Medical Staff Bylaws

McCullough-Hyde Memorial Hospital

A Medical Staff Document

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DEFINITIONS

ADVANCED PRACTICE PROVIDER or APP means those physician assistants, advanced practice registered nurses, and other eligible advanced practice providers, as designated in the APP Policy, who have applied for, or who have applied for and been granted, Privileges to practice at the Hospital either independently or in collaboration with, or under the supervision of, a Physician, Dentist, or Podiatrist, as applicable, with Medical Staff appointment and Privileges at the Hospital.

ADVERSE means a recommendation or action of the Medical Executive Committee or Board of Directors that denies, limits (*e.g.,* suspension, restriction, *etc.*), for a period in excess of fourteen (14) days, or terminates Medical Staff appointment and/or Privileges on the basis of professional conduct or clinical competence, or as otherwise defined in the Medical Staff Bylaws or Fair Hearing Policy.

AFFILIATE HOSPITAL(S) means Bethesda Hospital, Good Samaritan Hospital, and such other System hospitals as may hereinafter be added.

BOARD OF DIRECTORS or BOARD means the Board of Directors of the Hospital that has overall responsibility for the conduct of the Hospital including responsibility for the Medical Staff. Reference to the Board of Directors or Board shall include any Board committee or individual authorized by the Board to act on its behalf in designated matters.

CHIEF MEDICAL OFFICER or CMO means the Physician selected by the Hospital to serve as the chief medical officer for the System and as a System liaison to the Medical Staff. Associate CMOs shall report to the CMO. The applicable Associate CMO may serve as the CMO's authorized designee in the CMO's absence.

CHIEF OF STAFF means the chief officer of the Medical Staff who shall attain such position in accordance with the applicable procedure set forth in these Bylaws. A reference to the Chief of Staff shall include his/her authorized designee.

CLINICAL PRIVILEGES or PRIVILEGES means the permission granted to a Practitioner or an Advanced Practice Provider to render specific patient care, treatment, and/or services at/for the Hospital based upon the individual's professional license, education, training, experience, competence, ability, and judgment.

DENTIST means an individual who has received a Doctor of Dental Surgery ("D.D.S.") or Doctor of Dental Medicine ("D.M.D.") degree and who is currently licensed to practice dentistry in the State of Ohio unless otherwise provided by these Bylaws.

EX OFFICIO means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, without voting rights.

FEDERAL HEALTHCARE PROGRAM means Medicare, Medicaid, TriCare, or any other federal or state program providing healthcare benefits that is funded directly or indirectly by the United States government.

GOOD STANDING means that a Medical Staff Member has not received a suspension or restriction of his/her appointment and/or Privileges in the previous twelve (12) months and is not in arrears in dues payments. An automatic suspension for delinquent medical records that has been appropriately resolved shall not adversely affect the Member's Good Standing status.

HOSPITAL means McCullough-Hyde Memorial Hospital and the Hospital's provider-based locations.

HOSPITAL PRESIDENT means the individual appointed by the Board to act on its behalf in the operation and management of the Hospital. A reference to the Hospital President shall include his/her authorized designee.

MEDICAL EXECUTIVE COMMITTEE or MEC means the executive committee of the Medical Staff.

MEDICAL STAFF means those Medical Staff Members with such responsibilities and Prerogatives as defined in the Medical Staff category to which each has been appointed.

MEDICAL STAFF BYLAWS or BYLAWS means these Medical Staff Bylaws, and amendments thereto, that constitute the basic governing document of the Medical Staff.

MEDICAL STAFF DEPARTMENT means a grouping or division of Medical Staff clinical services as provided for in the Medical Staff Organization Policy.

MEDICAL STAFF DEPARTMENT CHAIR means the qualified Practitioner elected, in accordance with the procedure set forth in these Bylaws, as the head of a Department or who has otherwise been appointed pursuant to contract. A reference to a Department Chair shall include his/her authorized designee.

MEDICAL STAFF MEMBER or MEMBER means a Practitioner who has been granted appointment to the Medical Staff of the Hospital. A Medical Staff Member must also have applied for and been granted Privileges unless his/her appointment is to a Medical Staff category without Privileges or unless otherwise provided in these Bylaws. References to Medical Staff appointment shall mean the same thing as Medical Staff membership for purposes of the Medical Staff governing documents.

MEDICAL STAFF POLICY(IES) or POLICY(IES) means those additional Medical Staff governing documents, recommended by the Medical Executive Committee and approved by the Board, that serve to implement these Bylaws including the Credentials Policy, Organization Policy, Fair Hearing Policy, Advanced Practice Provider Policy, Professional Conduct Policy, Impairment/Wellness Policy, and Peer Review Program/Professional Practice Evaluation Policy.

MEDICAL STAFF RULES & REGULATIONS or RULES & REGULATIONS means the Medical Staff rules and regulations, recommended by the Medical Executive Committee and approved by the Board, that govern the provision of medical/other professional care, treatment, and services to Hospital patients.

MEDICAL STAFF YEAR means the period from January 1 of each year through December 31st.

PATIENT ENCOUNTER means a professional contact between a Practitioner and a patient whether an admission, consultation, or diagnostic, operative, or invasive procedure at the Hospital.

PHYSICIAN means an individual who has received a Doctor of Medicine ("M.D.") or Doctor of Osteopathic Medicine ("D.O.") degree and who is currently licensed to practice medicine in the State of Ohio unless otherwise provided in these Bylaws.

PODIATRIST means an individual who has received a Doctor of Podiatric Medicine ("D.P.M.") degree and who is currently licensed to practice podiatry in the State of Ohio unless otherwise provided in these Bylaws.

PRACTITIONER means an appropriately licensed Physician, Dentist, Podiatrist, or Psychologist.

PREROGATIVE means the right to participate, by virtue of Medical Staff category, granted to a Medical Staff Member and subject to the ultimate authority of the Board, the conditions and limitations imposed in these Bylaws, and applicable Hospital/Medical Staff policies.

PROFESSIONAL LIABILITY INSURANCE means professional liability insurance coverage of such kind, in such amount, and underwritten by such insurers as required and approved by the Board.

PSYCHOLOGIST means an individual with a doctoral degree in psychology or school psychology, or a doctoral degree deemed equivalent by the Ohio Board of Psychology, who is currently licensed to practice psychology in the State of Ohio unless otherwise provided in these Bylaws.

SPECIAL NOTICE means written notice sent by (a) certified mail, return receipt requested; or (b) personal delivery service with signed acknowledgement of receipt.

SYSTEM means TriHealth, Inc.

