hiring efforts involving the position
12 of medical director with the Medical Executive Committee. The Medical Executive
13 Committee or a subcommittee thereof designated by the Medical Executive Committee
14 shall interview the candidates qualified for the position. The hospital's decision shall be
15 consistent with the recommendations of the Medical Executive Committee.¹⁴⁷
16

17 **(3) Terms of Office**

18
19 The medical director [vice president of medical affairs] may resign at any time by notifying
20 the administrator in writing. Such resignation, which may or may not be contingent on
21 formal acceptances, shall take effect on the date of receipt or at any later time specified in
22 the notice of resignation. The medical director [vice president of medical affairs] shall not
23 be removed without cause. The medical director [vice president of medical affairs] shall be
24 removed upon the reasonable request of the Medical Executive Committee indicating the
25 cause for the request. Such removal shall not of itself constitute a diminution of the staff
26 membership, if any, of the medical director [vice president of medical affairs] or otherwise
27 give rise to any right of review. Any vacancy occurring in the office of the medical
28 director [vice president of medical affairs] shall be filled according to these bylaws.
29

30 **(4) Duties**

31
32 **(a)** The medical director [vice president of medical affairs]'s responsibilities
33 shall not usurp or conflict with the responsibilities of medical staff officers or
34 department [or section] chairmen as described in these bylaws. The medical
35 director [vice president of medical affairs] has no authority to represent the
36 medical staff or act independently regarding the medical staff's functions or
37 operations. The medical director [vice president of medical affairs] supervises
38 the medical staff office personnel, and carries out such quality improvement and
39 other duties as are specified in the medical director [vice president of medical

¹⁴⁶ Clarifying that a medical director is not mandatory, but any time one is taken on, the position is governed by the medical staff bylaws.

¹⁴⁷ Consistent with the AMA policy which provides that "(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 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

1 affairs] job description as approved by the Medical Executive Committee,
2 whose approval shall not be unreasonably withheld.
3

4 **(b)** The medical director [vice president of medical affairs] will not serve as a
5 member of any medical staff committee, and shall not chair or vote in medical
6 staff committee meetings. The medical director [vice president of medical
7 affairs] will have a vote if a member of a medical staff category that includes
8 voting rights among its prerogatives, but only in clinical departments or sections
9 in which the medical director [vice president of medical affairs] is a member
10 and in general medical staff meetings or elections.
11

12 **(c)** The medical director [vice president of medical affairs] will serve as an
13 advisor to the Medical Executive Committee and medical staff officers,
14 department directors [section chiefs] and committee chairs regarding
15 compliance with the medical staff documents, including the bylaws, rules and
16 regulations and policies.
17

18 **(d)** The medical director [vice president of medical affairs] will preserve the
19 confidentiality of peer review, credentialing and other medical staff data
20 obtained.¹⁴⁸ Information the medical director [vice president of medical affairs]
21 obtains through medical staff work will not be shared in a manner that is not
22 protected under state confidentiality and immunity statutes or that would violate
23 the medical staff bylaws, rules and regulations or policy.
24

25 **(e)** The medical director [vice president of medical affairs] will cooperate
26 with any requests of medical staff officers, department directors, and medical
27 staff committee chairpersons to preserve confidentiality and promote frank
28 discussion of medical staff matters, including leaving meetings to allow
29 discussion to proceed without administrative personnel present.

¹⁴⁸ O.C.G.A. § 31-7-143 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 and records of medical review committees shall not be subject to discovery or introduction into evidence in any civil action against a provider of professional health services arising out of the matters which are the subject of evaluation and review by such committee; and no person who was in attendance at a meeting of such committee shall be permitted or required to testify in any such civil action as to any evidence or other matters produced or presented during the proceedings of such committee or as to any findings, recommendations, evaluations, opinions, or other actions of such committee or any members thereof. However, information, documents, or records otherwise available from original sources shall not be construed as immune from discovery or use in any such civil action merely because they were presented during proceedings of such committee; nor shall any person who testifies before such committee or who is a member of such committee be prevented from testifying as to matters within his knowledge, provided that such witness may not be questioned regarding his testimony before such a committee or opinions formed by him as a result of such committee hearings.”

1 **ARTICLE III. MEMBERSHIP**¹⁴⁹

2
3 **A. Basis of Membership**

4
5 Membership in the medical staff can be granted only according to the processes established in
6 these bylaws and held only by professionals meeting the qualifications established under these
7 bylaws.

8
9 Membership in the medical staff can be revoked only according to the processes established in
10 these bylaws. Medical staff members cannot be fired from hospital employment or lose their
11 hospital contracts as a result of good-faith participation in medical staff activities or leadership
12 roles or otherwise fulfilling duties of medical staff membership.¹⁵⁰

13
14 **B. Qualifications**¹⁵¹

15
16 Each medical staff member:

- 17
18 1. Holds an M.D. or D.O. degree; a D.D.S. degree, or a D.P.M. degree, or its equivalent;¹⁵²
19
20 2. Is currently licensed to practice medicine [podiatry] or dentistry by the state of
21 Georgia;¹⁵³
22
23 3. Holds current Drug Enforcement Agency registration if relevant to the member’s
24 privileges;¹⁵⁴
25
26 4. Complies with generally accepted standards of practice;¹⁵⁵
27

149 Under JC Standard MS.01.01.01, Element of Performance 27, the medical staff bylaws are to include “[t]he process for appointment and re-appointment to membership on the medical staff.”

150 Medical staff members elected to serve in leadership positions for and by the medical staff should not be subject to hospital manipulation or retaliation for fulfilling their medical staff organization duties.

151 Meeting Georgia Regulation 111-8-40-.11(c)3, which requires that the medical staff bylaws, rules and regulations include: “...Description of the qualifications and performance to be met by a candidate in order for the medical staff to recommend appointment or reappointment by the governing body...” Further, JC 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.

152 Mandated by Georgia Regulation 111-8-40-.11(a)2(ii) which states, “Minimum requirements for medical staff appointments and clinical privileges shall include: ...[c]onfirmed educational qualifications for the position of appointment...” “Equivalents” permits foreign degrees to be accepted.

153 Mandated by Georgia Regulation 111-8-40-.11(a)2(i) which states, “Minimum requirements for medical staff appointments and clinical privileges shall include: ...[v]alid and current Georgia license to practice the respective profession...”

154 Mandated by Georgia Regulation 111-8-40-.11(a) 2(v) which states, “Minimum requirements for medical staff appointments and clinical privileges shall include: ... [c]urrent Drug Enforcement Agency registration, if applicable...”

155 Georgia Regulation 111-8-40-.11(c)5 requires that “...[t]he bylaws and rules and regulations ... shall include at a minimum... (a) requirement that members of the medical staff comply with ethical and professional standards; ...”

- 1 **5.** Abides by the ethical principles established by his/her profession;¹⁵⁶
- 2
- 3 **6.** Maintains health and mental status sufficient to perform medical and professional
- 4 duties;¹⁵⁷
- 5
- 6 **7.** Can provide continuous care or demonstrates to the satisfaction of the credentials
- 7 [medical executive] committee reliable and adequate coverage arrangements with other
- 8 medical staff members to meet patient needs;¹⁵⁸
- 9
- 10 **8.** Attests that he/she has not been convicted of any crime related to the medical staff
- 11 membership qualifications, functions or duties, as determined by the Medical Executive
- 12 Committee;
- 13
- 14 **9.** Is insured against professional liability for all clinical privileges requested;¹⁵⁹ however, a
- 15 temporary loss of professional liability insurance coverage (whether limited to "tail" coverage)
- 16 shall not be grounds for immediate termination of medical staff membership. The Medical
- 17 Executive Committee shall determine the length and other conditions of an individual waiver
- 18 of the coverage requirement;¹⁶⁰
- 19

¹⁵⁶ Georgia Regulation 111-8-40-.11(c)5 requires that "(t)he bylaws and rules and regulations ... shall include at a minimum... (a) requirement that members of the medical staff comply with ethical and professional standards..."

¹⁵⁷ Mandated by Georgia Regulation 111-8-40-.11(a)2(iv), which states, "Minimum requirements for medical staff appointments and clinical privileges shall include: ... [c]urrent health and mental status sufficient to perform medical and professional duties..."

¹⁵⁸ Implementing Georgia Regulation 111-8-40-.11(d)2, which states, "If not addressed through the medical staff bylaws or rules and regulations, the medical staff shall develop and implement policies to address, at a minimum: ... A requirement that every member of the medical staff provide appropriate medical care for each of their patients until the patient is stable for discharge or until care of the patient has been transferred to another member of the medical staff or to another facility."

¹⁵⁹ Applying AMA policy that "1. Each hospital medical staff should determine for itself whether or not it will require professional liability insurance coverage as a condition for membership on the hospital medical staff. 2. Our AMA also believes that, if equity demands that voluntary staff members should have insurance coverage so that the burden of financial loss would not fall entirely upon the hospital, then salaried hospital physicians should likewise be covered by adequate insurance or protected financially through self-insurance mechanisms established by the hospital, so that the burden would not fall unfairly upon the members of the voluntary medical staff." AMA Policy Compendium H-230.995

¹⁶⁰ 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 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

1 **10.** Is not excluded from participating in Medicare, Medicaid or any other federal health care
2 program when such exclusion has been affirmatively imposed by government enforcement
3 authorities, or accepted by the practitioner, as a sanction for unlawful conduct;¹⁶¹
4

5 **11.** Appropriately utilizes hospital facilities to provide quality patient care, consistent with
6 the utilization review plan as recommended by the Medical Executive Committee.¹⁶²
7

8 **C. Effect of other Affiliations or Memberships** 9

10 No professionals are entitled to medical staff membership solely because they are employed by
11 this hospital or its subsidiaries, have contracts with this hospital,¹⁶³ have or have had medical
12 staff membership or privileges at another health care facility, participate or do not participate in a
13 particular medical group, managed care organization, IPA, PPO, PHO, hospital-sponsored
14 foundation, or other organization or in contracts with a third-party payer which contracts with
15 this hospital. Lawful pursuit of business interests by members cannot adversely affect medical
16 staff membership.
17

18 **D. Discrimination Prohibited** 19

20 No person otherwise qualified as provided in these bylaws shall be denied medical staff
21 membership or particular clinical privileges solely on the basis of ethnic background, race,
22 culture, gender, sexual preference, language, religion, mental capacity and physical disability.¹⁶⁴
23

24 **E. Term** 25

26 **1. Length** 27

28 Each membership term is limited to two years,¹⁶⁵ subject to renewal consistent with these
29 bylaws [, which terms shall be staggered, based on the month membership was originally
30 granted].¹⁶⁶

¹⁶¹ 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.

¹⁶² O.C.G.A. § 31-7-7 states that "...the hospital shall act in a nondiscriminatory manner upon such application expeditiously and without unnecessary delay considering the applicant on the basis of the applicant's demonstrated training, experience, competence, and availability and reasonable objectives, including, but not limited to, the appropriate utilization of hospital facilities..." Under 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.

¹⁶³ Georgia Regulation 111-8-40-.11(a)1 states, "Any physician, podiatrist, or dentist providing patient care, whether directly or by contract with the hospital, shall obtain clinical privileges through the hospital's medical staff credentialing process."

¹⁶⁴ "The JC considers diversity to include race, culture, gender, religion, ethnic background, sexual preference, language, mental capacity and physical disability." JC Accreditation Manual, Introduction to Standard MS.06.01.03, Note 2.

¹⁶⁵ JC Standard MS.06.01.07, Element of Performance 9, 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. 42 U.S.C.S. §

1
2 **2. Resignation**
3

4 Any medical staff member may resign membership by providing written notice, stating the
5 effective date of resignation, to the medical staff office.
6

7 **F. Duties**
8

9 Medical staff members:
10

- 11 1. abide by the medical staff bylaws, rules and regulations and policies;¹⁶⁷
12
13 2. accept assignment to serve on standing and special medical staff committees;
14
15 3. cooperate with medical staff committees and representatives in the discharge of medical
16 staff functions, including responding promptly and appropriately to correspondence, including
17 special notices;
18
19 4. submit to mental or physical screenings, as requested by the Medical Executive
20 Committee, to establish continuing qualification for membership;¹⁶⁸
21
22 5. support fair peer review by participating appropriately in medical staff peer review
23 activities, such as providing information to medical staff committees regarding matters under
24 review or investigation, serving on hearing committees and acting as proctors as requested;
25
26 6. obtain consultation when a patient’s condition could be improved by involvement of
27 another member or other professional, or when otherwise appropriate;¹⁶⁹
28

11135(a); 45 C.F.R. § 60.10. Membership and privileges are most efficiently coordinated in the credentialing process.

¹⁶⁶ Staggering membership may improve the efficiency of the credentialing process.

¹⁶⁷ 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.”

¹⁶⁸ Mandated by Georgia Regulation 111-8-40-.11(c)6, which states “...The bylaws and rules and regulations ...shall include at a minimum:...Requirements for regular health screenings for all active members of the medical staff that are developed in consultation with hospital administration, occupational health, and infection control/safety staff. The health screenings shall be sufficient to identify conditions, which may place patients or other personnel at risk for infection, injury, or improper care. There shall be a mechanism for the reporting of the screening results to the hospital, either through the medical staff or otherwise...”

¹⁶⁹ To promote compliance with Georgia Regulation 111-8-40-.11(c)9, which states, “...The bylaws and rules and regulations ... shall include at a minimum : ... [a] requirement that referral for consultations will be provided to patients when a patient’s physical or mental condition exceeds the clinical expertise of the attending member of the medical staff...” Also, JC Standard MS.03.01.03, Element of Performance 4 states, “The organized medical staff, through its designated mechanism, determines the circumstances under which consultation or management by a doctor of medicine or osteopathy, or other licensed independent practitioner, is required.”

1 7. refrain from any retaliation against any other member of the medical staff because that
2 member claims a right or privilege afforded by, or seeks implementation of any provision of,
3 these medical staff bylaws.
4

5 **G. Dues**¹⁷⁰
6

7 Members shall pay annual dues in [an amount set by the Medical Executive Committee at the
8 first meeting of the medical staff year] [the amount of \$_____]. Failure to pay dues in a timely
9 manner shall be grounds for ineligibility for membership renewal or corrective action.
10

11 **H. Voting**
12

13 Voting by mail ballot or in meetings of the medical staff, its committees, departments, [sections]
14 and any subdivisions, shall be conducted in accordance with the bylaws. All [active] [medical]
15 staff members have the right to vote in medical staff meetings and in meetings of any committee,
16 [section], and department in which they are members. Any member who, by virtue of position,
17 attends a meeting in more than one capacity is entitled to only one vote. Unless otherwise
18 specified in the bylaws or at the time of appointment, only medical staff members may vote on
19 committee business. Under no circumstances shall an abstention or failure to vote be counted as
20 either an affirmative or negative vote. Voting by proxy is not permitted.¹⁷¹
21

22 **I. Emergency Call**¹⁷²
23

24 Medical staff membership or privileges do not require emergency call service. Emergency
25 department backup call panel service is voluntary.¹⁷³ [Members shall serve on call consistent
26 with compensation contracts entered into individually with the hospital.]¹⁷⁴ [Members shall
27 serve on call to the emergency department as determined by the department in which privileges
28 are held.]¹⁷⁵ [Medical staff members who are [55] years of age and older shall be exempt from
29 call duties.] [Medical staff members who have served [10] years on the active staff shall be
30 exempt from call duties.] [Medical staff members who have been granted a leave of absence as

¹⁷⁰ 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.

¹⁷¹ AMA policy provides that "...proxy voting prior to or at medical staff meetings should not be permitted in medical staff bylaws." AMA Policy Compendium H-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."

¹⁷² 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.

¹⁷³ Per MAG Policy # 130.976, "A physician's participation on a hospital's emergency department backup call panel shall be voluntary and shall not be required as a condition of medical staff privileges."

¹⁷⁴ Compensation for on-call service provided to hospitals is supported by AMA Policy Compendium H-130.948, "On-Call Physicians."

¹⁷⁵ 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.

1 outlined in the medical staff bylaws shall be exempt from call duties during the time of the
2 leave.] [Members who have upon written request received a waiver from the Medical Executive
3 Committee based on disability, hardship, medical staff leadership demands, or other reason shall
4 be exempt from call duties for the term of the waiver.]¹⁷⁶

5
6 **J. Leave of Absence**

7
8 **1. Member Request**

9
10 Any medical staff member may obtain a voluntary leave of absence from the medical staff
11 when he/she will be unavailable to provide services and fulfill medical staff duties for a period
12 of more than [four] consecutive months, upon submitting a notice to the medical staff office
13 stating the approximate period of leave desired, which may not exceed 12 months or the end of
14 the current membership term, whichever is shorter. The notice shall also state the date the
15 leave will begin, [which will not be sooner than 30 days from the date of the notice] by which
16 date the member must have completed all outstanding medical records at the hospital. If
17 medical records are not completed when the leave of absence begins, the Medical Executive
18 Committee may deny reinstatement. Members are not entitled to more than one leave of
19 absence during a two-year membership term unless the exception is approved by the Medical
20 Executive Committee. Abuse of the ability to obtain leaves of absence can be grounds for
21 denial of membership renewal. However, requests for leave of absence to fulfill military
22 service obligations [or medical missionary or other humanitarian service], to obtain additional
23 professional training, or to obtain treatment for a medical or behavioral condition shall not be
24 denied or result in denial of membership renewal.