SYSTEM CEO means the Chief Executive Officer of the System. A reference to the System CEO shall include his/her authorized designee.

OTHER

Authority of the Medical Staff. Subject to the authority and approval of the Board, the Medical Staff shall exercise such power as is reasonably necessary to discharge its responsibilities under the Medical Staff and Hospital governing documents.

Not a Contract. The Medical Staff Bylaws, Policies, and Rules & Regulations are not intended to and shall not create any contractual rights between the Hospital and any Practitioner. Any and all contracts of association or employment shall control contractual and financial relationships between the Hospital and its Practitioners.

Designee. Whenever an individual is authorized to perform a duty by virtue of his/her position (*e.g,* the System CEO, System CMO, Associate CMO, Chief of Staff, Department Chair, *etc.*), then reference to the individual shall also include the individual's designee.

ARTICLE I PURPOSES & RESPONSIBILITIES

1.1 PURPOSES

The purposes of this Medical Staff are to:

1.1-1 Provide a mechanism for accountability to the Board for the appropriateness of patient care services and the professional and ethical qualifications and conduct of each Practitioner with Medical Staff appointment and/or Privileges (and each APP with Privileges) at the Hospital to the end that patient care provided at the Hospital is maintained at a level of quality and efficiency that is consistent with professionally recognized standards of care.

1.1-2 Serve as the collegial body through which: Practitioners may obtain Medical Staff appointment and/or Privileges (and APPs may obtain Privileges) at the Hospital; Practitioners and APPs fulfill designated obligations; and, the medical/professional activities of the Hospital are directed and coordinated to create an environment that promotes quality and efficient patient care, teaching, and research services.

1.1-3 Provide appropriate educational experiences and opportunities for Practitioners, APPs, students, residents, fellows, and others.

1.1-4 Provide an orderly and systematic means by which Practitioners can give input to the Board, System CEO, and Hospital President on medico-administrative problems and on the Hospital's policy-making and planning process.

1.2 RESPONSIBILITIES

To effectuate the purposes enumerated above, the responsibilities of the Medical Staff are to:

1.2-1 Conduct, or participate in, activities to assess, maintain, and improve the quality and efficiency of medical care/professional services provided in the Hospital including, without limitation:

(a) Evaluating Practitioner/APP and Hospital performance.

(b) Engaging in the ongoing monitoring of patient care practices.

(c) Evaluating Practitioners' qualifications for appointment and reappointment to the Medical Staff and/or for Privileges and APPs' qualifications for Privileges.

(d) Promoting the appropriate use of the medical and health care resources at the Hospital for meeting patients' medical, social, and emotional needs consistent with sound health care resource utilization practices.

1.2-2 Make recommendations to the Board concerning appointments and reappointments to the Medical Staff (including category and Department assignments), Clinical Privileges, and corrective action.

1.2-3 Participate in the development, conduct, and monitoring of medical/other professional education and training programs and research activities.

1.2-4 Develop, maintain, and enforce Medical Staff Bylaws, Policies, and Rules & Regulations that are consistent with sound professional practices, organizational principles, and with applicable laws, rules, regulations, and accreditation standards.

1.2-5 Participate in the Hospital's long-range planning activities and assist in identifying community health needs and developing and implementing appropriate System/Hospital policies and programs to meet those needs.

1.2-6 Exercise, through the appropriate Medical Staff officers, Departments, and committees, the authority granted by these Bylaws and the associated Medical Staff Policies and Rules & Regulations to fulfill the above responsibilities in a timely and proper manner and to account thereon to the Board.

ARTICLE II QUALIFICATIONS FOR & OBLIGATIONS OF MEDICAL STAFF APPOINTMENT AND PRIVILEGES

2.1 QUALIFICATIONS

2.1-1 Unless otherwise provided in the Medical Staff Bylaws or Policies, each Practitioner who applies for Medical Staff appointment and/or Privileges at the Hospital must demonstrate to the satisfaction of the Medical Staff and Board, at the time of application and initial appointment/privileging and continuously thereafter, that he/she meets all of the following qualifications for appointment and/or Privileges:

(a) Baseline Qualifications

(1) Have and maintain a current, valid Ohio license to practice his/her profession (*i.e.,* medicine, dentistry, podiatry, or psychology) and compliance with the continuing education requirements for such licensure as determined by the applicable State licensure board.

(2) If necessary for the Privileges requested, have and maintain a current, valid Drug Enforcement Administration ("DEA") registration.

(3) Successful completion of applicable professional education.

(4) Successful completion of post-graduate training as follows:

(i) For Physicians: Successful completion of a post-graduate training program (*i.e.,* internship, residency, fellowship) in the specialty or specialties in which the applicant seeks Privileges which was, at the time attended, accredited by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA).

(ii) For Podiatrists: Successful completion of a podiatric medicine and surgery residency in a program which was, at the time attended, accredited by the Council on Podiatric Medical Education.

(iii) For Oral Surgeons: Successful completion of at least four (4) years of post-graduate training in an oral and maxillofacial surgery residency in a program which was, at the time attended, accredited by the Commission on Dental Accreditation.

(5) Satisfaction of the board certification requirements, as applicable, set forth in the Credentials Policy.

(6) Ability to read and understand the English language, to communicate effectively and intelligibly in English (written and verbal), and to prepare medical record entries and other required documentation in a legible and professional manner.

(7) Have and maintain current, valid Professional Liability Insurance.

(8) Be eligible to participate in Federal Healthcare Programs.

(9) Comply with state and/or federal vaccination requirements and implementing System, Hospital, and/or Medical Staff policies or obtain an approved qualified exemption therefrom.

(b) Additional Qualifications

(1) Obtain and maintain a provider number for Medicare issued by the Centers for Medicare and Medicaid Services and a provider number for Medicaid issued by the Ohio Department of Medicaid.

(2) Document and demonstrate the ability to:

(i) Provide patient care, treatment, and services consistent with acceptable standards of practice and available resources including current experience, clinical results, and utilization practice patterns.

(ii) Work with and relate to others in a cooperative and professional/ethical manner that maintains and promotes an environment of quality and efficient patient care.

(iii) Exercise the Privileges requested safely and competently with or without a reasonable accommodation.

(3) Comply with conflict of interest policies, if any, as applicable.

(4) Comply with criminal background check requirements.

(5) Agree to fulfill, and fulfill, the responsibilities of Medical Staff appointment and/or Privileges as set forth in these Medical Staff Bylaws.

(6) Satisfy such other qualifications as are set forth in the applicable Medical Staff category, Privilege set, and as otherwise provided in the Medical Staff governing documents.