25
26 During the period of the leave, the member shall not exercise clinical privileges at the hospital
27 and membership rights and responsibilities shall be inactive, but the obligation to pay dues, if
28 any, shall continue, unless waived by the Medical Executive Committee.

29
30 **2. Members' Reinstatement Responsibilities**

31
32 At least [six] weeks prior to the end of the leave period, the medical staff office shall provide
33 the member with a termination of leave form as promulgated by the Medical Executive
34 Committee. The member shall submit a summary of relevant activities during the leave. The
35 Medical Executive Committee shall make a recommendation to the Board that will be
36 processed in the same manner as all recommendations on medical staff membership renewal.
37 If the member's term of medical staff membership has expired during the leave of absence, the
38 request for reinstatement shall be made, processed and acted upon in the same manner as an
39 application for membership renewal.

40
41 Failure, without good cause, to return the completed termination of leave form shall be deemed
42 a voluntary resignation from the medical staff and shall result in automatic termination of
43 membership, privileges, and prerogatives. Such automatic termination shall be entitled to
44 hearing and appeal rights as provided under these bylaws for the sole purpose of determining

¹⁷⁶ 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).

1 whether the failure to request reinstatement was unintentional or excusable, or otherwise. A
2 request for medical staff membership subsequently received from a member so terminated
3 shall be submitted and processed in the manner specified for applications for initial
4 membership.

5 6 **K. Categories**

7
8 Members are classified by category.

9 10 **1. Active Staff**

11 12 **a) Practice**

13
14 Active members:

- 15
16 (1) regularly admit, attend, or provide services to patients in the hospital; [admit,
17 attend, or provide services to at least [25] patients in the hospital per year]; and/or
- 18
19 (2) serve as department chairs, [section chiefs,] representatives, or officers of the
20 medical staff.

21
22 [A member of the Active Staff who, upon application for membership renewal, does not
23 meet the specified qualifications in this section shall upon request be placed on
24 probationary status for a one-year period during which time he/she shall have no medical
25 staff voting privileges. At the conclusion of the probationary period, his/her status shall
26 be reviewed by the appropriate Department [and section] and the Credentials Committee,
27 which shall recommend to the Executive Committee whether to renew voting active
28 membership, or to move to a medical staff category for which the member qualifies.]¹⁷⁷

29 30 **b) Prerogatives**

31
32 Active staff members are entitled to

- 33
34 (1) exercise privileges granted in accordance with these bylaws;
- 35
36 (2) vote at medical staff meetings and in meetings of the departments [sections,]
37 and committees of which they are members;
- 38
39 (3) stand for nomination and election and, if elected, serve as medical staff
40 officers, department [and section] leaders and medical staff representatives.

41 42 **2. Affiliate Staff**

43 44 **a) Practice**

45
¹⁷⁷ Permits an active member time to build up practice after serving in office, without losing active staff status.

1 Affiliate members:

- 2
3 (1) do not admit patients [independently];¹⁷⁸
4
5 (2) refer patients to [hospitalists and other] members with admitting privileges;
6
7 (3) follow and visit patients in the hospital.
8

9 **b) Prerogatives**

10 Affiliate staff members are entitled to:

- 11
12
13 (1) exercise privileges granted in accordance with these bylaws;
14
15 (2) vote at medical staff meetings and in meetings of the departments [sections,]
16 and committees of which they are members.
17

18 **3. Consulting Staff**

19
20 **a) Practice**

21 Consulting staff members:

- 22
23
24 (1) consult on request of medical staff members;
25
26 (2) attend, admit or provide services to patients in the hospital.
27

28 **b) Prerogatives**

29 Consulting staff members are entitled to:

- 30
31
32 (1) exercise privileges granted in accordance with these bylaws;
33
34 (2) vote at medical staff meetings and in meetings of the departments [sections,]
35 and committees of which they are members. Consulting staff members who are
36 distant providers of telemedicine services shall be excused from any meeting
37 attendance requirements and may not exercise voting rights.
38

39 **4. Courtesy**

40
41 **a) Practice**

42
43 Courtesy staff members attend, admit or provide services to fewer than [25] patients in
44 the hospital during one year. Courtesy staff members who exceed the patient limit will

¹⁷⁸ 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.

1 be given the option to apply for active staff status. Any courtesy staff member reaching
2 the limit in two consecutive years must either move to active staff membership or resign
3 medical staff membership.
4

5 **b) Prerogatives**
6

7 Courtesy staff members are entitled to
8

9 (1) exercise privileges granted in accordance with these bylaws;
10

11 (2) vote at medical staff meetings and in meetings of the departments [sections,]
12 and committees of which they are members.
13

14 **5. Administrative**
15

16 The administrative staff shall consist of those members hired or contracted to perform only
17 administrative duties [full time] and do not have clinical privileges.
18

19 **a) Prerogatives**
20

21 Administrative staff members are entitled to attend medical staff department [section,]
22 and committee meetings without vote.
23

24 **6. [Federally Employed Military Staff]**
25

26 **a) Practice**
27

28 Federally employed military staff members:
29

30 (1) are exempt from Georgia licensure requirements but must be licensed in at
31 least one other state;
32

33 (2) are members in good standing of the active or provisional medical staff of
34 federal military facilities with whom the medical staff has a memorandum of
35 understanding in which specific operation criteria are delineated;
36

37 (3) attend, admit or provide services in the hospital to patients who are eligible for
38 care at military health care facilities.
39

40 **b) Prerogatives**
41

42 Federally employed military staff members are entitled to:
43

44 (1) exercise privileges granted in accordance with these bylaws;
45

1 (2) vote at meetings of the departments [sections,] and committees of which they
2 are members.]
3

4 **7. [Call Coverage Staff**
5

6 **a) Practice**
7

8 Call coverage staff members come to the Hospital when so scheduled to provide
9 emergency call coverage and admit patients consistent with privileges granted to them
10 pursuant to these bylaws.
11

12 **b) Prerogatives**
13

14 Call coverage staff members are entitled to:

15 (1) exercise privileges granted in accordance with these bylaws while on call;
16

17 (2) attend medical staff meetings and meetings of the departments [sections,] and
18 committees of which they are members, without voting rights.]
19
20

21 **8. Honorary Staff**
22

23 **a) Practice**
24

25 Honorary staff members:
26

27 (1) are invited to the category by the Medical Executive Committee to honor their
28 past service to the medical staff, without meeting medical staff membership
29 requirements;
30

31 (2) do not have clinical privileges.
32

33 **b) Prerogatives**
34

35 Honorary staff members:
36

37 (1) do not hold office or vote but may serve on medical staff committees with
38 vote;
39

40 (2) Do not pay medical staff dues;
41

42 (3) May attend all continuing education and medical staff meetings.
43

44 **9. Modification in Category**
45

1 A medical staff member may at any time request a promotion¹⁷⁹ in his/her staff category or
2 clinical privileges or modification of department assignment by submitting a written
3 application, on a form approved by the Medical Executive Committee, to the medical staff
4 office. Promotion may be recommended by the credentials committee to the Medical
5 Executive Committee following review of the member's performance within the hospital.¹⁸⁰
6 Change in category may also be recommended by the credentials committee to the Medical
7 Executive Committee without the member's request if the member's practice no longer
8 comports with the category to which the member has been assigned.
9

10 **ARTICLE IV. CREDENTIALING**¹⁸¹

11
12 Except in the limited cases specified in these medical staff bylaws, no person shall exercise
13 clinical privileges in the hospital unless and until that person applies for, receives the Medical
14 Executive Committee's recommendation for,¹⁸² and is granted medical staff membership and/or
15 privileges as set forth in these bylaws, or, with respect to allied health professionals, has been
16 granted privileges under applicable medical staff processes established in these medical staff
17 bylaws.

18
19 Except as otherwise specifically provided by these bylaws pertaining to exclusive contracts,
20 medical staff membership and clinical privileges shall only be determined using criteria
21 furthering the quality of health care, treatment and services provided at the hospital. Economic
22 credentialing shall not be implemented at this hospital.¹⁸³
23

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

¹⁷⁹ A member should not have to apply to resign privileges or move to a lower category.

¹⁸⁰ JC Standard MS.06.01.05.

¹⁸¹ The medical staff bylaws are to include "[t]he process for credentialing and re-credentialing licensed independent practitioners,..." under JC Standard MS.01.01.01, Element of Performance 26.

¹⁸² Georgia Regulation 111-8-40-.11(a)2 states, "The medical staff shall be responsible for the examination of credentials of any candidate for medical staff membership and for any other individuals seeking clinical privileges and for the recommendations to the governing body concerning appointment of such candidates." Under JC Standard MS.06.01.03, Element of Performance 2, "[t]he credentialing process is based on recommendations by the organized medical staff."

¹⁸³ Economic credentialing is strongly opposed by the American Medical Association, which defines economic credentialing 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;..." AMA Compendium H-230.975

1 **A. Application Form**
2

3 Application for medical staff membership and privileges is made in writing on a form approved
4 by the Medical Executive Committee¹⁸⁴ and signed by the applicant. Application forms are
5 submitted to the medical staff office along with a non-refundable application fee [as set by the
6 Medical Executive Committee annually] [of \$_____]¹⁸⁵ payable to the medical staff. No
7 application will be processed without payment of the fee. The application form requests at least:
8

9 **1.** Information demonstrating that the applicant meets all qualifications for membership
10 established by these bylaws;

11
12 **2.** The medical staff category, department [section] and specific clinical privileges the
13 applicant seeks;

14
15 **3.** Access to morbidity and mortality data and other applicant-specific data reviewed by an
16 organization that currently privileges the applicant, if available,¹⁸⁶ to establish current clinical
17 competence;¹⁸⁷

18
19 **4.** Recommendations from peers practicing in the same specialty, who are personally
20 familiar with the applicant’s ability to practice;¹⁸⁸

21
22 **5.** Any surname previously used by the applicant, such as maiden name, other married
23 names, and any aliases;

24
25 **6.** Information as to whether the applicant’s membership and/or clinical privileges have
26 ever, voluntarily or involuntarily,¹⁸⁹ been revoked, suspended, reduced or not renewed by any
27 other health care facility, medical or professional group or organization, and whether any
28 professional license, certificate or registration issued to the applicant has ever voluntarily or

¹⁸⁴ 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. Some medical staffs may approve the Georgia Uniform Practitioner Health care Credentialing Application Form and the Georgia Uniform Practitioner Health care Credentialing Reappointment Form for use by the medical staff. Both forms and background information are available at <http://www.georgiacredentialing.org/>

¹⁸⁵ 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 the application review.

¹⁸⁶ Called for by JC Standard MS.06.01.05, Element of Performance 9.

¹⁸⁷ To meet the requirements of JC Standard MS.06.01.05, Element of Performance 9, that the organized medical staff evaluate practitioner specific data and morbidity and mortality data, when available, before recommending privileges.

¹⁸⁸ Mandated by Georgia Regulation 111-8-40-.11 (a) 2(iii), which states, “Minimum requirements for medical staff appointments and clinical privileges shall include: . . . [r]eferences for practice and performance background; . . .” Further, JC Standard MS.07.01.03, Element of Performance 4 states that “[p]eer recommendations are obtained from a practitioner in the same professional discipline as the applicant with personal knowledge of the applicant’s ability to practice.”

¹⁸⁹ JC Standard MS.06.01.05, Element of Performance 9, asks that the medical staff evaluate both voluntary and involuntary actions.

1 involuntarily¹⁹⁰ been revoked, suspended, reduced, terminated or not renewed. The application
2 also will request information as to whether the applicant’s DEA registration has ever been
3 suspended or revoked or voluntarily or involuntarily relinquished;¹⁹¹
4

5 **7.** A statement that no health problems exist that could affect his or her ability to perform
6 the privileges requested.¹⁹² The applicant agrees to supply health status information as deemed
7 appropriate by the Medical Executive Committee, which may include a complete history and
8 physical examination. Any such examination shall be at the applicant's expense by a physician
9 approved by the Medical Executive Committee;¹⁹³

10
11 **8.** Agreement to present to the medical staff office a valid and current hospital picture
12 identification or government-issued picture identification;¹⁹⁴
13

14 **9.** Information on all final judgments or settlements in professional liability cases against
15 the applicant;¹⁹⁵
16

17 **10.** A statement that the applicant is or is not currently excluded from participation in
18 Medicare or any other federally funded program.¹⁹⁶
19

20 The applicant is responsible for ensuring that the information requested in the application is sent
21 to the medical staff office. If the application is missing information or needs clarification, the
22 medical staff office will contact the applicant electronically or otherwise expeditiously. The
23 applicant is responsible to satisfy any reasonable request for additional information or
24 clarification. If the applicant fails to provide all required information within [90] days of receipt
25 of the application in the medical staff office, despite notice of information that is outstanding, the
26 application will be considered to have been withdrawn, and the applicant shall not be entitled to

¹⁹⁰ JC Standard MS.06.01.05, Element of Performance 9, asks that the medical staff evaluate both voluntary and involuntary actions.

¹⁹¹ JC Standard MS.06.01.05, Element of Performance 9, asks that the medical staff evaluate both voluntary and involuntary actions.

¹⁹² Based on JC Standard MS.06.01.05, Element of Performance 6 and Georgia Regulation 111-8-40-.11(a)2(iv).

¹⁹³ 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 Standard MS Accreditation Manual for Health care Organizations, page 29.

¹⁹⁴ Called for by JC Standard MS.06.01.03, Element of Performance 5.

¹⁹⁵ JC Standard MS.06.01.05, Element of Performance 9, 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

¹⁹⁶ 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 Department of Health and Human Services (DHHS) Office of Inspector General.

1 hearing rights provided under these bylaws. The applicant may reapply when he/she can provide
2 complete information.

3
4 When the medical staff office has received and verified all required information, and has
5 obtained information on the applicant from the National Practitioner Data Bank and other
6 relevant practitioner data bases,¹⁹⁷ the medical staff office shall classify the application as
7 completed.

8 9 **B. Effect of Application**

10
11 Each applicant agrees to appear for interviews in regard to application, authorizes the medical
12 staff to consult with members of medical staffs of other hospitals with which the applicant has
13 been associated and with others who may have information bearing on applicant's competence
14 and ethical qualifications, consents to review of all records and documents related to the
15 applicant's professional qualifications for staff membership. The applicant releases from any
16 liability all representatives of the hospital and medical staff for their acts performed in good faith
17 and without malice in connection with verifying and evaluating the application and the
18 applicant's credentials, and releases from any liability all individuals and organizations who
19 provide information to the hospital in good faith and without malice concerning the applicant's
20 competence, ethics, character and other qualifications for staff membership and clinical
21 privileges, including information which otherwise may be privileged or confidential. The
22 applicant also agrees to be bound by the medical staff bylaws, rules and regulations during the
23 course of the application process, whether the membership and privileges requested are granted.

24 25 **C. Application Process**¹⁹⁸

26
27 The application process is coordinated by the medical staff office.

28 29 **1. [Section and] Department Review**

30
31 The completed application and all supporting information are reviewed by the [section and]
32 department in which the applicant seeks privileges. [The section review and recommendation
33 is provided to the department chair.] The department reviews the application and its
34 supporting documentation, which review may include a personal or telephone interview by the
35 department chair and members of the department. The department recommendation regarding
36 membership, membership category, and privileges, and any recommended limitations, based
37 on its evaluation of evidence of the applicant's training, experience, and demonstrated ability,
38 is reported to [the credentials committee.][the Medical Executive Committee.]

39 40 **2. Credentials Committee Review**

41

¹⁹⁷ Georgia Regulation 111-8-40-.11(a)2(vi) requires as a minimum requirement for medical staff appointments and clinical privileges "[e]vidence of inquiry through relevant practitioner databases, such as databases maintained by licensing Boards and the National Practitioner Data Bank..."

¹⁹⁸ Implementing JC Standard MS.01.01.01, Element of Performance 27, which calls for the medical staff bylaws to include "[t]he process for appointment and re-appointment to membership on the medical staff."