2.2 WAIVER OF QUALIFICATIONS

2.2-1 A written request for waiver of a qualification for Medical Staff appointment and/or Privileges may be submitted by a Practitioner to the Medical Staff Services Department for consideration by the Medical Staff and Board. The Practitioner requesting the waiver bears the burden of demonstrating that his/her qualifications are equivalent to, or exceed, the criterion/criteria in question; or, that there are other extraordinary circumstances that justify a waiver.

2.2-2 A qualification for Medical Staff appointment and/or Privileges may be waived, at the sole discretion of the Board, based upon demonstration of equivalent qualifications or extraordinary circumstances and a Board determination that such waiver will serve the best interests of patient care.

2.2-3 The applicable Department Chair shall consider the request for waiver and shall forward recommendations to the MEC for review. The MEC will make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Upon receipt of the MEC's recommendation, the Board shall either grant or deny the waiver request.

2.2-4 Once a waiver is granted, it shall remain in effect from the time it is granted until the Practitioner's resignation or termination of Medical Staff appointment/Privileges unless a shorter time period is recommended by the MEC and approved by the Board. The Practitioner must thereafter reapply for the waiver.

2.2-5 No Practitioner is entitled to a waiver. A determination by the Board not to grant a Practitioner's request for a waiver; or, the Hospital's inability to process an application; or, termination of a Practitioner's appointment and Privileges based upon failure to satisfy the qualifications for Medical Staff appointment and/or Privileges does not give rise to any procedural due process rights nor does it create a reportable event for purposes of federal or state law.

2.3 QUALIFICATIONS FOR MEDICAL STAFF APPOINTMENT WITHOUT PRIVILEGES

Applicants for Medical Staff appointment without Privileges shall meet such qualifications as set forth in the applicable Medical Staff category and as otherwise recommended by the MEC and approved by the Board.

2.4 BASIC OBLIGATIONS ACCOMPANYING MEDICAL STAFF APPOINTMENT AND/OR PRIVILEGES

2.4-1 Unless otherwise provided in the Medical Staff governing documents, each Practitioner granted Medical Staff appointment and/or Privileges at the Hospital shall, as applicable to the Medical Staff appointment and/or Privileges granted to each such Practitioner:

(a) Manage and coordinate his/her patients' care, treatment, and services at the level of quality and efficiency professionally recognized as appropriate at facilities such as the Hospital.

(b) Abide by the Medical Staff Bylaws, Policies, and Rules & Regulations and applicable System/Hospital policies including, but not limited to, the Hospital's "HIPAA/Notice of Privacy Practices of the Organized Health Care Arrangement," corporate responsibility plan, and conflict of interest policies, as applicable.

(c) Discharge such Medical Staff, committee, Department, and Hospital functions for which he/she is responsible by Medical Staff category assignment, appointment, election, or otherwise.

(d) Prepare and complete, in timely fashion, the medical record and other required documentation for all patients he/she admits or provides care, treatment, and/or services to in the Hospital.

(1) Incorporate into practice use of the Hospital's electronic medical record and technologic advances (including, but not limited to, computerized order entry) in the electronic medical record as they are made available to the Medical Staff.

(2) Complete educational sessions, as required, with respect to the Hospital's electronic medical record, computerized order entry system, *etc.*

(e) Provide or arrange for continuous, appropriate, and timely medical coverage and care for patients for whom he/she is responsible.

(1) As a precondition to the exercise of Privileges, a Practitioner must designate another Practitioner with comparable Privileges who has agreed to provide back-up coverage for the Practitioner's patients in the event the Practitioner is not available.

(f) Cooperate, in accordance with the Medical Staff Code of Professional Conduct, with other Practitioners, APPs, and Hospital personnel in relation to patient care, the orderly operation of the Hospital, and general attitude toward patients, the Hospital, and its personnel.

(g) Abide by the code of ethics established by the Practitioner's profession (*e.g.,* the American Medical Association Code of Medical Ethics, *etc.*).

(h) Cooperate and participate, as reasonably requested, in quality assurance/performance improvement, peer review, and utilization review activities whether related to oneself or others.

(i) Cooperate in any relevant or required review of a Practitioner's (including his/her own) qualifications or compliance with the Medical Staff governing documents and refrain from directly or indirectly interfering, obstructing, or hindering any such review whether by threat of harm or liability, by

withholding information, or by refusing to perform or participate in assigned responsibilities or otherwise.

(j) Comply with such notice requirements as are set forth in the Medical Staff governing documents including, but not limited to, the obligation to immediately notify the Medical Staff Services Department, in writing, of any substantive change to the information contained in or accompanying the Practitioner's application throughout any appointment/Privilege period as provided for in the Credentials Policy.

(k) Assist with Medical Staff approved education programs for students, interns, and residents, if applicable.

(l) Complete mandated Hospital education and training as directed by the MEC.

2.4-2 Failure to satisfy any of these basic obligations is grounds, as warranted by the circumstances, for denial of reappointment/regrant of Privileges or for corrective action pursuant to the procedure set forth in these Bylaws.

2.5 BASIC OBLIGATIONS OF APPOINTMENT WITHOUT PRIVILEGES

Practitioners for Medical Staff appointment without Privileges shall meet such obligations as set forth in the applicable Medical Staff category and as otherwise recommended by the MEC and approved by the Board.

ARTICLE III PROCEDURE FOR ACTING UPON APPLICATIONS FOR MEDICAL STAFF APPOINTMENT AND/OR PRIVILEGES

3.1 PROCEDURES FOR PRACTITIONER CREDENTIALING, APPOINTMENT/ REAPPOINTMENT, AND PRIVILEGING

3.1-1 Unless otherwise provided in these Bylaws or the applicable Medical Staff Policy:

(a) Applications for appointment/reappointment and/or Privileges/regrant of Privileges shall be submitted to the Medical Staff Services Department for credentialing/recredentialing. The Medical Staff Services Department shall organize and coordinate the collection and verification of information/material related to each application.

(b) When collection and verification is accomplished, each complete application packet/credentials file shall be reviewed and acted upon by the applicable Department Chair and the Medical Executive Committee.

(c) Initial appointments and reappointments to the Medical Staff and granting/regranting of Privileges shall be made by the Board. The Board shall act on appointments/reappointments and Privileges/regrant of Privileges only after there has been a recommendation from the MEC; provided, however, that the Board may act directly if the Board does not receive a recommendation from the MEC. Prior to taking such action, the Board will inform the MEC of the Board's intent and allow a reasonable period of time for response from the MEC.

3.1-2 The details related to the mechanisms for credentialing/recredentialing, processing applications for initial appointment, for reappointment, and for granting/regranting Privileges are outlined in the Credentials Policy for Practitioners.

3.1-3 The details related to the mechanisms for credentialing/recredentialing and processing applications for granting/regranting Privileges are outlined in the APP Policy for APPs.

3.1-4 The on-call Associate Chief Medical Officer, System Chief Medical Officer, System CEO, or Chief of Staff may, in accordance with the procedure set forth in the Credentials Policy or APP Policy, grant disaster Privileges to licensed volunteer Practitioners and APPs for the purpose of providing care, treatment, and services to patients in the event that the Hospital's emergency operations plan is activated and the Hospital is unable to meet immediate patient needs.

3.2 TERM OF MEDICAL STAFF APPOINTMENTS/PRIVILEGES

3.2-1 Appointments and reappointments to the Medical Staff and granting/regranting of Clinical Privileges are for a period of up to three (3) years.

3.2-2 An appointment/reappointment or grant/regrant of Privileges of less than three (3) years shall not be deemed Adverse for purposes of the Fair Hearing Policy.

3.3 NO ENTITLEMENT

3.3-1 No Practitioner shall be automatically entitled to appointment or to the exercise of particular Clinical Privileges merely because he/she:

(a) Is licensed to practice in this or in any other state.

(b) Is certified by a clinical board.

(c) Is a member of a professional organization.

(d) Is a member of a medical, dental, or other professional school faculty.

(e) Had, or presently has, medical staff appointment or privileges at another health care facility or in another practice setting.

(f) Had, or presently has, Medical Staff appointment and/or Privileges at this Hospital.

(g) Is, or is about to become, affiliated in practice with a Practitioner who has, or with a group of Practitioners one or more of who has/have, Medical Staff appointment and/or Privileges at this Hospital.

(h) Contracts with or is employed by the Hospital

3.4 ADDITIONAL CONSIDERATIONS

3.4-1 Any policies, plans, and objectives formulated by the Board concerning the Hospital's current and projected patient care needs and the availability of adequate facilities, equipment, staffing, and financial resources may also be considered by the applicable Medical Staff and Board authorities in making recommendations or taking action on new applications for Medical Staff appointment and/or Clinical Privileges and requests for additional Clinical Privileges during a current appointment/Privilege period.

3.5 NONDISCRIMINATION

3.5-1 No Practitioner shall be denied appointment and/or Privileges on the basis of: race; color; sex (including pregnancy); sexual orientation; gender identity; gender expression; transgender status; age (40 and older); religion; marital, familial, or health status; national origin; ancestry; disability (provided that the Practitioner can competently exercise the Privileges requested with or without a reasonable accommodation); genetic information; veteran or military status; or any other characteristic(s) or class protected by applicable law.

ARTICLE IV CATEGORIES OF THE MEDICAL STAFF

4.1 CATEGORIES

The Medical Staff shall be divided into the following categories: active (with Privileges), courtesy, reciprocal, affiliate, consulting peer review, retired, and emeritus.

4.2 ACTIVE MEDICAL STAFF CATEGORY (WITH PRIVILEGES)

4.2-1 QUALIFICATIONS

(a) The active Medical Staff category with Privileges shall consist of Practitioners who:

(1) Satisfy the qualifications set forth in Section 2.1 of these Bylaws.

(2) Regularly exercise Privileges at the Hospital and provide for continuous care of their patients.

(3) Actively participate and substantially contribute to the activities of the Hospital and Medical Staff in an ongoing and consistent manner through committee assignments, leadership roles, and significant participation in Medical Staff activities.

4.2-2 PREROGATIVES

(a) Active Medical Staff Members with Clinical Privileges may:

(1) Exercise such Clinical Privileges as are granted including, but not limited to, the ability to admit patients to the Hospital.

(2) Hold Medical Staff office subject to the qualifications to do so.

(3) Serve as a Department Chair subject to the qualifications to do so.

(4) Serve as an MEC at-large member subject to the qualifications to do so.

(5) Serve as a member or chair of a Medical Staff committee subject to the qualifications to do so.

(6) Vote on Medical Staff matters and on matters of the Medical Staff Department and Medical Staff committees of which the Member is a member.

4.2-3 OBLIGATIONS

(a) Active Medical Staff Members with Privileges shall:

(1) Fulfill the responsibilities set forth in Section 2.4.

(2) Assume all of the functions and responsibilities of appointment to the active Medical Staff category with Privileges including, but not limited to, actively participating, as required, in on-call rotation schedules assigned by his/her Department Chair and timely response to consultation requests.

(3) Participate in professional practice evaluation activities as assigned (*e.g.,* supervise Practitioners in the Member's same profession who are under focused professional practice evaluation, *etc.*).

(4) Be expected to attend meetings of the Medical Staff and meetings of the Department to which assigned.

(5) Upon acceptance of a Medical Staff committee assignment, carry out such assignment in the same manner as required of any other committee member including satisfying such meeting attendance requirements as are applicable.

(6) Timely pay all Medical Staff dues, fees, and assessments.

4.3 COURTESY MEDICAL STAFF CATEGORY (WITH PRIVILEGES)

4.3-1 QUALIFICATIONS

(a) The courtesy Medical Staff category shall consist of Practitioners who:

(1) Satisfy the qualifications set forth in Section 2.1 of these Bylaws.

(2) Are members in good standing of the active medical staff with clinical privileges at another accredited Ohio hospital requiring performance improvement/quality assessment activities similar to this Hospital. The Practitioner shall hold at such other hospital the same privileges, without restriction, that he/she is requesting at this Hospital. An exception to this qualification may be recommended by the MEC and approved by the Board, in its sole discretion, for good cause provided the Practitioner is otherwise qualified by education, training, and experience to competently provide the requested care, treatment, and/or services.

(3) Meet one (1) of the following requirements:

(i) Are requesting appointment and Privileges for the sole purpose of providing specialty/consulting services in a specialty area in which there is a need at the Hospital and are willing and able to come to the Hospital as scheduled or to

promptly respond when called to render clinical services within their area of expertise; **OR,**

(ii) Are requesting Medical Staff appointment and Privileges for the sole purpose of serving as a preceptor (or being precepted) not otherwise related to the Hospital's graduate medical education programs; **OR,**

(iii) Are requesting Medical Staff appointment and Privileges for the sole purpose of providing back-up coverage to another Practitioner on the Medical Staff; **OR,**

(iv) Are requesting Medical Staff appointment and Privileges for the sole purpose of providing Hospital-approved temporary staffing (*e.g.,* extended *locum tenens* coverage, *etc.*); **OR**,

(v) Are requesting Medical Staff appointment and Privileges for the sole purpose of participating in a teaching program sponsored by an accredited academic institution (which can involve students, residents, or fellows) that includes the provision of patient care.