1 The credentials committee reviews the [section and] department recommendations, and
2 evaluates the supporting information. The credentials committee may elect to interview the
3 applicant [by telephone] and seek additional information to complete its recommendation on
4 the application. The credentials committee makes a recommendation to the Medical Executive
5 Committee as to membership and membership category, privileges and any limitations on
6 those privileges, based on its evaluation of the evidence of the applicant’s training, experience
7 and ability to meet all qualifications established by these bylaws.
8

9 **3. Medical Executive Committee Review**

10 **a) Medical Executive Committee Action**

11
12
13 At its next scheduled meeting following receipt of the department [and credentials
14 committee] recommendation, the Medical Executive Committee shall act on the
15 application. If necessary, it may return the application back to the [credential committee]
16 department for further evaluation or to obtain additional information, specifying a date
17 for the recommendation to be provided to the Medical Executive Committee. The
18 medical executive action may be deferred, for good cause, to the next scheduled Medical
19 Executive Committee meeting. The Medical Executive Committee recommendation
20 shall specify action on membership, and if membership is recommended, membership
21 category, clinical privileges, any limitations on privileges, and any other conditions to be
22 attached on membership and privileges.
23

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

25
26 The Medical Executive Committee’s favorable recommendation shall be forwarded to the
27 Board for action consistent with these bylaws.
28

29 The applicant is provided notice according to these bylaws of any adverse
30 recommendation of the Medical Executive Committee. The hearing provisions of these
31 bylaws will govern any subsequent action.
32

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

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

39
40 The Board acts on membership and privileges only after there has been a recommendation
41 from the Medical Executive Committee,¹⁹⁹ or if a hearing was held on a negative
42 recommendation, after a hearing committee decision.²⁰⁰

¹⁹⁹ According to JC Standard MS.02.01.01, Elements of Performance 8 and 11, “the medical staff executive committee makes recommendations, as defined in the medical staff bylaws, directly to the governing body on, at

1
2 **a) Board Adopts Medical Executive Committee Action**
3

4 The Board acts on favorable medical executive recommendations, and on unfavorable
5 Medical Executive Committee recommendations on medical staff memberships and
6 privileges in which no hearing was held, at the next Board meeting. The Board gives
7 great weight to the recommendation of the Medical Executive Committee.²⁰¹ Board
8 adoption of the Medical Executive Committee recommendation constitutes the final
9 action. The administrator notifies the applicant of the final action.
10

11 **b) Board Rejects Medical Executive Committee Action**
12

13 If the Board’s preliminary decision is contrary to the favorable recommendation of the
14 Medical Executive Committee in whole or in part, the Board of Trustees may remand the
15 matter to the Medical Executive Committee for further consideration. If the Board’s
16 preliminary decision remains adverse to the applicant in whole or in part, the
17 administrator provides notice to the applicant according to these bylaws. The hearing
18 provisions of these bylaws will govern any subsequent action.
19

20 **D. Application for Membership Renewal²⁰²**
21

22 At least [five months] prior to the expiration of a membership term, the medical staff office
23 sends membership renewal application forms to the member. The medical staff office sends a
24 reminder to the member if no information has been received on the application. If the member
25 does not file a completed application for membership renewal, the membership will expire at
26 the end of the membership term.
27

28 **1. Supporting Information**
29

30 The membership renewal application shall request updates to the information provided in
31 previous membership application processes. In the event that there is a delay in obtaining any
32 required information, or if clarification of information is needed, the applicant will be notified
33 of his/her responsibility to obtain the necessary information. All applications for membership
34 and privileges renewal are processed in the same manner as applications for new membership
35 under these bylaws. The membership renewal application process results in re-determination
36 of the member’s eligibility for medical staff membership and assignment to the requested
37 medical staff membership category.
38

least...the delineation of privileges for each practitioner privileged through the medical staff process (and) medical staff membership.”

²⁰⁰ See Article VIII for the process that governs actions following a hearing.

²⁰¹ Consistent with Georgia Regulation 111-8-40-.09(b), which states, “The governing body shall appoint members of the medical staff within a reasonable period of time after considering the recommendations of the medical staff, if any...”

²⁰² Meeting the requirement of Georgia Regulation 111-8-40-.11(a)3 that “[t]he medical staff shall evaluate at least biennially the credentials and professional performance of any individual granted clinical privileges for consideration for reappointment.”

1 The membership renewal application will be considered in conjunction with review of the
2 member-specific morbidity and mortality data, as compared with aggregate data,²⁰³ the medical
3 staff record of the member’s compliance with membership duties under these bylaws, and
4 other information about the member’s practice at the hospital.²⁰⁴

5
6 **2. Insufficient Information**

7
8 To obtain additional information as needed regarding a member’s membership renewal
9 application, the relevant department [and section] requests that the member provide additional
10 recommendations from peers in the same specialty personally familiar with the member’s
11 practice.²⁰⁵

12
13 **E. Process Timeline**²⁰⁶

14
15 The Board acts on the application within [90] days from the date the application is deemed fully
16 verified and completed by the medical staff office.

17
18 **F. Expedited Credentialing Process**²⁰⁷

19
20 A completed application for membership or membership renewal can be expedited if it
21 documents each of these criteria:²⁰⁸

22

²⁰³ Called for under JC Standard MS.06.01.05, Element of Performance 9.

²⁰⁴ JC Standard MS.06.01.05, Elements of Performance 6 and 9.

²⁰⁵ “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.

²⁰⁶ JC Standard MS.06.01.05, Element of Performance 10, states, “[c]ompleted 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 hospital completes the credentialing and privileging decision process in a timely manner.” Georgia Regulation 111-8-40-.09(b) requires that the Board act “...within a reasonable period of time after considering the recommendations of the medical staff...” However, Georgia statutes require, “Whenever any licensed doctor of medicine, doctor of podiatric medicine, doctor of osteopathic medicine, or doctor of dentistry shall make application for permission to treat patients in any hospital owned or operated by the state, any political subdivision thereof, or any municipality, the hospital shall act in a nondiscriminatory manner upon such application expeditiously and without unnecessary delay considering the applicant on the basis of the applicant’s demonstrated training, experience, competence, and availability and reasonable objectives, including, but not limited to, the appropriate utilization of hospital facilities; but in no event shall final action thereon be taken later than 90 days following receipt of the application; provided, however, whenever the applicant is licensed by any governmental entity outside the continental limits of the United States, the hospital shall have 120 days to take action following receipt of the application. This subsection shall apply solely to applications by licensed doctors of medicine, doctors of podiatric medicine, doctors of osteopathic medicine, and doctors of dentistry who are not members of the staff of the hospital in which privileges are sought at the time an application is submitted and by those not privileged, at such time, to practice in such hospital under a previous grant of privileges...” O.C.G.A. § 31-7-7.(a)

²⁰⁷ Implementing JC Standard MS.06.01.11, which states that “[a]n expedited governing body approval process may be used for initial appointment and reappointment to the medical staff and for granting privileges when criteria for that process are met.”

²⁰⁸ JC Standard MS.06.01.11, Element of Performance 1, states, “The organized medical staff develops criteria for an expedited process for granting privileges.”

- 1 **1.** No current or previously successful challenges to any professional licensure or
2 registration;
- 3
- 4 **2.** No involuntary termination of medical staff membership at any other organization;
- 5
- 6 **3.** No involuntary limitation, reduction, denial, or loss of clinical privileges to date;
- 7
- 8 **4.** No excessive number or unusual pattern of professional liability actions resulting in final
9 judgment against the applicant.²⁰⁹ Applications meeting these criteria are reviewed by the
10 relevant department chair(s); if approved, by the credentials chair; if approved, by the Medical
11 Executive Committee, in lieu of the application process described in these bylaws. If any of
12 these medical staff authorities make any adverse recommendation, the application shall no
13 longer be eligible for expedition, and shall revert to the regular application process. An
14 expedited application may be acted upon by a committee of the hospital Board, if permitted by
15 the hospital’s bylaws or policy.
- 16

17 **G. Credentials Files**²¹⁰

18 All medical staff credentialing files shall be subject to confidentiality requirements and
19 protections of state and federal law.²¹¹

20

21

22 **1. Hospital Closure**

23 In the event of closure of the hospital, the credentialing files shall be placed with a custodian
24 mutually acceptable to the medical staff and the hospital.²¹²

25

26

27 **2. Access To Credentials Files**

28 Upon taking a corrective action, access to the subject’s credentials file shall be governed by the
29 hearing procedures established in these medical staff bylaws. In all other circumstances,
30 access is governed by this section.
31
32

²⁰⁹ As called for by JC Standard MS.06.01.11, Elements of Performance 3-6.

²¹⁰ 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

²¹¹ Georgia’s confidentiality protections are described by the court in *Emory Clinic v. Houston* as “an absolute embargo upon the discovery and use of all proceedings, records, findings and recommendations of peer review groups and medical review committees in civil litigation.”

²¹² Georgia Regulation 111-8-40-.03(c)2(g)1 mandates that “Prior to the hospital closure, the hospital shall inform the Department of the planned storage location for patients’ medical records, medical staff information, and other critical information after closure. The hospital shall publish in a widely circulated newspaper(s) in the hospital’s service area a notice indicating where medical records and other critical information can be retrieved and shall notify the Department of Transportation of the anticipated date of closure for removal of the hospital locator signs. Following closure, the Department shall be notified of any change in location of the patients’ medical records, medical staff information, and other critical information from the published location.”

1 a) Only those medical staff leaders and committee members and administrative
2 personnel whose duties require access to the credentials files of a particular credentials
3 file are permitted to request and review its contents.
4

5 b) Medical staff members shall be granted access to their own credentials file upon
6 request,²¹³ but only under the following conditions:
7

8 (1) the member shall request access in writing, on a form provided by the medical
9 staff office, directed to the chief of staff or the chief of staff's designee;
10

11 (2) the member may review the file only in the medical staff office, at a time
12 convenient to the member and the medical staff office manager [the president of the
13 medical staff or designee], in whose presence the member's review will take place.
14 The member may receive a copy of only those documents provided by or addressed
15 personally to the member. A written summary of all other information, including
16 medical staff committee findings, letters of reference, proctoring reports,
17 complaints, and incident reports, but not disclosing the source of the information,
18 shall be provided, if requested, to the member by the medical staff office manager
19 [the chief of the medical staff or designee], within a reasonable period of time;
20

21 (3) members may request that the Medical Executive Committee correct or delete
22 inaccuracies from their files. Such requests must be in writing, supporting the
23 request. The member shall be notified promptly, in writing, of the decision of the
24 Medical Executive Committee. In any case, a member shall have the right to add a
25 statement to his or her credentials file responding to any information contained in
26 the file.
27

28 3. Contents of Credentials Files 29

30 Documentation [of an unusual quality or source] about the professional competence or the
31 conduct of a member other than routine information from medical staff quality improvement
32 activities shall be directed by the medical staff office to the relevant department chairman to
33 determine whether the information is obviously specious, incorrect or unreliable and should be
34 discarded rather than inserted into the member's credentials file.
35

36 4. Use of Credentials File in Credentialing²¹⁴ 37

38 Prior to making its recommendation on membership renewal, the credentials committee
39 reviews the contents of the members' credentials file. In the event that adverse information is
40 not utilized as the basis for a request for corrective action or adverse recommendation in the
41 membership renewal process, the credentials committee shall recommend to the Medical
42 Executive Committee that the adverse information be removed from the file and discarded.

²¹³ 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.

²¹⁴ 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.

1 The Medical Executive Committee may determine that such information is required for
2 continuing evaluation of the member’s character, competence or professional performance.

3
4 **ARTICLE V. PRIVILEGING**²¹⁵

5
6 Only those clinical privileges specifically requested by²¹⁶ and granted to the member by the
7 Board, upon Medical Executive Committee recommendation, in accordance with these bylaws,
8 can be exercised in the hospital.

9
10 Clinical privileges may be modified or terminated by the Board only upon recommendation of
11 the Medical Executive Committee, and only for reasons directly related to quality of patient
12 care²¹⁷ and other provisions of the medical staff bylaws.

13
14 **A. Requirements for privileges**²¹⁸

15
16 **1. Application**

17
18 To request privileges, an applicant or member must complete the privileging request form
19 establishing the criteria for each privilege recommended by the department and approved by
20 the Medical Executive Committee.²¹⁹ Privilege requests must be made in conjunction with
21 membership and membership renewal applications,²²⁰ but may also be made during the
22 membership term if additional privileges are sought.

23
24 All requests for clinical privileges shall be processed pursuant to the procedures described in
25 Article IV²²¹ and accordingly determined, based on the applicant’s education, training,

²¹⁵ JC Standard MS.01.01.01, Element of Performance 14, states that the medical staff bylaws include “[t]he process for privileging and re-privileging licensed independent practitioners...”

²¹⁶ To prevent members from having to accept privileges they did not request and do not wish to have, as under some “core” privileges arrangements.

²¹⁷ 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

²¹⁸ Required by Georgia Regulation 111-8-40-.11(c)4, which states, “...The bylaws and rules and regulations...shall include at a minimum: ...[c]riteria and procedures for recommending the privileges to be granted to individual physicians, dentists, or podiatrists...”

²¹⁹ Mandated by Georgia Regulation 111-8-40-.11 (a) 2(vii), which states, “...Minimum requirements for medical staff appointments and clinical privileges shall include: ... [c]ongruity of the qualifications and/or training requirements with the privilege requested. ...”

²²⁰ Required under Georgia Regulation 111-8-40-.11(a) 3, which states, “The medical staff shall evaluate at least biennially the credentials and professional performance of any individual granted clinical privileges for consideration for reappointment.”

²²¹ “Any physician, podiatrist, or dentist providing patient care, whether directly or by contract with the hospital, shall obtain clinical privileges through the hospital’s medical staff credentialing process.” Georgia Regulations 111-8-40-.11(a)1.

1 professional competence, compliance with accepted standards of care, current health status,²²²
2 and the other requirements consistent with the criteria adopted in these bylaws.²²³

3
4 **2. Board Certification**²²⁴

5
6 Departments [The Medical Executive Committee] may [shall] include in the criteria for
7 privileges specific Board certification and eligibility requirements relevant to specific clinical
8 privileges.

9
10 **3. Resource Availability**²²⁵

11
12 For every privileges request, the department’s recommendation for clinical privileges affirms
13 that the hospital has the ability at the time or will have at a specified time to provide adequate
14 facilities and supportive services for the applicant.
15

²²² JC Standard MS.06.01.05, Element of Performance 6, states “[a]n applicant submits a statement that no health problems exist that could affect his or her ability to perform the privileges requested.”

²²³ Mandated by Georgia Regulation 111-8-40-.11(a) 2(vii) which states, “...Minimum requirements for medical staff appointments and clinical privileges shall include: ... [c]ongruity of the qualifications and/or training requirements with the privilege requested...”

²²⁴ Georgia Regulation 111-8-40-.02 defines Board certified and Board eligibility:

“(a) *Board certified* means current certification of a licensed physician by a specialty Board recognized by the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) or other nationally recognized specialty’s certifying Board.

(b) *Board eligible* means a licensed physician who meets the criteria for examination for the designated specialty as published by that nationally recognized specialty’s certifying Board.” Effective January 1, 2012, a new ABMS policy limits the period of time that may elapse between the completion of residency training and achievement of Board Certification (see Board Eligibility Policy at www.abms.org).

²²⁵ 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.”

1 **4. Proctoring**²²⁶

2
3 New medical staff members, and those granted new clinical privileges, undergo proctoring.
4 Performance on an appropriate number of cases within a specified time period, as established
5 by the [department] rules and regulations, shall be observed by the chairman or the chairman's
6 designee. When the required number of cases has been proctored, the department shall review
7 the proctoring reports and recommend to the Medical Executive Committee, based on the
8 evaluation of the types and numbers of cases observed and the member's performance,
9 acceptance of the member's satisfaction of the relevant proctoring requirements, continuation
10 of a period of proctoring on some or all privileges for stated reasons, or termination of some or
11 all privileges.

12
13 **B. Types of Privileges**

14
15 **1. [Dependent privileges]**²²⁷

16
17 Dependent privileges restrict members to admit and care for patients only in conjunction with a
18 physician holding independent privileges. Members holding dependent privileges are
19 responsible for obtaining the involvement of appropriate members with independent privileges
20 in their admissions and inpatient care. Dependent privileges alone do not render the member
21 ineligible for any category or affect ability to vote, serve on committees or hold office.]
22

²²⁶ 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

²²⁷ 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.

1 **2. Admitting Privileges**²²⁸

2
3 Privileges to admit patients to the hospital must be specifically requested and are granted only
4 to qualified requestors meeting the clinical criteria for admitting privileges²²⁹ recommended by
5 departments to the Medical Executive Committee. Admitting privileges are not exclusive to
6 hospital employees, members with hospital contracts, or to any single specialty.²³⁰

7
8 **3. Contract Privileges**

9
10 Medical staff members may provide services under contract with the hospital subject to the
11 following conditions:

12
13 **a)** a member providing services pursuant to a hospital contract, exclusive or
14 otherwise,²³¹ must qualify for and be granted clinical privileges and satisfy the same
15 medical staff membership qualifications in the same manner, and must fulfill all of the
16 obligations of the appropriate membership category, as any other applicant or medical
17 staff member;²³²

18
19 **b)** prior to the issuing of any new or renewed exclusive contract, the Medical
20 Executive Committee must review the quality of care ramifications of continued
21 exclusivity or of imposition of exclusivity on any department service or privileges and
22 make a recommendation to the Board as to whether exclusivity is appropriate.²³³ The
23 Medical Executive Committee shall collect information from the members of medical
24 specialties that would be affected, from the hospital administration, and from other
25 interested parties, in order to make an informed recommendation;²³⁴ however, the actual

228 “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

229 “The governing body shall appoint members of the medical staff within a reasonable period of time after considering the recommendations of the medical staff, if any, and shall ensure the following: 1. That every inpatient is under the care of a qualified member of the medical staff...” Georgia Regulation 111-8-40-.09 (b)1.