4.3-2 PREROGATIVES

(a) Courtesy Medical Staff Members may:

(1) Exercise such Clinical Privileges as are granted including, but not limited to, the ability to admit patients to the Hospital.

(2) Not hold Medical Staff office.

(3) Not serve as a Department Chair.

(4) Not serve as a Medical Staff committee chair.

(5) Serve as a member of a Medical Staff committee, with the exception of the MEC, subject to the qualifications to do so, and vote on matters of the Medical Staff committee(s) of which he/she is a member.

(6) Attend meetings of the Medical Staff and the Department of which he/she is a member; provided, however, that courtesy Members may not vote on Medical Staff or Department matters.

4.3-3 OBLIGATIONS

(a) Courtesy Medical Staff Members shall:

(1) Fulfill the responsibilities set forth in Section 2.4.

(2) Actively participate, as required, in on-call/rotation schedules assigned by the applicable Department Chair and timely respond to consultation requests.

(3) Participate in professional practice evaluation activities as assigned.

(4) Be encouraged to attend meetings of the Medical Staff and meetings of the Department to which assigned.

(5) Upon acceptance of a Medical Staff committee assignment, carry out such assignment in the same manner as required of any other committee member including satisfying such meeting attendance requirements as are applicable.

(6) Timely pay all Medical Staff dues, fees, and assessments.

4.4 RECIPROCAL MEDICAL STAFF (WITHOUT PRIVILEGES)

4.4-1 PRIMARY PURPOSE

(a) The primary purpose of this Medical Staff category is to:

(1) Provide for broad collaboration between the Hospital and Affiliate Hospital medical staffs to promote and further effective peer review and quality of care for patients.

(2) Permit and facilitate joint Medical Staff committee participation between Affiliate Hospitals.

4.4-2 QUALIFICATIONS

(a) The reciprocal Medical Staff category shall consist of Practitioners who:

(1) Have an active appointment with Privileges at an Affiliate Hospital; OR, have appointment at an Affiliate Hospital in a Medical Staff category other than active and agree to serve as a member of a joint Medical Staff committee at the Hospital.

(2) Do not otherwise hold appointment to another Medical Staff category at the Hospital.

(3) Appointments to this category shall be automatic upon confirmation of satisfaction of the qualifications set forth in §4.4-2 (a)(1) and (2).

(4) Practitioners automatically appointed to this category who want to exercise Clinical Privileges at the Hospital may, alternatively, apply

for Medical Staff appointment and Privileges at the Hospital provided that they qualify to do so.

4.4-3 PREROGATIVES

(a) Reciprocal Medical Staff Members may:

(1) Not be granted Privileges at the Hospital.

(2) Not hold Medical Staff office or serve as a Department Chair.

(3) Not vote on Medical Staff or Department matters.

(4) Serve as a member or chair of Medical Staff committees, with the exception of the MEC, subject to the qualifications to do so.

(5) Vote on matters of Medical Staff committees of which the Practitioner is a member.

4.4-4 OBLIGATIONS

(a) Reciprocal Medical Staff Members shall:

(1) Upon acceptance of a Medical Staff committee assignment, carry out such assignment in the same manner as required of any other committee member including satisfying such meeting attendance requirements as are applicable.

(2) Not be assessed Medical Staff dues, fees, or assessments.

4.5 AFFILIATE MEDICAL STAFF (WITHOUT PRIVILEGES)

4.5-1 QUALIFICATIONS

(a) The affiliate Medical Staff category shall consist of Practitioners who:

(1) Satisfy the qualifications set forth in Section 2.1 with the exception that a Practitioner appointed to the affiliate Medical Staff without Privileges shall not be required to have or maintain board certification.

(2) Do not exercise Privileges at the Hospital but practice in the community the Hospital serves.

(3) Participate and contribute to the activities of the Hospital and Medical Staff as assigned or as elected/appointed.

4.5-2 PREROGATIVES

(a) Affiliate Medical Staff Members may:

(1) Not be granted or exercise Clinical Privileges at the Hospital.

(2) Visit his/her patients who are in the Hospital and review those patients' Hospital medical records consistent with the Hospital's medical record/HIPAA policies and subject to training, as required, with respect to view only access to the electronic medical record.

(3) Not make entries in the medical record or otherwise participate in the provision of care, treatment, or services to patients at the Hospital.

(4) Not hold Medical Staff office or vote on Medical Staff matters.

(5) Not serve as a Department Chair or vote on Department matters.

(6) Not chair a Medical Staff committee.

(7) Serve as a member of a Medical Staff committee, with the exception of the MEC, subject to the qualifications to do so.

(8) Vote on matters of Medical Staff committees of which the Practitioner is a member.

4.5-3 OBLIGATIONS

(a) Affiliate Medical Staff Members shall:

(1) Fulfill the responsibilities set forth in Section 2.4 to the extent applicable to a request for Medical Staff appointment without Privileges.

(2) Accept Emergency Department patient assignments for follow up outpatient care in the Practitioner's office practice.

(3) Timely pay all Medical Staff dues, fees, and assessments.

4.6 CONSULTING PEER REVIEW MEDICAL STAFF (WITHOUT PRIVILEGES)

4.6-1 QUALIFICATIONS

(a) The consulting peer review Medical Staff category shall consist of Members who must:

(1) Practice either locally or in another city/state in which the Practitioner has a current, valid, unrestricted license to practice; and, be a member of the active medical staff in good standing at another accredited hospital; **OR**,

(2) Be a Practitioner who is a recognized expert in his or her field who has retired from active practice at another accredited hospital within the last twelve (12) months.

(b) Possess skills needed at the Hospital for a specific peer review project or for peer review consultation on an occasional basis when requested by Hospital administration, the Board, or a Medical Staff leader/committee.

(c) Meet such other qualifications, if any, as set forth in the Medical Staff Peer Review Program Policy, as such policy may be amended from time to time, or as otherwise recommended by the MEC and approved by the Board.

4.6-2 PREROGATIVES

(a) Consulting peer review Medical Staff Members may:

(1) Not be granted or exercise Clinical Privileges at the Hospital.

(2) Not hold Medical Staff office.

(3) Not serve as a Department Chair or Medical Staff committee member or chair.

(4) Attend Medical Staff, Department and Medical Staff committee meetings but is not entitled to vote on Medical Staff, Department, or Medical Staff committee matters.