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

231 Georgia courts have upheld hospital contracts limiting specified services to contracting professionals in *Cobb County Kennestone Hosp. Auth.* and *St. Mary’s v. Radiology Professional Corp.*, among other cases, but also have recognized in *Whitaker v. Houston County Hosp. Auth.*, as “well-established law” that the hospital’s ability to enter into exclusive contracts is not unlimited. Rather, according to the *St. Mary’s v. Radiology Professional Corp.* decision, “to ensure its right to terminate staff privileges to maintain exclusive relationships, hospitals must so provide either in the bylaws or in a contract with the individual physician (and not just in the contracts with the physician’s professional corporation.)”

232 Georgia Regulation 111-8-40-.11(a)1 states, “Any physician, podiatrist, or dentist providing patient care, whether directly or by contract with the hospital, shall obtain clinical privileges through the hospital’s medical staff credentialing process.”

233 JC Standard LD.04.03.09, Element of Performance 1, states, “Clinical leaders and medical staff have an opportunity to provide advice about the sources of clinical services to be provided through contractual agreement.”

234 “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

1 terms of the contract and any financial information related to the contract, including but
2 not limited to the remuneration to be paid to medical staff members under contract, are
3 not relevant and therefore shall neither be disclosed to the Medical Executive Committee
4 nor discussed as part of this exclusive contracting evaluation process;²³⁵
5

6 c) no privileges will be terminated, restricted, or reduced by operation of any hospital
7 contract for any reason without the same rights of hearing and appeal as are available to
8 all members of the medical staff.²³⁶
9

10 **4. Dentists' and Podiatrists' Privileges**

11 a) admitting and other clinical privileges of dentists and podiatrists may not exceed the
12 scope of their licensure;

13 b) patients admitted by dentists and podiatrists must receive all necessary and
14 appropriate medical evaluations and care;

15 c) any dispute between a dentist or podiatrist and a physician member regarding
16 proposed treatment must be promptly resolved by the department director [president].
17

18 **5. Disaster Privileges**

19 **a) Conditions²³⁷**

20 Disaster privileges may be granted only when the hospital cannot meet immediate patient
21 needs and the hospital disaster plan has been activated. Individuals with disaster
22 privileges shall be identified as described in the hospital disaster plan. The department
23 [medical staff] rules and regulations delineate supervision responsibilities over disaster
24 privileges holders and all matters relating to the exercise of disaster privileges.
25

26 **b) Circumstances**

27 The president or his/her designees,²³⁸ may on a case-by-case basis, grant disaster
28
29
30
31
32
33

should hold a hearing, as defined by the medical staff and f to permit interested parties to express their views on the hospital's proposed action." AMA Policy Compendium H-225.985

²³⁵ 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.

²³⁶ 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. Under *Whitaker v. Houston* and *St. Mary's v. Radiology Professional Corp.*, if the bylaws or the physician's individual contract do not specifically waive hearing rights, adverse contract-related actions warrant hearing rights as provided in medical staff bylaws for non-contract adverse actions. Providing for hearing rights in the medical staff bylaws protects all involved.

²³⁷ To meet JC Standard EM.02.02.13, Element of Performance 1, "The hospital grants disaster privileges to volunteer licensed independent practitioners only when the Emergency Operations Plan has been activated in response to a disaster and the hospital is unable to meet immediate patient needs."

1 privileges but only upon presentation of a valid picture identification issued by a state, or
2 federal agency and any of the following:²³⁹

3
4 (1) a current hospital picture identification that clearly identifies professional
5 designation;

6
7 (2) a current license to practice;

8
9 (3) primary source verification of the license;

10
11 (4) identification establishing that the individual is a member of a Disaster
12 Medical Assistance Team (DMAT), MRC, ESAR-VHP, or other state or federal
13 organization or groups;

14
15 (5) identification granted by a federal, state or municipal entity establishing that
16 the individual has been granted authority to render patient care, treatment, and
17 services in disaster circumstances;

18
19 (6) identification by current hospital staff or medical staff member(s) with
20 personal knowledge regarding the volunteer's ability to act as a licensed
21 independent practitioner during a disaster.

22
23 **c) Verification**

24
25 Primary source verification of the credentials of individuals with disaster privileges is a
26 high priority and is initiated as soon as the immediate situation is under control.

27 Verification and determination as to continuation of privileges are completed within 72
28 hours from the time the volunteer practitioner presents to the organization.²⁴⁰

29
30 **6. Emergency Privileges²⁴¹**

31
32 In case of emergency in which serious permanent harm or aggravation of injury or disease
33 could result to a patient, or in which the life of a patient is in immediate danger, any medical
34 staff member with clinical privileges shall be permitted, and the hospital staff will assist, to
35 provide appropriate care within the scope of the member's license. Any and all
36 implementation of emergency privileges shall be subsequently reviewed by the Credentials
37 Committee.
38

²³⁸ 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. See also JC Standard MS.01.01.01, Element of Performance 14.

²³⁹ As called for by JC Standard EM.02.02.13, Element of Performance 5.

²⁴⁰ As called for by JC Standard EM.02.02.13, Elements of Performance 7 and 8.

²⁴¹ "The medical staff shall establish a system for the approval of temporary or emergency staff privileges when needed." Georgia Regulation 111-8-40-.11(a) 4.

1 **7. History and Physical Privileges**²⁴²

2
3 Every patient receives a history and physical within 24 hours of admission, unless a previous
4 history and physical performed within 30 days of admission is on record, in which case that
5 history and physical will be updated within 24 hours of admission.²⁴³ Every patient admitted
6 for surgery must have a history and physical within 24 hours prior to surgery, unless a previous
7 history and physical performed within 30 days prior to the surgery is on record, in which case
8 that history and physical will be updated within 24 hours of the surgery.²⁴⁴ Only those granted
9 privileges to do so may conduct history and physicals or update histories and physicals.
10 Privileges to conduct a history and physical or an update to a history and physical are granted
11 only to physicians or oral/maxillofacial surgeons who are members of the medical staff or
12 seeking temporary privileges.²⁴⁵

13
14 **8. New Privileges**

15
16 Requests to provide services or perform procedures not currently being provided at the hospital
17 are submitted in writing to the medical staff office, and include a description of the privileges
18 requested and the equipment, space, personnel, and resources required to safely provide the
19 new procedure or services. The department(s) submits a recommendation to the Medical
20 Executive Committee, including criteria for any privilege the department recommends adding.
21 If the Medical Executive Committee supports addition of the service, it shall forward its
22 recommendation to the Board for final action. If the Board adopts the recommendation, the
23 requestor will be provided the opportunity to apply for the new privilege(s).
24

242 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.”

243 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.” Georgia Regulation 111-8-40-.19(a)1 states, “A history and physical examination shall be completed within the first twenty-four (24) hours after admission. A history and physical examination completed by either the patient’s physician or the appropriate practitioner operating under the direction of the physician as authorized by law no more than thirty (30) days prior to the admission may be accepted but must be updated to reflect the patient’s condition at the time of admission. Where the patient is admitted solely for oromaxillofacial surgery, such history and physical may be completed by the oromaxillofacial surgeon.”

244 Georgia Regulation 111-8-40-.28(a)2 states, “The hospital shall have bylaws, rules, or policies and procedures developed by the medical staff which requires that within twenty-four (24) hours prior to surgery either a history and physical examination or an update of a previous history and physical is completed for every surgical patient. Where an update is used, the previous history and physical examination must not have occurred more than thirty (30) days prior to surgery.”

245 “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; under Georgia Regulation 111-8-40-.19(a)1, “...Where the patient is admitted solely for oromaxillofacial surgery, such history and physical may be completed by the oromaxillofacial surgeon.”

1 **9. Telemedicine Privileges**

2
3 Only those privileges specifically recommended by the Medical Executive Committee to be
4 provided via telemedicine are available at this hospital.²⁴⁶ Licensed independent practitioners
5 at a different facility (referred to as the “distant site”) who wish to provide services to patients
6 at this hospital via a telemedicine link must apply for telemedicine privileges at this hospital.

7
8 **10. Temporary Privileges**²⁴⁷

9
10 The administrator grants temporary privileges if requested by a practitioner, upon written
11 recommendation of [the department chair where the privileges will be exercised and] the
12 president,²⁴⁸ only in the following two circumstances and subject to the conditions of this
13 section.

14
15 **a) Circumstances**

16
17 Temporary privileges are only available to pending applicants or to fulfill an important
18 patient need,²⁴⁹ as described in this section.

19
20 **(1) Pending Applications**

21
22 Temporary privileges can be granted to applicants who request them while their
23 applications for initial privileges is awaiting review and approval of the Medical
24 Executive Committee and the **Board**, after verification of the following:²⁵⁰

- 25
26 **a)** a complete application for medical staff membership and privileges;
27
28 **b)** current licensure;
29
30 **c)** relevant training or experience;
31
32 **d)** current competence;
33
34 **e)** ability to perform the clinical privileges requested;

²⁴⁶ JC Standard MS.13.01.03 states, “[t]he 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.”

²⁴⁷ “The medical staff shall establish a system for the approval of temporary or emergency staff privileges when needed.” Georgia Regulation 111-8-40-.11(a) 4.

²⁴⁸ 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.

²⁴⁹ The Rationale for JC Standard MS.06.01.13 states, “[t]here 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 are: To fulfill an important patient care, treatment, and service need; when a new applicant for new privileges with a complete application that raises no concerns is awaiting review and approval of the medical staff executive committee and the governing body.”

²⁵⁰ Each element called for under JC Standard MS.06.01.13, Element of Performance 3.

- 1
2 f) other criteria required by the medical staff bylaws;
3
4 g) National Practitioner Data Bank query and evaluation of information
5 received;
6
7 h) no current or previously successful challenge to licensure or registration;
8
9 i) no involuntary termination of medical staff membership at any hospital or
10 other entity;
11
12 j) no involuntary limitation, reduction, denial or loss of clinical privileges.
13

14 Temporary privileges should not be recommended if a department or the credentials
15 committee has already recommended against a favorable action or there are doubts
16 that the applicant will be granted medical staff membership and privileges by the
17 Board. Temporary privileges shall automatically terminate if the applicant's initial
18 membership application is withdrawn.²⁵¹ All temporary privileges granted are time
19 limited and shall automatically terminate at the end of the designated period, which
20 shall not exceed 120 days cumulatively.²⁵²
21

22 (2) Patient Care Need

23
24 Temporary privileges can be granted for a period of [90] days²⁵³ to fulfill an
25 important patient care, treatment or service,²⁵⁴ such as providing specific medical
26 skills needed to care for a patient that no one on the medical staff possesses,
27 covering for an absent medical staff member or otherwise filling in when a medical
28 staff member is not available to provide the care needed,²⁵⁵ after verification of
29 current licensure and current competence.²⁵⁶ The privileges are limited to the
30 specific need that was the basis of the application. A practitioner requesting
31 temporary privileges more than [twice] in one year will be required to apply for
32 medical staff membership and privileges or face denial of an additional round of
33 temporary privileges.
34

²⁵¹ Added to clarify that temporary privileges granted during the pendency of an application cease automatically, should the application be withdrawn.

²⁵² The limit established by JC Standard MS.06.01.13, Element of Performance 6.

²⁵³ 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.

²⁵⁴ As stated in the rationale for JC Standard MS.06.01.13.

²⁵⁵ 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.

²⁵⁶ As called for by JC Standard MS.06.01.13, Element of Performance 2.

1 **b) Conditions**
2

3 All persons requesting or receiving temporary privileges shall be bound by the medical
4 staff bylaws and rules and regulations. If temporary privileges are denied or terminated
5 for a reportable reason, hearing rights shall apply.²⁵⁷
6

7 Requirements for observation, consultation and/or reporting may be imposed by the
8 department chair responsible for supervision.
9

10 **C. Relinquishing Privileges**²⁵⁸
11

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

²⁵⁷ 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.

²⁵⁸ To provide a means for members to surrender privileges on their own terms for their own reasons.

1 **ARTICLE VI. PEER REVIEW**²⁵⁹

2
3 For purposes of this article, the term “member” means a medical staff member or other
4 practitioner who provides services under privileges granted by the hospital. All members shall
5 participate in peer review activities as requested or appointed pursuant to these bylaws in good
6 faith, consistent with state and federal legal standards.²⁶⁰

7
8 **A. Ongoing and Focused Peer Review Standards**²⁶¹

9
10 [The peer review committee] Each department determines, on a continuing basis, the type of data
11 to collect for use in ongoing professional practice evaluation,²⁶² and the criteria to be used for
12 focused peer review of a member or other practitioner’s services provided under privileges held
13 in the department, whenever quality patient care issues are identified.²⁶³ The Medical Executive
14 Committee is responsible for consistent use of criteria in peer review.²⁶⁴ The results of ongoing
15 and focused peer review are the bases for decisions regarding membership and privileges.²⁶⁵

²⁵⁹ Under Georgia Regulation 111-8-40-.02(m), “Peer review means the procedure by which professional health care providers evaluate the quality and efficiency of services ordered or performed by other professional health care providers in the hospital for the purposes of fostering safe and adequate treatment of the patients and compliance with standards set by an association of health care providers and with the laws, rules, and regulations applicable to hospitals.”

²⁶⁰ 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).” 42 USCS § 11112 (6/13/13) O.C.G.A. § 31-7-141 places conditions on state law immunity as follows: “There shall be no monetary liability on the part of and no cause of action for damages shall arise against any member of a duly appointed medical review committee for any act or proceeding undertaken or performed within the scope of the functions of any such committee if the committee member acts without malice or fraud. This immunity shall apply only to actions by providers of health services, and in no way shall this Code section render any medical review committee immune from any action in tort or contract brought by a patient or his successors or assigns. This Code section shall not affect the immunity of an officer or an employee of a public corporation.” Under *Patrick v. Floyd* and *Patton v. St. Francis Hospital*, the HCQIA preempts or trumps the Georgia statute’s malice exemption.

²⁶¹ JC Standard MS.08.01.01 states, “The organized medical staff defines the circumstances requiring monitoring and evaluation of a practitioner’s professional performance.”

²⁶² 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.”

²⁶³ Implementing Georgia Regulation 111-8-40-.11(c)14 which states that the bylaws, rules and regulations include at a minimum “A mechanism for peer review of the quality of patient care, which includes, but is not limited to, the investigation of reportable patient incidents involving patient care ...” and JC Standard MS.08.01.01, Element of Performance 2, “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.”

²⁶⁴ Under JC Standard MS.08.01.01, Element of Performance 4, “focused professional practice evaluation is consistently implemented in accordance with the criteria and requirements defined by the organized medical staff.” The MEC is well positioned to see that all peer review recommendations uniformly utilize the criteria that the MEC has defined.

²⁶⁵ Implementing JC Standard MS.08.01.03, Element of Performance 3, “Information resulting from the ongoing professional practice evaluation is used to determine whether to continue, limit, or revoke any existing privilege(s).”

1 Only those peer review standards adopted by the Medical Executive Committee shall be used in
2 evaluating members.²⁶⁶

3
4 **B. Behavior Adversely Affecting Patient Care**²⁶⁷

5
6 Behavior by medical staff members while on hospital property²⁶⁸ that generates a complaint by
7 another medical staff member, a member of the hospital clinical or administrative staff, or
8 individuals in contact with the medical staff member at the hospital other than patients,²⁶⁹ will be
9 responded to exclusively²⁷⁰ according to these bylaws.

10
11 **1. Definition of Behavior Adversely Affecting Patient Care**

12
13 Inappropriate conduct, or other forms of offensive behavior by a medical staff member that
14 jeopardizes quality patient care or the ability of others to provide quality patient care at the
15 hospital, or threatens, or constitutes verbal, physical or visual abuse of, patients or others

²⁶⁶ To limit peer review to standards adopted by peers rather than imposed by third party payers or the hospital.

²⁶⁷ AMA Council on Ethics and Judicial Affairs 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

²⁶⁸ The behavior of members outside the hospital need not be regulated by the medical staff; however, behavior in the hospital parking garage or on the lawn should be included.

²⁶⁹ Problems between the member and his/her patient are addressed by the standards applicable to the physician (or other professional)/patient relationship.

²⁷⁰ 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.