(5) Not be assigned to a Medical Staff Department.

(6) Review medical records and peer review materials retained by the Hospital for the purpose of rendering an opinion on the quality of health care provided to patients by Practitioners or APPs granted Privileges at the Hospital.

(7) Otherwise perform related peer review services as specifically requested.

4.6-3 OBLIGATIONS

(a) Consulting peer review Medical Staff Members shall:

(1) Abide by the Medical Staff Bylaws and Policies and System/Hospital policies and procedures, as applicable.

(2) Be willing to accept consulting peer review appointments for the limited purpose of evaluating Practitioners' or APP’s credentials and otherwise reviewing selected charts in order to render an opinion on the professional conduct/clinical competence of Practitioners/APPs

or the quality of health care provided to patients by Practitioners/APPs granted Privileges at the Hospital.

(3) Perform such other duties as set forth in the Medical Staff Peer Review Program Policy, as such policy may be amended from time to time, and/or as otherwise requested and agreed upon.

(4) Not be required to pay Medical Staff dues, fees, or assessments.

4.6-4 LIMITED APPOINTMENT

Appointment to the consulting peer review Medical Staff category shall be solely for the purpose of conducting peer review in a particular case or situation and shall terminate upon the Practitioner's completion of his/her consulting peer review duties in connection with the peer review matter without any procedural rights under the Fair Hearing Policy.

4.7 RETIRED MEDICAL STAFF (WITHOUT PRIVILEGES)

4.7-1 QUALIFICATIONS

(a) The retired Medical Staff category shall consist of Practitioners who have retired from Hospital practice and request transfer to the retired Medical Staff appointment category.

4.7-2 PREROGATIVES

(a) Retired Medical Staff Members may:

(1) Not be granted or exercise Privileges at the Hospital.

(2) Not hold Medical Staff office.

(3) Not serve as a Department Chair.

(4) Serve as a member or chair of a Medical Staff committee, with the exception of the MEC, subject to the qualifications to do so, and vote on matters of the Medical Staff committee(s) of which the Practitioner is a member or chair.

(5) Attend meetings of the Medical Staff and Department of which the Practitioner is a member but may not vote on Medical Staff or Department matters.

4.7-3 OBLIGATIONS

(a) Retired Medical Staff Members shall:

(1) Have no Medical Staff obligations; provided, however, that upon acceptance of a Medical Staff committee assignment, a Practitioner will carry out such assignment in the same manner as required of any other committee member including satisfying such meeting attendance requirements as are applicable.

(2) Not be required to pay Medical Staff dues, fees, or assessments.

4.8 EMERITUS MEDICAL STAFF (WITHOUT PRIVILEGES)

4.8-1 QUALIFICATIONS

(a) The emeritus Medical Staff category shall consist of Practitioners who have:

(1) Retired from Hospital practice and who have provided exceptional contributions to the Hospital and Medical Staff.

(2) Served on the active Medical Staff for at least ten (10) years with significant participation in Medical Staff governance, education, research, patient care quality and safety initiatives, and/or Hospital administrative activities.

(b) Appointment to the emeritus Medical Staff category is an honor awarded through the procedure set forth in the Medical Staff Credentials Policy. No Practitioner may apply for appointment to the emeritus Medical Staff category.

4.8-2 PREROGATIVES

(a) Emeritus Medical Staff Members may:

(1) Not be granted or exercise Privileges at the Hospital.

(2) Not hold Medical Staff office.

(3) Not serve as a Department Chair.

(4) Serve as a member or chair of a Medical Staff committee, with the exception of the MEC, subject to the qualifications to do so, and vote on matters of the Medical Staff committee(s) of which the Practitioner is a member or chair.

(5) Attend meetings of the Medical Staff and Department of which the Practitioner is a member but may not vote on Medical Staff or Department matters.

4.8-3 OBLIGATIONS

(a) Emeritus Medical Staff Members shall:

(1) Have no Medical Staff obligations; provided, however, that upon acceptance of a Medical Staff committee assignment, a Practitioner will carry out such assignment in the same manner as required of any other committee member including satisfying such meeting attendance requirements as are applicable.

(2) Not be required to pay Medical Staff dues, fees, or assessments.

ARTICLE V MEDICAL STAFF OFFICERS; MEC AT-LARGE MEMBERS

5.1 IDENTIFICATION OF MEDICAL STAFF OFFICERS

5.1-1 The officers of the Medical Staff shall be the:

(a) Immediate Past Chief of Staff

(b) Chief of Staff

(c) Chief of Staff Elect

5.2 QUALIFICATIONS OF MEDICAL STAFF OFFICERS & MEC AT-LARGE MEMBERS

5.2-1 Each Medical Staff officer must meet the following qualifications:

(a) Be a Member of the active Medical Staff category, with Clinical Privileges, in Good Standing.

(b) Be qualified by training, experience, and administrative ability for the office.

(c) Demonstrate interest in maintaining quality medical care at the Hospital.

(d) Be knowledgeable concerning the duties of the office.

(e) Be board certified unless such requirement is otherwise waived in accordance with the procedure set forth in these Bylaws.

(f) Have demonstrated a high degree of interest in and support of the Medical Staff and Hospital by his/her Medical Staff activity at the Hospital.

(g) Agree to faithfully discharge the duties and exercise the authority of the office held and work in a professional manner.

(h) Comply with applicable conflict of interest policies, as such policies may be amended from time to time.

5.2-2 Each MEC at-large member must meet the following qualifications:

(a) Be a Member of the active Medical Staff, with Clinical Privileges, in Good Standing.

(b) Comply with applicable conflict of interest policies, as such policies may be amended from time to time.

5.3 DISCLOSURE OF CONFLICTS OF INTEREST

5.3-1 All candidates for Medical Staff office or membership on the Medical Executive Committee shall disclose, in writing, any conflicts of interest with the Hospital.

5.3-2 The requirement to disclose conflicts of interest is an ongoing obligation of Practitioners for as long as they hold Medical Staff appointment and/or Privileges at the Hospital.

5.4 NOMINATION PROCEDURE

5.4-1 The Medical Executive Committee shall prepare a slate of nominees for the office of Chief of Staff Elect.

5.4-2 The Medical Executive Committee shall confirm that each nominee is eligible and willing to serve.

5.5 ATTAINMENT OF MEDICAL STAFF OFFICE/MEC AT-LARGE MEMBER POSITION

5.5-1 Automatic Succession

(a) Upon completion of his/her term, the Chief of Staff automatically succeeds to the office of Immediate Past Chief of Staff.

(b) Upon completion of his/her term, the Chief of Staff Elect automatically succeeds to the office of the Chief of Staff.

5.5-2 Election

(a) Subject to subsection (c), election of the Chief of Staff Elect shall occur in one of the following ways as determined by the MEC:

(1) By a majority affirmative vote of those Medical Staff members eligible to vote who are present and voting at a Medical Staff meeting at which a quorum is present.

OR

(2) By ballot, without a Medical Staff meeting. In such event, written or electronic ballots shall be distributed to each MEC member eligible to vote. Completed ballots shall be returned within the time period specified and according to the instructions that accompany the ballot. Ballots received after the stipulated date shall not be counted. The candidate who receives a majority affirmative vote of the total votes returned by the stipulated date shall be elected as the Chief of Staff Elect.

(b) In the event that there are three (3) or more candidates for the position of Chief of Staff Elect and no candidate receives a majority vote in

accordance with the procedure set forth in (a)(1) or (a)(2), there shall be successive voting such that the name of the candidate receiving the fewest votes is omitted from each successive vote until a majority is obtained by one candidate.

(c) Election of the Chief of Staff Elect is subject to approval of the Board. If the Board votes to disapprove the Chief of Staff Elect elected by the voting Members of the Medical Staff, the Board's decision will be accompanied by the reasoning for its action in writing and referred to the Joint Conference Committee. Following review and recommendation by the Joint Conference Committee, the matter will be referred back to the Board for final action.

5.5-3 Appointment

(a) MEC at-large members are appointed by the Chief of Staff.

5.6 TERM OF MEDICAL STAFF OFFICE OR POSITION

5.6-1 New Medical Staff officers and MEC at-large members shall assume their duties as of January 1 following the election.

5.6-2 Each Medical Staff officer and MEC at-large member shall serve a two (2) year term.

5.6-3 Each Medical Staff officer and MEC at-large member serves until the end of his/her term, and until a successor is selected, unless the Practitioner sooner resigns or is removed from his/her office/position.

5.6-4 Qualified Practitioners shall be eligible for reappointment as a MEC at-large member for an unlimited number of terms.

5.7 DUTIES

5.7-1 The duties of each Medical Staff officer are set forth in the Medical Staff Organization Policy.

5.7-2 The MEC at-large members will serve as voting members of the Medical Executive Committee. The duties of the MEC are set forth in Section 7.3.

5.8 VACANCY IN OFFICE

5.8-1 If there is a vacancy in the office of the Immediate Past Chief of Staff, the Medical Executive Committee may elect to leave the position vacant for the remainder of the unexpired term or appoint a former Past Chief of Staff to fill the office on an interim basis for the remainder of the unexpired term.

5.8-2 If there is a vacancy in the office of the Chief of Staff prior to the expiration of the Chief of Staff's term, the Chief of Staff Elect shall assume the duties and authority of the Chief of Staff for the remainder of the unexpired term. The Chief of Staff Elect shall thereafter serve his/her term as Chief of Staff.

5.8-3 In the event of a vacancy in the office of Chief of Staff Elect, an eligible, qualified, and willing active Medical Staff Member shall be appointed by the Medical Executive Committee to assume the duties and authority of the Chief of Staff Elect on an interim basis for the remainder of the unexpired term. A new Chief of Staff Elect will thereafter be elected. The Practitioner appointed to serve in the interim role of Chief of Staff Elect may subsequently be considered for election.

5.8-4 A vacancy in an MEC at-large member position shall be filled in the same manner in which the original selection was made.

5.9 RESIGNATION

5.9-1 A Medical Staff officer or MEC at-large member may resign at any time by giving written notice to the Medical Executive Committee.

5.9-2 Such resignation takes effect on the date specified in the resignation notice or as otherwise agreed upon by the resigning Practitioner and the Medical Executive Committee.

5.10 REMOVAL

5.10-1 <u>Mechanism</u>

(a) Removal of a Medical Staff officer may be <u>initiated</u> by:

(1) A majority vote of the MEC calling for removal of a Medical Staff officer; OR,

(2) A written petition signed by not less than two-thirds (2/3rds) of the Medical Staff Members eligible to vote calling for removal of a Medical Staff officer; OR,

(3) A Board recommendation calling for removal of a Medical Staff officer.

(b) Following initiation of a removal action, a Medical Staff officer may <u>be removed</u> by either:

(1) A majority secret ballot vote of the active Medical Staff Members, in Good Standing, present and eligible to vote at a regular or special Medical Staff meeting at which a quorum is present; <u>OR</u>,

(2) The Board acting upon its own initiative. When the Board is contemplating action to remove an officer it shall first refer the matter to the Joint Conference Committee. Board action after receiving the Joint Conference Committee's report shall be the final decision of the Board in the matter.

(c) The Practitioner shall be afforded the opportunity to speak in his or her own behalf before the Medical Staff or Board, as applicable, prior to a vote on removal.

(d) MEC at-large members may be removed by the Chief of Staff.

5.10-2 Grounds for Removal. Permissible grounds for removal of a Medical Staff officer or MEC at-large member include, without limitation:

(a) Conduct detrimental to the interests of the Medical Staff or the Hospital.

(b) Inability to fulfill the duties of the office or position.

(c) Failure to perform the duties of the office or position in an appropriate manner.

(d) Failure to continuously satisfy the qualifications for the position.

(e) Imposition of a summary suspension, an automatic suspension (other than for delinquent medical records), or a corrective action resulting in a final Adverse decision.

5.10-3 Grounds for Automatic Removal. Automatic termination of Medical Staff appointment and/or Privileges shall result in an automatic removal of the Practitioner from his/her office or position.

ARTICLE VI MEDICAL STAFF DEPARTMENTS

6.1 CREATION, MODIFICATION, & ELIMINATION OF DEPARTMENTS

6.1-1 Subject to the qualifications set forth below, Medical Staff Departments may be created, renamed, eliminated, or combined (*e.g.,* for better organizational efficiency and improved patient care) upon recommendation of the MEC and approval by the Board.

(a) The following criteria shall apply in making Medical Staff Department designations:

(1) The area of practice represents a major general or distinct field of medical practice at the Hospital.

(2) The level of clinical activity at the Hospital is substantial enough to warrant imposing the responsibility to accomplish the functions assigned to Departments.

(3) Practitioners to be assigned to the Medical Staff Department agree to and carry out the meeting, review, and other activities required of Departments at the Hospital.

(4) There are at least three (3) Department members who are active Medical Staff Members with Privileges currently engaged in that area of practice at the Hospital.