1 involved with providing patient care at the hospital²⁷¹ is disruptive behavior²⁷² prohibited by
2 these bylaws. Verbal, visual or physical abuse directed against any individual (e.g., against
3 another medical staff member, house staff, hospital employees or patients) on the basis of race,
4 religion, color, national origin, ancestry, physical disability, mental disability, medical
5 disability, age, marital status, sex or sexual orientation will be considered harassment.
6 Unwelcome sexual advances, requests for sexual favors, or verbal, visual or physical activity
7 through which submission to sexual advances is made an explicit or implicit condition of
8 employment or future employment-related decisions, unwelcome conduct of a sexual nature
9 that has the purpose or effect of unreasonably interfering with a person’s work performance or
10 that creates an offensive, intimidating or otherwise hostile work environment is sexual
11 harassment.²⁷³ Nothing in this section or these Bylaws is intended to prohibit acceptable²⁷⁴
12 behavior, which includes constructive criticism, patient advocacy, exercise of rights granted
13 under these bylaws, fair competition, or pursuit of business interests by practitioners.
14

15 **2. Referral for Assistance**

16
17 Behavior that indicates that the medical staff member suffers from a physical, mental or
18 emotional condition will be referred to the medical staff wellness committee or otherwise
19 evaluated to promote assisting the medical staff member while protecting others.²⁷⁵
20

21 **3. Severity Levels**

22
23 To aid in responding appropriately to a complaint, behavior adversely affecting patient care is
24 classified here into three levels of severity. Level I behavior is the most severe violation. Any
25 corrective action will be commensurate with the nature and severity of the behavior.
26

27 Level I: Physical violence or other physical abuse that is directed at people;
28 sexual harassment or harassment involving physical contact.
29

²⁷¹ The behavior to be addressed by the medical staff has to fall within the purview of the medical staff organization-professionalism and patient care quality. If the behavior is not related to patient care or professional ethics, the legal protections provided for peer review are not likely to apply. To qualify as a medical review committee and the protections afforded such committees, the committee must be formed “to evaluate and improve the quality of health care rendered by providers of health service or to determine that health services rendered were professionally indicated or were performed in compliance with the applicable standard of care or that the cost of health care rendered was considered reasonable by the providers of professional health services in the area,” under O.C.G.A. § 31-7-140. Implementing that definition, O.C.G.A. § 31-7-141 bars monetary liability and causes of action for damages arising from such a committee’s action, if the committee acts in good faith, and O.C.G.A. § 31-7-143 protects such committee’s records and proceedings from discovery. The confidentiality protections apply to qualified committees even if the activities are marred by malice. *Patton v. St. Francis Hospital et al.*

²⁷² JC Standard LD.03.01.01, Element of Performance 4, calls for the code of conduct to define “...acceptable behavior and behaviors that undermine a culture of safety.”

²⁷³ Based on federal law prohibiting sexual harassment.

²⁷⁴ JC Standard LD.03.01.01, Element of Performance 4, calls for the code of conduct to define “...acceptable behavior and behaviors that undermine a culture of safety.”

²⁷⁵ 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.

1 Level II: Verbal abuse such as unwarranted²⁷⁶ yelling, swearing or cursing; threatening,
2 humiliating, sexual or otherwise inappropriate comments directed at a person or persons
3 verbally; visual abuse such as threatening, humiliating, sexual or otherwise inappropriate
4 writing or picture(s) directed at a person or persons, or physical violence or abuse directed in
5 anger at an inanimate object; repeat offenses.
6

7 Level III: Verbal abuse that is directed at-large, but has been reasonably perceived by a
8 witness to be disruptive behavior as defined above imposing burdensome, idiosyncratic
9 requirements on nursing staff, residents or others that are not generally accepted in the medical
10 profession and that, in light of the particular circumstances, cannot be reasonably expected to
11 result in improved patient care or significant administrative efficiency.
12

13 **4. Evaluating Behavior Adversely Affecting Patient Care** 14

15 Behavior by members of the medical staff that affects or may affect patient care, or refusal of
16 members to cooperate with the disruptive behavior procedures, may result in corrective action,
17 which shall be carried out according to the medical staff bylaws. Behavior by members of the
18 medical staff that has no impact on patient care, and therefore does not meet the threshold
19 requirements for resolution under this bylaws section but constitutes violence or harassment as
20 described under hospital human resources policies, may be resolved by administrative action as
21 described below.²⁷⁷ Repeated instances of behavior that adversely affects patient care will be
22 considered cumulatively and action shall be taken accordingly.
23

24 **a) Medical Staff Behavior Complaint Process** 25

26 Complaints about a medical staff member's behavior must be in writing, signed and
27 directed to the Medical Executive Committee. The president shall provide the
28 complainant with a written acknowledgement of the complaint and the bylaws or those
29 sections of the bylaws addressing conduct, and shall appoint a review subcommittee [of
30 two] to review the complaint immediately. The committee and the president shall make
31 an initial determination of authenticity²⁷⁸ and severity, and act accordingly. In all cases,
32 the member involved shall be provided with a copy of these bylaws and a copy of the
33 complaint.²⁷⁹ [The president may initially protect the identity of the complainant if, in
34 his/her judgment, such protection is appropriate and does not prevent the member from
35 adequately defending himself/herself against the allegations.] Requests by a complainant
36 that "nothing should be done" about an event and that the report is "for information only"
37 cannot be granted.
38

39 Complaints will be processed according to the level of severity assigned:
40

²⁷⁶ Recognizing that in emergency situations, calling out for instruments, drugs, or help may actually be appropriate.

²⁷⁷ Action by medical staff members that do not affect patient care should not go without response, but are outside the medical staff's scope.

²⁷⁸ To screen out false reports. JC Standard MS.11.01.01, Element of Performance 6, states that the process should address "[e]valuation of the credibility of a complaint, allegation or concern."

²⁷⁹ To permit the accused member to prepare a meaningful response.

1 Level I: The committee interviews the complainant, any witnesses and the medical staff
2 member within 24 hours of receiving the complaint.

3
4 Level II: The committee interviews the complainant, any witnesses and the medical staff
5 member within five working days of receiving the complaint.

6
7 Level III: The committee interviews the complainant, any witnesses and the medical staff
8 member within 10 days of receiving the complaint.

9
10 Subsequent to this fact-gathering, the committee shall recommend one or more of the
11 following actions to the Medical Executive Committee:

- 12
13 i. take no action against the member based on a finding that the behavior was
14 not inappropriate;
- 15
16 ii. issue a warning;
- 17
18 iii. refer the member to the medical staff well-being committee;
- 19
20 iv. recommend corrective action pursuant to the medical staff bylaws.

21
22 Any corrective action will be commensurate with the nature and severity of the member's
23 behavior.

24
25 **b) Behavior Complaints Not Handled By Medical Staff Behavior Complaint**
26 **Process**

27
28 Threatening, harassing or other offensive behavior that is directed against a medical staff
29 member by a hospital employee, Board member, contractor, or other member of the
30 hospital community shall be reported by the member to the hospital pursuant to hospital
31 policy governing conduct.²⁸⁰ Behavior by a medical staff member toward a hospital
32 employee, Board member, contractor or other member of the hospital community, which
33 does not fall within the definition of behavior adversely affecting patient care above, but
34 violates hospital policy governing conduct, shall be dealt with according to that hospital
35 policy, so long as the hospital policy has been approved by the Medical Executive
36 Committee.²⁸¹

280 To ensure that medical staff members are protected against disruptive behavior.

281 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.

1 **C. External Peer Review**²⁸²

2
3 External peer review will take place as part of focused review, investigation, application
4 processing, or at any other time only under the following circumstances, if and only if deemed
5 appropriate by the relevant medical staff department, the Medical Executive Committee or the
6 Board:

- 7
8 **1.** Vague or conflicting recommendations from committee or department review(s) where
9 conclusions from this review could directly and adversely affect an individual’s membership or
10 privileges.
11
12 **2.** Lack of internal expertise, in that no one on the medical staff has adequate expertise in
13 the clinical procedure or area under review.
14
15 **3.** When the medical staff needs an expert witness for a fair hearing, for evaluation of a
16 credentials file or for assistance in developing a benchmark for quality monitoring.
17
18 **4.** To promote impartiality in peer review.
19

20 A member subject to review or investigation can request the hospital or medical staff to obtain
21 external peer review, and shall have an opportunity to reasonably object to the selection of a
22 particular external peer reviewer.
23

24 **D. Investigation**

25
26 **1. Authority**

27
28 The Medical Executive Committee has the exclusive authority to initiate an investigation
29 involving a member, and shall do so when reliable information indicates a member’s actions
30 may be detrimental to patients, unethical, contrary to the medical staff bylaws and rules and
31 regulations, or below applicable professional standards, or is otherwise reportable under state
32 regulations as a patient incident.²⁸³ The Medical Executive Committee may also initiate

²⁸² Circumstances requiring evaluation of a professional’s performance must be defined for compliance with JC Standard MS.08.01.01. Focused professional practice evaluation processes include external peer review, which should be addressed in medical staff bylaws to promote fair and uniform deployment. External review can also be useful for other medical staff evaluation such as application processing.

²⁸³ Georgia Regulation 111-8-40-.07(2)(a) defines Patient Incidents Requiring Report and requires reporting and investigation, as follows: “1. The hospital’s duly constituted peer review committee(s) shall report to the Department, as required below, whenever any of the following incidents involving hospital patients occurs or the hospital has reasonable cause to believe that a reportable incident involving a hospital patient has occurred: (i) Any unanticipated patient death not related to the natural course of the patient’s illness or underlying condition; (ii) Any rape which occurs in a hospital; (iii) Any surgery on the wrong patient or the wrong body part of the patient; and (iv) Effective three (3) months after the Department provides written notification to all hospitals the hospital’s duly constituted peer review committee(s) shall also report to the Department, whenever any of the following incidents involving hospital patients occurs or the hospital has reasonable cause to believe that a reportable incident involving a hospital patient has occurred: (I) Any patient injury which is unrelated to the patient’s illness or underlying condition and results in a permanent loss of limb or function; (II) Second or third degree burns involving twenty (20) percent or more of the body surface of an adult patient or fifteen (15) percent or more of the body surface of a child

1 investigation if it determines that a request for corrective action or other report resulting from
2 the medical staff behavior complaint process, from ongoing professional practice evaluation,
3 external peer review, focused review or any other peer review or quality improvement process
4 warrants investigation.

5
6 At all times the Medical Executive Committee retains both authority and discretion to refer the
7 member to the medical staff wellness committee, to terminate an investigation, to impose
8 summary suspension, and/or to take whatever action may be warranted by the circumstances
9 consistent with these bylaws.

10 11 **2. Procedure**

12 13 **a) Investigating Committee²⁸⁴**

14
15 The Medical Executive Committee conducts the investigation or delegates the
16 investigation to a standing medical staff committee or special medical staff committee
17 appointed for the purpose of conducting the investigation. The Medical Executive
18 Committee sends special notice to the member that an investigation is being conducted
19 and extending the opportunity to provide information in a manner and upon such terms as
20 the investigating committee deems appropriate. The individual or body investigating the
21 matter may in its discretion interview the member but an investigating committee
22 interview is not a hearing and does not entitle the member to any procedural rights. The

which burns were acquired by the patient in the hospital; (III) Serious injury to a patient resulting from the malfunction or intentional or accidental misuse of patient care equipment; (IV) Discharge of an infant to the wrong family; (V) Any time an inpatient, or a patient under observation status, cannot be located, where there are circumstances that place the health, safety, or welfare of the patient or others at risk and the patient has been missing for more than eight (8) hours; and (VI) Any assault on a patient, which results in an injury that requires treatment. 2. The hospital's peer review committee(s) shall make the self-report of the incident within twenty-four (24) hours or by the next regular business day from when the hospital has reasonable cause to believe an incident has occurred. The self-report shall be received by the Department in confidence and shall include at least: (i) The name of the hospital; (ii) The date of the incident and the date the hospital became aware that a reportable incident may have occurred; (iii) The medical record number of any affected patient(s); (iv) The type of reportable incident suspected, with a brief description of the incident; and (v) Any immediate corrective or preventative action taken by the hospital to ensure against the replication of the incident prior to the completion of the hospital's investigation. 3. The hospital's peer review committee(s) shall conduct an investigation of any of the incidents listed above and complete and retain on site a written report of the results of the investigation within forty-five (45) days of the discovery of the incident. The complete report of the investigation shall be available to the Department for inspection at the facility and shall contain at least: (i) An explanation of the circumstances surrounding the incident, including the results of a root cause analysis or other systematic analysis; (ii) Any findings or conclusions associated with the review; and (iii) A summary of any actions taken to correct identified problems associated with the incident and to prevent recurrence of the incident and also any changes in procedures or practices resulting from the internal evaluation using the hospital's peer review and quality management processes. 4. The Department shall hold the self-report made through the hospital's peer review committee(s) concerning a reportable patient incident in confidence as a peer review document or report and not release the self-report to the public. However, where the Department determines that a rule violation related to the reported patient incident has occurred, the Department will initiate a separate complaint investigation of the incident. The Department's complaint investigation and the Department's report of any rule violation(s) arising either from the initial self-report received from the hospital or an independent source shall be public records.

²⁸⁴ Such a committee should qualify as a "medical review committee" and the attendant protections under Georgia law, consistent with O.C.G.A. § 31-7-140.

1 investigating committee prepares a written report of the investigation to the Medical
2 Executive Committee within the time frame set by the Medical Executive Committee.
3 The report may include recommendations for action.
4

5 **b) Result of Investigation**
6

7 In a timely manner, at the conclusion of the investigation, [but in any event within 60
8 days after receipt of the request or allegation,] [unless deferred by the Medical Executive
9 Committee for good cause] the Medical Executive Committee
10

- 11 (1) determines that the allegation was not substantiated or otherwise determines
12 that no further action is warranted, and closes the investigation.²⁸⁵ If appropriate,
13 the Medical Executive Committee determines that any reference to the investigation
14 shall be removed from the medical staff member’s file;
15
- 16 (2) defers action, for a reasonable time, for good cause;
17
- 18 (3) Refers the member [to the medical staff wellness committee] for evaluation
19 and/or therapy;
20
- 21 (4) takes corrective action consistent with these bylaws.
22

23 The Medical Executive Committee shall provide special notice of the conclusions and
24 recommendation to the affected medical staff member.
25

26 **E. Corrective Actions²⁸⁶**
27

28 Based on an investigation, the medical staff behavior complaint process, reports or requests from
29 medical staff departments or committees or on otherwise reliable information that a member’s
30 actions are detrimental to patients, unethical, contrary to the medical staff bylaws and rules and
31 regulations, or below applicable professional standards, the Medical Executive Committee:
32

- 33 • issues a warning, letter of admonition or letter of reprimand;
34
- 35 • recommends supervision²⁸⁷ or mandatory consultation for a stated period of time or
36 number of cases;

²⁸⁵ The federal appellate case, *John Doe, M.D. v. Levitt*, points out the need to identify that an investigation has been formally closed, short of final action by the Board.

²⁸⁶ “The medical staff shall review and, when appropriate, recommend to the governing body denial, limitation, suspension, or revocation of the privileges of any practitioner who does not practice in compliance with the scope of privileges, the medical staff bylaws, rules and regulations, generally accepted standards of practice, or hospital policies and procedures.” Georgia Regulation 111-8-40-.11(b)4. Further, JC 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.”

²⁸⁷ “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.

- 1 • recommends reduction, suspension or revocation of clinical privileges;
- 2
- 3 • recommends suspension or revocation of medical staff membership;
- 4
- 5 • takes other corrective actions as warranted by the facts.
- 6

7 **1. Summary Suspension**²⁸⁸

8
9 Summary suspension is imposed by a medical staff authority to immediately suspend the
10 privilege(s) and/or membership involved until further notice. The subject is provided special
11 notice immediately.

12
13 **a) Basis**²⁸⁹

14
15 Summary suspension of any or all privileges and/or medical staff membership can be
16 imposed only if necessary to prevent imminent danger to the health of an individual.²⁹⁰
17 Summary suspension is not imposed to punish past conduct. Summary suspension is peer
18 review activity, which may lead to a final adverse action, but is not itself a final peer
19 review action.

20
21 **b) Authority**

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 executive committee. (5)
The scope of the medical staff supervision should be limited to the provision of services that have been restricted,
are clearly questionable, or are under question, as determined by the department chair or medical staff executive
committee. (6) The duration of the medical staff supervision should be limited to the amount of time necessary to
adequately assess the degree of clinical competence in the area of skill being assessed. (7) Medical staff supervision
should include a sufficient volume of procedures or admissions for meaningful assessment. (8) Medical staff
supervisors should provide periodic performance reports on each patient to the appropriate designated medical staff
committee. The reports should be transcribed or transcripted by the medical staff office to assure confidentiality.
The confidentiality of medical staff supervision reports must be strictly maintained. (9) Physicians whose
performance is supervised should have access to the performance reports submitted by medical staff supervisors and
should be given the opportunity to comment on the contents of the reports.” AMA Policy Compendium H-375.967
²⁸⁸ 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.”

²⁸⁹ 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.”

²⁹⁰ The HCQIA extends federal immunity to summary suspensions that are carried out to prevent imminent danger
to individuals.

1 The president, president-elect, the secretary, the treasurer, [the secretary-treasurer], and
2 the chair(s) of the department(s) in which the member has privileges each has authority to
3 summarily suspend all or any portion of the privileges of a member.
4

5 **c) Medical Executive Committee Action**
6

7 As soon as practicable, but within three days after a summary suspension is imposed, the
8 Medical Executive Committee convenes to review the summary suspension, and ratify
9 the action or terminate or modify the suspension, each of which actions would be
10 immediately implemented. The Medical Executive Committee may also recommend
11 such further corrective action as is appropriate to the facts, combine another corrective
12 action with any remaining summary suspension action, or recommend sanctions that do
13 not trigger procedural rights. The Medical Executive Committee immediately provides
14 special notice of its action to the member.
15

16 **2. Automatic Suspension²⁹¹**
17

18 Automatic suspension is triggered by an objective occurrence identified by these bylaws,
19 without action by the medical staff, to immediately suspend privilege(s) or membership
20 effective upon information received by the medical staff office.
21

22 **a) Basis²⁹²**
23

24 **(1) Controlled Substances.** Any revocation, probation, or suspension of the
25 member's registration or certification to prescribe automatically causes a
26 suspension of the member's ability to order or prescribe medications in the hospital.
27

28 **(2) Failure to Pay Dues.** Failure to pay medical staff dues after [two] notices
29 stating the amount due, and the ramifications of failure to pay dues as of day 15
30 after the date of final notice automatically suspends the member's privileges and
31 membership until dues are paid.
32

33 **(3) License.** Any revocation, probation, or suspension of the member's license to
34 practice automatically suspends the member's privileges and membership.
35

36 **(4) Medical Record Delinquency.** Failure to complete medical records
37 according to the schedule established in the medical staff rules and regulations²⁹³
38 generates a written [electronic][telephonic] warning that failure to complete records
39 will result in automatic suspension of privileges within five days of the notice. The
40 day before suspension will be imposed, the member receives special notice of the

²⁹¹ JC Standard MS.01.01.01, Element of Performance 31, states that the medical staff bylaws must also include "[t]he process for automatic suspension of a practitioner's medical staff membership or clinical privileges."

²⁹² JC Standard MS.01.01.01, Element of Performance 28, states that medical staff bylaws must include the "[i]ndications for automatic suspension of a practitioner's medical staff membership or clinical privileges."

²⁹³ Under Georgia Regulation 111-8-40-.11(c)12., medical staff bylaws, rules and regulations should include "[t]he requirements for the completion of medical records..."

1 date and time automatic suspension will be imposed. Suspension continues until all
2 medical records responsibilities are fulfilled.

3
4 **(5) Professional Liability Insurance Lapse.** Failure to maintain the amount of
5 professional liability insurance as required under these bylaws will result in
6 automatic suspension of membership, until the member provides verification to the
7 medical staff office of adequate professional liability coverage. The affected
8 member may petition the Medical Executive Committee to allow the suspended
9 practitioner [six months] to provide evidence to the Medical Executive Committee
10 of professional liability coverage in the amount required, or to accept an alternative
11 solution for the loss of insurance.

12
13 **(6) Current Medicare Sanction.**²⁹⁴ Action by Medicare or other federally
14 funded program will result in the automatic suspension of membership and
15 privileges for the course of the exclusion.

16
17 **(7) Failure to Attend Department [Section] Meeting After Special Notice.**
18 Failure by the practitioner to attend a department [section] meeting to which the
19 practitioner has received special notice that the practitioner's actions will be
20 discussed, as provided in these bylaws,²⁹⁵ shall result in an automatic suspension of
21 the practitioner's privileges, which shall remain in effect until the matter is
22 resolved.

23
24 **b) Medical Executive Committee Action**

25
26 Members may provide the medical staff office information that the underlying cause of
27 the automatic suspension is incorrect, which will be considered by the Medical Executive
28 Committee unless the president sooner overturns the suspension based on
29 incontrovertible evidence that the suspension was an error. At its next meeting, the
30 Medical Executive Committee shall review all automatic suspensions occurring since its
31 last meeting and may recommend further corrective action or any action it deems
32 appropriate.

33
34 **c) Effect of Automatic Suspension**

35
36 If a member is automatically suspended for more than six consecutive months, he or she
37 shall be deemed to have voluntarily resigned medical staff membership and/or the
38 affected privileges. Automatic suspension or limitation does not give rise to procedural
39 rights under these bylaws.

40
41 **3. Patient Coverage in the Event of Corrective Action**
42

²⁹⁴ 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.

²⁹⁵ Under section II.D.1.b, Special Attendance.

1 Upon the imposition of a suspension of any kind, or any corrective action that limits the
2 member’s ability to provide care or services to inpatients, the president shall have the authority
3 to provide for alternative coverage of those patients. The wishes of the patients shall be
4 followed in the selection of an alternative member, if possible.
5

6 **4. Abuse of Process**
7

8 Threats, retaliation or attempted retaliation by members against complainants will give rise to
9 corrective action pursuant to the medical staff bylaws. Individuals who submit a complaint or
10 complaints that are determined to be false shall be subject to corrective action under the
11 medical staff bylaws or hospital employment policies, whichever applies to the individual.
12

13 **ARTICLE VII. HEARING AND APPEALS PROCESS²⁹⁶**
14

15 **A. Initiation and Hearing**
16

17 **1. Triggering Events**
18

19 **a) Recommendations or Actions:**
20

21 The following recommendations or actions, if recommended or taken by the Medical
22 Executive Committee or proposed to be taken or taken by the Board under circumstances
23 in which no prior right to request a hearing existed,²⁹⁷ entitle the respondent to a hearing
24 under timely and proper request.
25

- 26 (1) Denial of initial or renewed medical staff membership;
- 27
- 28 (2) Suspension of staff membership;
- 29
- 30 (3) Revocation or reduction of staff membership;
- 31
- 32 (4) Denial or restriction of requested clinical privileges;
- 33
- 34 (5) Reduction, summary suspension, restriction, or revocation of clinical
35 privileges;
- 36
- 37 (6) Imposition of any mandatory concurrent consultation or supervision
38 requirement;
- 39

²⁹⁶ JC Standard MS.01.01.01, Element of Performance 34, calls for medical staff bylaws to include “The fair hearing and appeal process (refer to Standard MS.10.01.01), which at a minimum shall include:

- The process for scheduling hearings and appeals
- The process for conducting hearings and appeals”

²⁹⁷ The Board may propose an adverse action on an application that has received only favorable action from the medical staff, but the applicant should not be denied hearing rights regarding the proposed final action.

1 (7) [Restriction or denial of access to the hospital facilities and resources
2 necessary to exercise clinical privileges.]²⁹⁸
3

4 **b) Notice of Adverse Recommendation or Action:**
5

6 The administrator promptly gives the respondent special notice of an adverse
7 recommendation or action informing the respondent:²⁹⁹
8

9 (1) of the recommendation or action, and the reasons for it, including
10 identification of the medical staff bylaw section, rule, regulation or policy allegedly
11 violated, description of the respondent’s alleged acts or omissions, a list by number
12 of the specific or representative patient records in questions and/or the other reason
13 or subject matter forming the basis for the adverse action;
14

15 (2) that the respondent has 30 days after receiving the notice to submit a written
16 request for a hearing to the administrator, either in person or by certified or
17 registered mail;
18

19 (3) of the rights related to the hearing available to the respondent pursuant to
20 these bylaws.
21

22 **c) Waiver by Failure to Request a Hearing:**
23

24 A respondent who fails to request a hearing within the time and in the manner here
25 specified waives the right to any hearing or appellate review to which the respondent
26 might otherwise have been entitled. Such waiver applies only to the matters that were the
27 basis for the adverse recommendation or action triggering the notice. The effect of a
28 waiver is as follows:
29

30 (1) After adverse recommendation by the medical executive committee:
31

32 A waiver of a hearing on the Medical Executive Committee recommendation shall
33 also constitute a respondent’s waiver of a right to appeal the Board’s adoption of
34 that recommendation. The Board considers the adverse recommendation as soon as
35 practicable following the waiver. The Board’s action has the following effect:
36

37 (a) If the Board’s action accords in all respects with the Medical Executive
38 Committee’s recommendations, it shall then become effective as the final
39 decision of the Board.
40

²⁹⁸ 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, consistent with *Satilla v. Bell*.

²⁹⁹ These elements are all to be disclosed in the notice, under the HCQIA hearing standards.

1 (b) If, on the basis of the same information and material considered by the
2 Medical Executive Committee in formulating its recommendation, the Board
3 proposes a different adverse action, then the matter shall be resubmitted to the
4 Medical Executive Committee as a new adverse action, subject to the notice and
5 hearing procedures set forth in these bylaws.
6

7 **B. Hearing Prerequisites**

8

9 **1. Notice of Time and Place for Hearing**

10
11 Within seven days after receiving a request for hearing, the administrator shall arrange and
12 schedule a hearing, and shall send the respondent special notice of the time, place and date of
13 the hearing, and a list of the witnesses (if any) expected to testify at the hearing.³⁰⁰ The hearing
14 date shall be not less than 30 or more than 60 days after the administrator has given special
15 notice to the respondent, unless there are valid reasons for non-receipt of the special notice; in
16 which case the date of the hearing can be extended. A hearing for a respondent who is under
17 suspension must be held not later than 21 days after the respondent has been given special
18 notice, if the respondent so requests.³⁰¹
19

20 **2. Statement of Issues and Events**

21
22 The notice of hearing must contain a concise statement of the respondent's alleged acts or
23 omissions, a list by number of the specific or representative patient records in question, and
24 any other reasons or subject matter forming the basis for the adverse action or recommendation
25 which is the subject of the hearing. A list of witnesses expected to testify at the hearing on
26 behalf of the Medical Executive Committee or the Board will be included in the notice. The
27 right to the hearing may be forfeited if the respondent fails, without good cause, to appear.
28

29 **3. Appointment of Hearing Committee**

30
31 **a) Medical staff members:** A hearing occasioned by an adverse recommendation by
32 the Medical Executive Committee or an adverse action by the Board is conducted by a
33 hearing committee appointed by the administrator from a list of medical staff members³⁰²
34 who are not in economic competition with the respondent³⁰³ or otherwise biased against
35 the respondent, provided by the president. The president shall designate one of the
36 members as chairman of the committee.
37

³⁰⁰ Called for by HCQIA hearing standards.

³⁰¹ The HCQIA hearing standards require 30 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.

³⁰² "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

³⁰³ To allow the medical staff input into the membership of the committee while satisfying the HCQIA requirement that the hospital appoint the committee.

1 **b) Service on hearing committee:** A medical staff member is not disqualified from
2 serving on a hearing committee solely because of prior knowledge of the facts involved
3 or what the member supposes the facts to be. The member or members whose adverse
4 recommendation or action initiated the hearing shall not serve on the hearing
5 committee.³⁰⁴
6

7 **c) Voir dire:** The respondent shall have the right to a reasonable opportunity to
8 challenge the impartiality of the hearing committee members and the hearing officer.
9 The hearing officer shall establish the procedure by which this right may be exercised,
10 which may include reasonable requirements that questions be proposed in writing in
11 advance of the hearing and that the questions be presented and responded to by the
12 hearing officer. The hearing officer shall rule on any challenges in accordance with
13 applicable legal principles defining standards of impartiality for hearing panels and
14 hearing officers in proceedings of this type.
15

16 **C. Hearing Procedure**

17 **1. Personal Presence:**

18
19
20 The personal presence of the respondent is required at the hearing. [A respondent who fails
21 without good cause to appear and proceed at the hearing waives the right to hearing and appeal
22 with the same consequences as provided above regarding waivers.] If the respondent fails
23 without good cause to appear and proceed with the hearing requested, the hearing committee
24 will review the adverse recommendation or decision, as well as any pertinent available
25 information and recommend that the adverse recommendation or decision involved be
26 considered as voluntarily accepted, or recommend that the recommendation be rejected, or that
27 a different corrective action be recommended. If the hearing committee recommends that the
28 adverse recommendation or decision be considered as voluntarily accepted, further hearing and
29 appeal rights are waived, and the recommendation will be forwarded to the Board for final
30 action. If the hearing committee recommends that the recommendation be completely rejected,
31 the Medical Executive Committee will be provided with the opportunity to appeal under the
32 appeal process established by these bylaws. If the hearing committee recommends that a
33 different corrective action be recommended, the recommendation will be treated as a new
34 recommendation for corrective action under these bylaws.
35

36 **2. Presiding Office**

37
38 The hearing officer, if appointed, or if not appointed, the hearing committee chairman, shall be
39 the presiding officer. If a hearing officer is appointed, the hearing officer, who shall be an
40 attorney-at-law who does not routinely represent the hospital, the respondent or the medical
41 staff, shall be mutually agreed upon by the president in consultation with the Medical
42 Executive Committee, on behalf of the medical staff, and by the administrator, on behalf of the

³⁰⁴ 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.

1 Board, and shall be appointed by the administrator on behalf of the Board.³⁰⁵ The hearing
2 officer may not be in direct economic competition with the practitioner involved.³⁰⁶
3

4 The presiding officer shall maintain decorum and assure that all participants have a reasonable
5 opportunity to present relevant oral and documentary evidence. The presiding officer shall
6 determine the order of procedure during the hearing and shall make all rulings on matters of
7 procedure. A hearing officer shall have no vote on the committee, but may participate in the
8 committee deliberations and write the final recommendation and report as directed by the
9 committee.
10

11 **3. Representation**

12

13 The respondent may be accompanied and represented at the hearing by an attorney or by any
14 other person of the respondent's choice.³⁰⁷ The Medical Executive Committee or Board,
15 depending on whose recommendation or action prompted the hearing, shall appoint an attorney
16 or other individual to represent it.
17

18 **4. Rights of Parties**

19

20 During a hearing, each party may:

- 21 a) call and examine witnesses;
- 22 b) introduce exhibits;
- 23 c) cross-examine any witness on any matter relevant to the issues;
- 24 d) impeach any witness;
- 25 e) rebut any evidence;
- 26
- 27
- 28
- 29
- 30
- 31

32 If the respondent does not testify on his or her own behalf, the respondent may be called and
33 examined as if under cross-examination.
34

³⁰⁵ To accommodate the HCQIA requirement that the hospital should appoint the hearing officer, while allowing the medical staff to participate in the decision.

³⁰⁶ Consistent with HCQIA standards.

³⁰⁷ The subject has the right to be represented by an attorney or any other person of the subject's choice, under HCQIA hearing standards.

1 **5. Pre-Hearing Meeting**

2
3 The presiding officer may require a pre-hearing conference for purposes of document
4 exchange, establishing basic rules concerning the number and type of witnesses who may be
5 called by either party, the length of testimony, role of legal counsel, length of direct and cross-
6 examination, order and length of initial and closing arguments as well as other matters deemed
7 necessary to the conduct of a fair, orderly, and efficient hearing process.
8

9 **6. Procedure and Evidence**

10
11 The hearing need not be conducted according to rules of law relating to the examination of
12 witnesses or presentation of evidence. Any relevant matter upon which responsible persons
13 might customarily rely in the conduct of serious affairs may be considered regardless of the
14 admissibility of such evidence in a court of law. Each party shall be entitled, prior to or during
15 the hearing, and at the close of the hearing,³⁰⁸ to submit memoranda which shall become part
16 of the hearing record.
17

18 **7. Official Notice**

19
20 In reaching a decision, the hearing committee may take official notice, either before or after
21 submission of the matter for decision, or any generally accepted technical or scientific matter
22 relating to the issues under consideration and of any facts that may be judicially noticed by the
23 courts of the state where the hearing is held. Parties present at the hearing must be informed of
24 the matters to be noticed, and those matters must be noted in the hearing record. Any party
25 shall be given opportunity, on timely request, to request that a matter be officially noticed and
26 to refute any official noticed matter by evidence or by written or oral presentation of authority,
27 in a manner to be determined by the hearing committee.
28

29 **8. Burdon of Proof³⁰⁹**

30
31 The Medical Executive Committee shall have the initial duty to present evidence in support of
32 its action or recommendation. The respondent shall be obligated to present evidence in
33 response. Any member applying for privileges he or she does not currently hold or an
34 applicant applying for medical staff membership and privileges shall bear the burden of
35 persuading the hearing committee, by a preponderance of the evidence, of his or her
36 qualifications by producing information that allows for adequate evaluation and resolution of
37 reasonable doubts concerning his or her current qualifications for membership and privileges.
38 The respondent shall not be permitted to introduce information requested by the medical staff
39 but not produced during the application process without establishing that the information could
40 not have been produced previously in the exercise of reasonable diligence.
41

³⁰⁸ Under the HCQIA standards, the subject also has the right to submit a written statement at the close of hearing.

³⁰⁹ 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.

1 Except as provided above, throughout the hearing, the Medical Executive Committee
2 shall bear the burden of persuading the hearing committee, by a preponderance of the
3 evidence,³¹⁰ that its action or recommendation is reasonable and warranted. If the
4 evidence on a particular issue is so evenly balanced that the hearing committee is
5 unable to say that the evidence on either side preponderates, the hearing committee
6 must find on that issue against the party who had the burden of proving it. In
7 evaluating the evidence, the hearing committee should consider all of the evidence
8 bearing on every issue regardless of which party produced it or had the burden of proof
9 on the issue.

10 **9. Hearing Record**

11 A record of the hearing shall be made by a court reporter. Transcripts shall be made available
12 upon request of any party, at reasonable cost.³¹¹

13 **10. Postponement**

14 Request for postponement of a hearing may be granted by the hearing committee only upon
15 showing a good cause and only if the request is made as soon as is reasonably practical.

16 **11. Presence of Hearing Committee Members and Vote**

17 A majority of the hearing committee must be present throughout the hearing and deliberations.
18 If a committee member is absent from any substantial part of the proceedings, that member
19 may not participate in the deliberations or the decision.

20 **12. Recesses and Adjournment**

21 The presiding officer may recess and reconvene the hearing without additional notice for the
22 convenience of the participants or for the purpose of obtaining new or additional evidence or
23 consultation. The hearing committee must reconvene in a timely manner and in any event the
24 recess must not exceed 10 days. Upon conclusion of the presentation of oral and written
25 evidence, the hearing shall be closed. At the close of hearing, both the parties to the hearing
26 may provide the hearing committee with a written statement.³¹² The hearing committee shall,
27 at a time convenient to itself, conduct its deliberations outside the presence of the parties.
28 Upon conclusion of its deliberations, the hearing shall be adjourned. Adjournment shall be no
29 later than seven days after the hearing is closed.

30 **D. Hearing Committee and Further Action**

³¹⁰ “Preponderance of the evidence” means evidence that has more convincing force than that opposed to it.

³¹¹ All records should be made consistently by a 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.

³¹² The HCQIA calls for the right to submit a written statement at the close of the hearing.

1 **1. Hearing and Committee Report**

2
3 Within 10 days after final adjournment of the hearing, the hearing committee makes a written
4 report of its findings and recommendations, with specific reference to the hearing record and
5 other documentation considered, and forward the report along with the record and other
6 documentation to the Medical Executive Committee.

7
8 **2. Notice and Effect of Results**

9
10 **a) Notice:** The administrator promptly sends a copy of the result and the basis for the
11 decision to the respondent by special notice, to the president, and to the Board.

12
13 **b) Effect of favorable result:** If the hearing committee’s result is favorable to the
14 respondent, the administrator shall include in the notice to the Medical Executive
15 Committee its right to request an appellate review by the Board as provided in these
16 bylaws.³¹³ If there is no appeal by the Medical Executive Committee, the Board may act
17 on the hearing committee result or refer the matter back to the Medical Executive
18 Committee for further consideration. Any referral back shall state the reasons, set a time
19 within which a subsequent recommendation must be made, and may include a directive
20 for any additional hearing. After receiving a subsequent recommendation and any new
21 evidence, the Board takes action.

22
23 If the Board’s action is favorable, it becomes the final action. If the Board determines
24 that the hearing committee’s result is not supported by the evidence or was not reached
25 consistent with these bylaws, it may reject it and impose the original Medical Executive
26 Committee recommendation or a variant thereof. If the Board determines to impose a
27 variant of the original action, and such action would adversely and differently affect the
28 respondent, the administrator then promptly provides the respondent with special notice
29 informing the respondent of the right to request a new hearing on the changed action.

30
31 **c) Effect of an adverse result:** If the decision by the hearing committee is adverse to
32 the respondent, then special notice of the hearing committee decision shall notify the
33 respondent of the right to request an appellate review by the Board as provided these
34 bylaws. If there is no appeal, the Board shall act on the hearing committee result. The
35 Board may adopt the hearing committee’s result as the final action. If the Board
36 determines that the hearing committee’s result is not supported by the evidence or was
37 not reached consistent with these bylaws, it may reject it and impose a variant thereof or
38 determine that no action against the respondent should be taken. If the Board imposes a
39 variant adverse action, the administrator shall then promptly provide the respondent with
40 special notice informing the respondent of the right to request an appellate review by the
41 Board.

42

³¹³While the MEC 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.

1 **E. Initiation and Prerequisites of Appellate Review**

2
3 **1. Request for Appellate Review**

4
5 A party has 10 days after receiving special notice to file a written request for an appellate
6 review. The request must be delivered to the administrator in person or by certified or
7 registered mail and may include a request for a copy of the hearing committee report and
8 record and all other material, favorable to unfavorable, if not previously forwarded, that was
9 considered in taking the adverse recommendation or action. If the party wishes to be
10 represented by an attorney at any appellate review appearance, the request for appellate review
11 must so state.

12
13 **2. Waiver by Failure to Request Appellate Review**

14
15 A respondent who fails to request an appellate review within the time frame and in the manner
16 specified waives any right to a review.

17
18 **3. Notice of Time and Place for Appellate Review**

19
20 The administrator delivers a timely and proper request to the chairman of the Board. As soon
21 as practicable, the Board schedules and arranges for an appellate review which shall be not less
22 than ten 10 days nor more than 21 days after the administrator received the request; provided,
23 however, that appellate review for a member who is under a suspension then in effect shall be
24 held as soon as the arrangements for it may be reasonably made, but not later than 21 days after
25 the administrator received the request. At least 10 days prior to the appellate review, the
26 administrator sends the respondent special notice of the time, place and date of the review.
27 The time may be extended by the appellate review body for good cause and if a request is
28 made as soon as is reasonably practical.

29
30 **4. Appellate Review Body**

31
32 The Board shall determine whether the appellate review shall be conducted by the Board as a
33 whole or by an appellate review committee of three members of the Board appointed by the
34 chairman of the Board. If a committee is appointed, one of its members shall be designated as
35 chairman, and its decision shall be adopted by the Board as the final action at its next meeting
36 unless it is not supported by the evidence or reached in a manner inconsistent with these
37 bylaws.³¹⁴ No members may participate in or act on the appeal if they are in direct economic
38 competition with the appellant or member or otherwise biased against the individual or
39 personally benefit from the outcome.³¹⁵

40

³¹⁴ 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.

³¹⁵ The appellate body also must be impartial.

1 **F. Appellate Review Procedure and Final Action**

2
3 **1. Nature of Proceedings**

4
5 The proceedings by the review body are a review based upon the hearing record, the hearing
6 committee’s report, all subsequent results and action, the written statements, if any, provided
7 below and any other material that may be presented and accepted under this article.
8

9 **2. Written Statements**

10
11 The parties may submit written statements detailing the findings of fact, conclusions and
12 procedural matters with which each disagrees and the reasons therefor. The written statements
13 may cover any matters raised at any step in the hearing process. The statements are submitted
14 to the appellate review body through the administrator at least 10 days prior to the scheduled
15 date of the review, except if the time is waived by the review body. The administrator shall
16 provide a copy of the statements to the opposing parties at least 10 days prior to the scheduled
17 date of the appellate review.
18

19 **3. Presiding Officer**

20
21 The chairman of the appellate review body is the presiding officer, who shall determine the
22 order of procedure during the review, make all required rulings and maintain decorum.
23

24 **4. Oral Statements**

25
26 The appellate review body allows the parties or their representatives to personally appear and
27 make oral statements in favor of their positions.³¹⁶ Any party or representative appearing is
28 required to answer questions put by any member of the review body.
29

30 **5. Consideration of New or Additional Matters:**

31
32 New or additional matters or evidence not raised or presented during the original hearing or in
33 the hearing report and not otherwise reflected in the record may be introduced at the appellate
34 review only in the discretion of the review body and as the review body deems appropriate,
35 only if the party requesting consideration of the matter of evidence shows that it could not have
36 been discovered with reasonable diligence in time of the initial hearing and that the new or
37 additional matters would have reasonable likelihood of changing the result. The requesting
38 party shall provide, through the administrator, a written, substantive description of the matter
39 or evidence to the appellate review body and the other party at least three days prior to the
40 scheduled date of the review.
41

³¹⁶ 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.

1 **6. Powers**

2
3 The appellate review body has all the powers granted to the hearing committee, and any
4 additional powers that are reasonably appropriate to, or necessary for the discharge of
5 responsibilities.

6
7 **7. Presence of Members and Vote**

8
9 A majority of the review body must be present throughout the review and deliberations. If a
10 member is absent from any part of the proceedings, he/she shall not be permitted to participate
11 in the deliberations or the decision.

12
13 **8. Recesses and Adjournments**

14
15 The review body may recess and reconvene the proceedings without additional notice for the
16 convenience of the participants or for the purpose of obtaining new or additional evidence or
17 consultation. At the conclusion of the oral statements, if allowed, the appellate review shall be
18 closed. The review body shall then, at a time convenient to itself, conduct its deliberations
19 outside the presence of the parties. The appellate review shall be adjourned at the conclusion
20 of those deliberations.

21
22 **9. Action Taken**

23
24 The review body may affirm, modify or reverse the result or action or in its discretion, may
25 refer the matter back to the hearing committee for further review and recommendation to be
26 returned to it within 21 days and in accordance with its instructions. Within 10 days after
27 receipt of such recommendation after referral, the review body shall take action. The action is
28 immediately effective if the review body is the Board itself, or if the review body is a
29 committee, the decision shall be directly referred to the Board for final action. The decision
30 shall be in writing, shall specify the reasons for the action taken and shall be forwarded to the
31 president, the medical executive and credential committees, the respondent,³¹⁷ and the
32 administrator.

33
34 **G. General Provisions**

35
36 **1. Number of Hearings and Reviews**

37
38 Notwithstanding any other provision of the medical staff bylaws, no respondent is entitled to
39 request more than one evidentiary hearing and appellate review with respect to the subject
40 matter that is the basis of the adverse recommendation or action.

41

³¹⁷ 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.

1 **2. Release**

2
3 By requesting a hearing or appellate review under this plan, the respondent agrees to be bound
4 by the provisions of the medical staff bylaws relating to immunity from liability.
5

6 **3. Challenges to Rules**

7
8 The hearing committee is not authorized to modify, limit, or overrule any rule or requirement,
9 and shall not entertain challenges to such rules and requirements. Any medical staff member
10 who wishes to challenge an established rule or requirement involving the subject matter of a
11 hearing must first notify the Medical Executive Committee of the rule or requirement he/she
12 wishes to challenge, and of the basis for the challenge. If the Medical Executive Committee
13 decides to reconsider the particular rule or requirement, the Medical Executive Committee may
14 stay the action recommended against the member pending the outcome of the process of
15 reconsidering the rule or requirement.
16

17 **ARTICLE VIII. ALLIED HEALTH PROFESSIONALS**

18
19 Each allied health professional (AHP) shall be assigned to the medical staff department [and
20 section] [service] appropriate to his or her occupational or professional training and, unless
21 otherwise specified in the medical staff bylaws, rules and regulations, shall be subject to terms
22 and conditions paralleling those specified for medical staff members as they may logically be
23 applied to AHPs, whether employed by the hospital or another health care entity or by licensed
24 independent practitioners, to promote a uniform standard of quality patient care.
25

26 **A. Sponsored AHPs**

27
28 In the event an AHP's required sponsor or supervisor loses or resigns clinical privileges or the
29 legal right to sponsor and/or supervise the AHP, then the AHP's privileges are automatically
30 suspended. This shall not be deemed an adverse action, and shall not entitle the AHP to the
31 procedural rights set forth in this article. The AHP may be reinstated upon substitution, within 90
32 days, of another qualified medical staff member sponsor or supervisor. If the sponsor or
33 supervisor is not substituted within this period, the AHP privileges terminate.
34

35 **B. AHP Hearing and Appeal Process³¹⁸**

36
37 **1. Hearing Process**

38
39 Whenever the Medical Executive Committee or the Board makes a recommendation or
40 proposes to take an action to restrict or deny an AHP's clinical privileges for more than 30
41 days or any application therefor, the administrator shall provide the AHP with written notice of

³¹⁸ JC Standard MS.01.01.01, Element of Performance 34, calls for bylaws to include "[a] fair hearing and appeal process..." JC Standard MS.10.01.01, Element of Performance 1, states that the fair hearing and appeal process "is designed to provide a fair process that may differ for members and nonmembers of the medical staff. (See also MS.06.01.09, EP 5)." Because the HCQIA does not apply to any other professionals other than dentists and physicians, its hearing standards need not be met either.

1 the recommendation, the reasons therefor and the time period within which the AHP can
2 request a hearing.³¹⁹ If a hearing is requested, the president shall name, and the administrator
3 shall appoint, a committee of three unbiased medical staff members and allied health
4 professionals with clinical privileges³²⁰ to hear the AHP's objections to the proposed action or
5 recommendation no sooner than 30 days from the date of the request. A record of the hearing
6 shall be made. The committee's recommendation shall be in writing, shall reflect
7 consideration of the information presented at the hearing, and shall be provided to the AHP, the
8 Medical Executive Committee, and the Board.

9 10 **2. Appeals**

11
12 The AHP and the Medical Executive Committee each have the right to appeal the committee's
13 recommendation by submitting written statements to the Board within 30 days of receipt of the
14 recommendation. The Board, or a committee thereof, shall review the parties' written
15 submissions. If the appeal is reviewed by a committee, it shall promptly provide the parties
16 and the Board with its recommendation. Upon consideration of the hearing committee
17 recommendation and the information presented at appeal, the Board shall take final action and
18 shall thereupon provide all parties with its decision, and the reasons therefor, in writing.

19 20 **3. Reporting**

21
22 Final actions regarding AHPs' privileges shall not be reported to the National Practitioner Data
23 Bank.³²¹

24 25 **ARTICLE IX. INDEMNIFICATION³²²**

26
27 The hospital shall defend (or cover the costs incurred for defense by), and cover settlements,
28 judgments and damages amounts on behalf of any medical staff leader or other member of the
29 medical staff serving on or assisting any hospital or medical staff committee, or assisting in peer
30 review or quality management activities involving care provided at the hospital, involved in
31 claims arising out of such activities, so long as the member of the medical staff acted in good
32 faith.

³¹⁹ 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."

³²⁰ JC Standard MS.10.01.01, Element of Performance 4, states, "The organized medical staff has developed a fair hearing and appeal process addressing quality of care issues that has the following characteristics: 4. Identifies the composition of the hearing committee as a committee that includes impartial peers. (See also MS.06.01.09, EP 5)"

³²¹ Adverse actions against allied health professionals are optional under the National Practitioner Data Bank (NPDB) 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.

³²² 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.

1 **ARTICLE X. BYLAWS, RULES AND REGULATIONS AND POLICY**
2 **AMENDMENT AND EFFECT**³²³

3
4 Medical staff organization documents shall be adopted and amended strictly and exclusively
5 according to the process established in these bylaws.
6

7 **A. Policy**
8

9 The Medical Executive Committee, or the medical staff, after communicating with the members
10 of its Medical Executive Committee present,³²⁴ shall review, develop and adopt policies that are
11 binding upon the medical staff and its members and those otherwise holding clinical
12 privileges.³²⁵ Such policies must be consistent with the medical staff bylaws, rules and
13 regulations. Only policies adopted consistent with this section are binding upon the medical staff
14 and its members. Any medical staff policies approved by the Board are upheld by the Board.³²⁶
15 Amendments to medical staff policies are to be distributed in writing to medical staff members
16 and those otherwise holding clinical privileges in a timely and effective manner.³²⁷
17

18 **B. Rules and Regulations**
19

20 The medical staff shall initiate and adopt such rules and regulations as may be necessary to
21 implement more specifically the general principles found within these bylaws and to delineate
22 the level of practice that is to be required of each practitioner in the hospital.³²⁸ Suggestions for
23 changes in the rules and regulations may be referred to the Bylaws Committee, which shall
24 present its recommendations in a timely fashion to the Medical Executive Committee for review
25 and comment and referral to the medical staff. In addition, rules and regulations amendments
26 can be proposed by a petition signed by [20] members in good standing, without any committee

³²³ Under JC Standard MS.01.01.01, Elements of Performance 24 and 25, medical staff bylaws are to include the processes for adopting and amending medical staff bylaws, rules and regulations, and policies.

³²⁴ Implementing JC 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...”

³²⁵ Consistent with JC Standard MS.01.01.01, Element of Performance 1, which states that “[t]he organized medical staff develops medical staff bylaws, rules and regulations, and policies.”

³²⁶ JC Standard MS 01.01.01, Element of Performance 7, states, “[t]he governing body upholds the medical staff bylaws, rules and regulations, and policies that have been approved by the governing body.”

³²⁷ Consistent with JC 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.

³²⁸ 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 Georgia Regulation 111-8-40-.11(c)7; designation of who is qualified to conduct an emergency medical screening examination where emergency services are provided, called for in Georgia Regulation 111-8-40-.11(c)8; requirements for the patient’s history and physical examination, called for in Georgia Regulation 111-8-40-.11(c)10; requirements for medical records completion, called for in Georgia regulations 111-8-40-.11(c)12; requirements for verbal orders, called for in Georgia Regulation 111-8-40-.11(c)13; and autopsy requirements, called for in Georgia Regulation 111-8-40-.11(d).

1 review.³²⁹ The rules and regulations shall only be amended, added to, or repealed at a regular or
2 special meeting of the medical staff at which a quorum is present by a majority vote of those
3 active staff members present. All amendments, additions, or recommendations for rule and
4 regulations repeal must be presented to the medical staff at least 15 days prior to the meeting at
5 which they are to be acted upon. Rules and regulations changes shall become effective when
6 approved by the Board,³³⁰ which shall not be unreasonably withheld.³³¹

8 **C. Bylaws Amendment**³³²

9
10 The medical staff shall initiate and adopt such medical staff bylaws as may be appropriate for
11 operation of the medical staff.³³³ Suggestions for changes in the bylaws shall be referred to the
12 Bylaws Committee, which shall present its recommendations in a timely fashion to the Medical
13 Executive Committee for review and comment and referral to the staff. In addition, medical staff
14 bylaws amendments can be proposed by a petition signed by [20] members in good standing,
15 without any committee review.³³⁴ All amendments, additions, or recommendations for medical
16 staff amendment must be circulated to the medical staff at least 15 days prior to the meeting at
17 which they are to be acted upon. Amendments can be made at a regular or special meeting of the
18 medical staff at which a quorum is present, by a majority vote of those active staff members

³²⁹ JC 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.”

³³⁰ Georgia Regulation 111-8-40-.09 (b) states, “The governing body shall appoint members of the medical staff within a reasonable period of time after considering the recommendations of the medical staff, if any, and shall ensure the following: “...2. That the medical staff is organized and operates under medical staff bylaws and medical staff rules and regulations, which shall become effective when approved by the governing body;...”

³³¹ “The AMA believes that (1) the medical staff bylaws, rules and regulations should be initiated and adopted by the voting members of 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 Executive Committee of the medical staff, whose members are selected in accordance with criteria and standards established by the medical staff bylaws; and (3) the voting members of 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

³³² 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...” Under JC Standard MS.01.01.01, Element of Performance 24, the medical staff bylaws are to include “[t]he process for adopting and amending the medical staff bylaws.”

³³³ JC Standard MS.01.01.01, Element of Performance 1, states, “The organized medical staff develops medical staff bylaws, rules and regulations, and policies.”

³³⁴ JC 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.”

1 present. Bylaws amendments shall become effective when approved by the Board,³³⁵ which shall
2 not be unreasonably withheld.³³⁶
3

4 **D. Technical Amendments**

5

6 The Medical Executive Committee has the authority to adopt such amendments to the policies,
7 rules and regulations, and bylaws as are, in its judgment, strictly technical clarifications, or
8 renumbering of the bylaws or amendments made necessary because of punctuation, spelling or
9 other errors of grammar or expression. After adoption, such amendments shall be communicated
10 in writing to the medical staff and to the Board. Such amendments shall be effective
11 immediately but are subject to reversal by vote of the medical staff or the Board within 90 days
12 of adoption by the Medical Executive Committee. The action to amend may be taken by motion
13 acted upon in the same manner as any other motion before the Medical Executive Committee.
14

15 **E. Direct Medical Staff Amendment Process**³³⁷

16

17 In addition to the processes established in this article, amendments to the medical staff bylaws,
18 rules and regulations and policies can be adopted by action of the medical staff, without action
19 by the Medical Executive Committee, at any general medical staff meeting or any special
20 medical staff meeting called for the purpose of amending the bylaws, provided a quorum is
21 present, by a majority vote of those active members present.
22

23 **F. Effect of the Policies, Rules and Regulations and Bylaws**

24

25 **1. Effect of Conflicts**

26

27 **a) Among Medical Staff Documents.** If there is a conflict between the policies and
28 the rules and regulations, the rules and regulations prevail. If there is a conflict between
29 the bylaws and rules and regulations, the bylaws shall prevail.
30

³³⁵ Georgia Regulation 111-8-40-.09(b) states, “The governing body shall appoint members of the medical staff within a reasonable period of time after considering the recommendations of the medical staff, if any, and shall ensure the following: ... 2. That the medical staff is organized and operates under medical staff bylaws and medical staff rules and regulations, which shall become effective when approved by the governing body...” JC Standard MS.01.01.01, Element of Performance 2 states, “...(medical staff) [b]ylaws become effective only upon governing body approval.”

³³⁶ “The AMA believes that (1) the medical staff bylaws, rules and regulations should be initiated and adopted by the voting members of 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 Executive Committee of the medical staff, whose members are selected in accordance with criteria and standards established by the medical staff bylaws; and (3) the voting members of 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

³³⁷ JC 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. ”

1 **b) Between Medical Staff Bylaws and Hospital Documents.** If there is a conflict
2 between the medical staff bylaws and the hospital bylaw or policies, the medical staff
3 bylaws shall prevail as the only mutually adopted document.³³⁸
4

5 **2. Exclusivity**
6

7 The mechanisms described herein shall be the sole method for the initiation, adoption,
8 amendment, or repeal of the medical staff rules and regulations.
9

10 **3. Effect of the Bylaws**
11

12 Upon adoption and approval of these bylaws, the hospital and the medical staff agree that these
13 bylaws shall be binding upon the medical staff,³³⁹ its members,³⁴⁰ and upon the hospital,³⁴¹ and
14 upon any successor interest in this hospital. Affiliations between the hospital and other
15 hospitals, health care systems or other entities shall not, of themselves, affect these bylaws.³⁴²

³³⁸ Under JC 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.

³³⁹ Under JC Standard MS.01.01.01, Element of Performance 5, “[t]he medical staff complies with the medical staff bylaws, rules and regulations, and policies.”

³⁴⁰ AMA Principles 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

³⁴¹ As Georgia courts stated in *St. Mary’s Hospital* and reiterated in *Satilla*, “...notwithstanding the broad power of a hospital authority to control the administrative, operational, and managerial functions of the facility and its staff, a public hospital authority cannot abridge or refuse to follow its existing bylaws concerning staff privileges...Since the issue is existence of a legal duty to follow procedures established pursuant to state law, not the presence of state action, we see no reason to distinguish between public and private hospitals in this context. Both are required to establish staff bylaws; therefore, both should be required to follow those bylaws.” This section also implements JC Standard MS.01.01.01, Element of Performance 7, which states that “[t]he governing body upholds the medical staff bylaws, rules and regulations, and policies that have been approved by the governing body.”

³⁴² “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

**MAG MODEL MEDICAL STAFF BYLAWS
TABLE OF AUTHORITIES**

CASES

Abbreviation Used in Model Bylaws	Complete Title	Citation	Summary
<i>Alonso v. Hosp. Auth. of Henry County</i>	Alonso v. Hospital Authority of Henry County et al.	175 Ga. App. 198, 332 S.E.2d 884 (1985)	The exclusive contract failed to reference the medical staff bylaws termination procedures, so Dr. Alonso had no contract right to the bylaws provisions. Dr. Alonso was limited to the contract termination process, which was appropriately followed.
<i>Baldwin County Hosp. Auth. v. Wright</i>	Baldwin County Hospital Authority et al. v. Wright	202 Ga. App. 9, 413 S.E.2d 484 (1991)	An order allowing Dr. Wright to discover committee proceedings was overturned because Georgia statutes provide an absolute privilege, even in the face of bad faith.
<i>Cobb County Kennestone Hosp. Auth. v. Prince</i>	Cobb County-Kennestone Hospital Authority v. Prince et al.	242 Ga. 139, 249 S.E.2d 581 (1978)	A hospital can enforce its resolution/policy (here, requiring the use of hospital-owned equipment) through credentialing and privileging actions, akin to hospital decisions to exclusively contract, as an administrative decision not subject to judicial intervention.
<i>Emory Clinic v. Houston</i>	Emory Clinic v. Houston; and vice versa	258 Ga. 434, 369 S.E.2d 913 (1988)	A malpractice action seeking information from the peer review/medical review process yielded this

			frequently quoted Georgia Supreme Court opinion describing state peer review laws as placing “an absolute embargo upon the discovery and use of all proceedings, records, findings and recommendations of peer review groups and medical review committees in civil litigation.”
<i>Doe v Leavitt</i>	John Doe, M.D. v. Leavitt, Secretary of HHS	552 F.3d 75 (1st Cir. 2009)	Denying physician’s challenge to data bank report on the grounds that the investigation had not been closed.
<i>South Georgia Medical Center v. Meeks</i>	Hospital Authority Of Valdosta And Lowndes County, D/B/A South Georgia Medical Center v. Meeks	285 Ga. 521, 678 S.E.2d 71 (2009)	Limiting peer review confidentiality protection to peer review committee evaluations, stripping it from the credentialing information itself.
<i>Hollowell v. Jove</i>	Hollowell v. Jove, et al.	247 Ga. 678, 279 S.E.2d 430 (1981)	Disclosing whether medical review committee meetings included review of a certain case, and who attended the meetings, intruded on committee proceedings and was not allowed under Georgia confidentiality protection.
<i>Patrick v. Floyd</i>	Patrick v. Floyd Medical Center, et al	255 Ga. App. 435, 565 S.E.2d 491 (2002)	Compares and contrasts the Georgia state law immunity for peer review with the federal immunity established in

			the HCQIA. Georgia statute “protects peer review <i>unless</i> (the peer reviewer) was motivated by malice toward any person affected by such activity.” (O.C.G.A. § 31-7-132) The HCQIA does not disqualify peer review motivated by malice but protects peer review that meets its conditions of good faith peer review. The court held that Georgia’s “motivating malice” condition is preempted by the HCQIA.
<i>Patton v. St Francis</i>	Patton v. St. Francis Hospital et al.	260 Ga. App. 202, 581 S.E.2d 551 (2003)	Yearlong review of Dr. Patton’s care in a case in which failure to order a test may have changed the outcome, which resulted in termination recommendation. Dr. Patton’s request for committee minutes and other peer review information was appropriately denied due to the strong legislative intent to protect review proceedings from discovery and grant immunity from civil liability to review participants.
<i>Lee v. Hosp. Auth. of Colquitt County</i>	Jerry Jackson Lee II, D.O. v. Hospital Authority of Colquitt County	397 F.3d 1327 (11th Cir. 2005)	Dr. Lee asked to resign in lieu of proceeding with investigation of his competence and

			obtained a letter stating his privileges had not been adversely acted upon. His challenge to the hospital's report of his resignation to the National Practitioner Data Bank was unsuccessful because the report was consistent with the HCQIA.
<i>Satilla v. Bell</i>	Satilla Health Services Inc. v. Bell et al.; Satilla Health Services Inc. v. Pilcher et al.	280 Ga. App. 123, 633 S.E.2d 575 (2006)	Hospital's attempt to impose exclusivity by contract and by barring non-contracting cardiologists' access to hospital resources through Board resolution failed under the court's finding that Georgia law did not permit an exclusive contract with a corporation to trump medical staff bylaws.
<i>St. Mary's v. Radiology Professional Corporation</i>	St. Mary's Hospital of Athens, Inc. v. Radiology Professional Corporation, et al.	205 Ga. App. 121, 421 S.E.2d 731 (1992)	St. Mary's Hospital's attempt to terminate its contract with Dr. Cohen and his professional corporation was inconsistent with medical staff bylaws provisions on termination of privileges. The court held that, like public hospitals, private hospitals cannot arbitrarily ignore or abridge medical staff bylaws; both public and private hospitals must follow the medical staff

			<p>bylaws. The court acknowledged the hospital's right to exclusively contract but held that it cannot exercise that right in a manner inconsistent with the medical staff bylaws. The decision instructs hospitals that they can terminate privileges to protect exclusivity for contracts, but only if permitted by the bylaws themselves or the contracts with individual physicians (rather than only in the physician's professional corporations contracts).</p>
<p><i>Stein v. Tri-City Hosp. Auth.</i></p>	<p>Stein v. Tri-City Hospital Authority d/b/a South Fulton Hospital</p>	<p>192 Ga. App. 289, 384 S.E.2d 430 (1989)</p>	<p>Dr. Stein's challenge against revocation of membership due to his failure to meet new malpractice insurance requirements failed. Medical staff bylaws authority over members does not support contract rights in members. In Georgia, the practice of medicine is a privilege not a right. Georgia follows the minority view in that bylaws which are subject to the ultimate authority of the governing Board of the hospital do not constitute a binding agreement between the medical staff and the hospital.</p>

<p><i>Whitaker v. Houston County Hosp. Auth.</i></p>	<p>Whitaker v. Houston County Hospital Authority et al.; and vice versa</p>	<p>272 Ga.App. 870, 613 S.E.2d 664 (2005)</p>	<p>Dr. Whitaker's challenge to termination of all his privileges, not only those made exclusive by contract, failed even though the hospital could not disregard the medical staff bylaws under Georgia law, because the contract Dr. Whitaker had signed clearly stated that all privileges would terminate with the contract, and that the right to challenge the termination would be waived. There is no question that a hospital authority has the right to enter into an exclusive contract.</p>
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FEDERAL REGULATIONS & STATUTES

Abbreviation Used in Model Bylaws	Complete Title	Citation	Summary
EMTALA	Emergency Medical Treatment and Active Labor Act of 1986	42 U.S.C. §1395dd see also: EMTALA INTERP GUIDELINES 42 C.F.R. §489.24 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. § 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. §482.42(a)	Medicare Conditions of Participation	42 C.F.R. §482.42(a) et seq.	Federal regulations setting forth the requirements for Medicare participation, including the section cited that calls for designation of an infection control officer or officers.
Medicare exclusion	OIG Exclusion from Federal Health Care Programs	42 C.F.R. §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 regulations	National Practitioner Data Bank for Adverse Information on Physicians and Other Health Care Practitioners	45 C.F.R. § 60.1 et seq.	Regulations detailing what licensure actions, credentialing action and malpractice payments must be reported federally.

STATE REGULATIONS & STATUTES

Abbreviation Used in Model Bylaws	Complete Title	Sections Cited	Summary
Georgia Regs	<p align="center">Department of Community Health (DCH) Rules Of Department Of Community Health Health care Facility Regulation</p> <p align="center">Chapter 111-8-40 Rules And Regulations For Hospitals</p>	<p align="center">GA Comp. R. & Regs. 111-8-40 et seq.</p> <p align="center">(replaced 290-9-7 et seq.)</p>	<p>Georgia DCH Rules and Regulations for hospitals setting out the minimum requirements for state licensure.</p>
O.C.G.A. § 31-7-x	<p align="center">Title 31 Chapter 7 Regulation And Construction Of Hospitals And Other Health Care Facilities (2012)</p>	<p align="center">O.C.G.A. § 31-7-1 et seq.</p>	<p>Georgia statutes including peer review and confidentiality protections for medical staff.</p>
O.C.G.A. § 31-12-x	<p align="center">Title 31 Chapter 12 Control of Hazardous Conditions, Preventable Diseases, And Metabolic Disorders (2012)</p>	<p align="center">O.C.G.A. § 31-12-2(a)</p>	<p>Authorized DCH to require reporting of certain diseases and related data for statistical and research purposes, such as the Georgia Comprehensive Cancer Registry.</p>

OTHER RESOURCES

Abbreviation Used in Model Bylaws	Complete Title	Citation	Summary
American College of Surgeons Commission on Cancer, Cancer Program Standards	American College of Surgeons Commission on Cancer, Cancer Program Standards 2012 V1.1	www.facs.org/cancer/coc/programstandards2012.pdf	The multi-disciplinary Commission on Cancer of the American College of Surgeons establishes standards for the delivery of cancer care; assesses compliance with those standards through surveys; collects standardized and quality data from accredited health care settings to measure quality and monitor treatment patterns and outcomes; monitors clinical surveillance activities; and develops educational interventions to improve cancer care outcomes.
AMA Policy Compendium	Policies of the American Medical Association House of Delegates	www.ama-assn.org/ama/pub/about-ama/our-people/house-delegates/policyfinder.page?	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	www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page	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

	Medical Ethics, and current Opinions of the AMA Council on Ethical and Judicial Affairs (CEJA)		ethical issues.
Georgia Uniform Health care Practitioner Credentialing Application Form & Reappointment Form		www.georgiacredentialing.org/	The forms were developed by the Georgia Hospital Association, the Georgia In-House Counsel Association, the Georgia Association Medical Staff Services and the Georgia Association of Health Plans, with input from the Medical Association of Georgia.
JC Standard	Joint Commission Hospital Accreditation Standards	Joint Commission Comprehensive Accreditation Manual For Hospitals: The Official Handbook (2013). 2013 Update 1	The Joint Commission is the primary hospital standards – setting and accreditation body, governed by a Board of Commissioners that includes AMA representatives. Note “JC Standard MS 01.01.01” went into effect March 31, 2011.
MAG Policy	Medical Association of Georgia Policy Compendium	Draft 2013: www.mag.org/sites/default/files/downloads/2013-current-policies-draft-031913.pdf 2012: www.mag.org/sites/default/files/downloads/HOD2012-policy-compendium-final.pdf	Policy statements adopted by the MAG House of Delegates based on professional principles, scientific standards, and the experience of Georgia practicing physicians
Robert's Rules of Order (Tenth	Robert's Rules of Order (Tenth	Robert's Rules of Order Newly Revised, 10th ed. (Cambridge,	Long-standing code of parliamentary

Edition)	Edition)	Mass.: Perseus Publishing, 2000)	procedure to facilitate meetings and organization operations.
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