(b) The current Medical Staff Departments are set forth in the Medical Staff Organization Policy.

6.2 QUALIFICATIONS OF MEDICAL STAFF DEPARTMENT CHAIRS

6.2-1 Each Department Chair must meet the following qualifications:

(a) Be a Member of the active Medical Staff, with Clinical Privileges, in Good Standing.

(b) Be qualified by training, experience, and administrative ability for the position.

(c) Be knowledgeable concerning the duties of the position.

(d) Be board certified unless such requirement is otherwise waived in accordance with the procedure set forth in these Bylaws.

(e) Comply with applicable conflict of interest policies, as such policies may be amended from time to time.

(1) All candidates for a Department Chair position shall disclose, in writing, any conflicts of interest with the Hospital.

(2) The requirement to disclose conflicts of interest is an ongoing obligation of Practitioners for as long as they hold Medical Staff appointment and/or Privileges at the Hospital.

6.3 ATTAINMENT OF DEPARTMENT CHAIR POSITION

6.3-1 Department Chairs

(a) The chair of each Department shall be elected every other year by Department members eligible to vote.

(b) The Medical Executive Committee shall prepare a slate of eligible and willing candidates to be voted on, in such manner as determined by the then current Department Chair, at a Department meeting prior to January 1. Any voting member of the Department may request that such vote be taken by written ballot at the Department meeting. A Department Chair shall be elected by majority vote of those Department members eligible to vote who are present and voting at a Department meeting at which a quorum is present.

(c) Alternatively, a Department Chair may be elected by written or electronic ballot without a Department meeting. In such event, ballots shall be distributed to each Department member eligible to vote. Completed ballots shall be returned within the time period specified and according to the instructions that accompany the ballot. Ballots received after the stipulated date shall not be counted. The candidate who receives a majority vote of the total votes returned by the stipulated date shall be elected as the Department Chair.

(d) In the event that there are three (3) or more candidates for the position and no candidate receives a majority vote in accordance with the procedure set forth in (b) or (c), there shall be successive voting such that the name of the candidate receiving the fewest votes is omitted from each successive vote until a majority is obtained by one candidate.

(e) If, for any reason, a Department Chair is not elected pursuant to this section and the current Department Chair does not wish to continue to temporarily serve as set forth in Section 6.4-1 (c), the Chief of Staff shall have the authority to appoint an interim acting Department Chair.

6.4 POSITION TERM

6.4-1 Department Chairs

(a) New Department Chairs shall assume their duties as of January 1 following their election.

(b) A Department Chair shall be elected to serve a two (2) year term.

(c) A Department Chair shall serve until the end of his/her term, and until a successor is selected, unless the Practitioner sooner resigns or is removed from his/her position.

(d) Qualified Practitioners shall be eligible for reelection for an unlimited number of terms.

6.5 DUTIES

6.5-1 Department Chairs shall:

(a) Oversee the clinically related activities of the Department.

(b) Oversee the administratively related activities of the Department, unless otherwise provided by the Hospital.

(c) Provide continuing surveillance of the professional performance of Practitioners and APPs with Privileges in the Department.

(d) Recommend to the Medical Staff the criteria for Privileges that are relevant to the care provided in the Department.

(e) Recommend Privileges for each member of the Department/Section.

(f) Assess and recommend to the relevant Hospital authority off-site sources for needed patient care, treatment, and services not provided by the Department or Hospital.

(g) Integrate the Department into the primary functions of the Hospital.

(h) Coordinate and integrate interdepartmental and intradepartmental services.

(i) Develop and implement policies and procedures that guide and support the provision of care, treatment, and services by members of the Department.

(j) Recommend a sufficient number of qualified and competent Practitioners and APPs to provide care, treatment, and services within the Department.

(k) Determine the qualifications and competence of Department personnel who are not Practitioners and who provide care, treatment, and services within the Department (*i.e.,* APPs).

(l) Provide continuous assessment and improvement of the quality of care, treatment, and services provided by members of the Department.

(m) Assist with maintenance of quality control programs, as appropriate.

(n) Provide for orientation and continuing education of all persons in the Department.

(o) Recommend space and other resources needed by the Department.

6.6 VACANCY

6.6-1 A Department Chair vacancy due to any reason shall be filled for the unexpired term through one of the following mechanisms, at the sole discretion of the Chief of Staff:

(a) Appointment of an interim Department Chair by the Chief of Staff; or,

(b) A special election by the voting members of the Department in the manner, to the extent applicable, set forth in Section 6.3-1(b) and (c) or (d).

6.7 RESIGNATION

6.7-1 A Department Chair may resign at any time by giving written notice to the Chief of Staff.

6.7-2 Such resignation takes effect on the date specified in the resignation notice or as otherwise agreed upon by the resigning Practitioner and Chief of Staff.

6.8 REMOVAL OF DEPARTMENT CHAIR

6.8-1 <u>Mechanism</u>

(a) An elected Department Chair may be removed by:

(1) A two-thirds (2/3rds) vote of the voting members of the applicable Medical Staff Department who are present and voting at a regular or special Department meeting at which a quorum is present; OR,

(2) A two-thirds (2/3rds) vote of the voting members of the MEC present and voting at a regular or special MEC meeting at which a quorum is present; OR,

(3) The Board.

(b) The Practitioner shall be afforded the opportunity to speak in his or her own behalf before the Department, MEC, or Board, as applicable, prior to a vote on removal.

6.8-2 Grounds for Removal. Permissible grounds for removal of a Department Chair include, without limitation:

(a) Conduct detrimental to the interests of the Medical Staff or the Hospital.

(b) Inability to fulfill the duties of the position.

(c) Failure to perform the duties of the position in an appropriate manner.

(d) Failure to continuously satisfy the qualifications for the position.

(e) Imposition of a summary suspension, an automatic suspension (other than for delinquent medical records), or a corrective action resulting in a final Adverse decision.

6.8-3 Grounds for Automatic Removal. Automatic termination of Medical Staff appointment and/or Privileges shall result in an automatic removal of the Practitioner from his/her position.

ARTICLE VII MEDICAL EXECUTIVE COMMITTEE

7.1 MEC COMPOSITION

7.1-1 The voting members of the Medical Executive Committee shall be the:

(a) Immediate Past Chief of Staff

(b) Chief of Staff, who shall chair the MEC and vote only in the event of a tie

(c) Chief of Staff Elect

(d) Chair of each Medical Staff Department

(e) One (1) or more eligible at-large Medical Staff Members

7.1-2 The non-voting *Ex Officio* members of the Medical Executive Committee shall be the:

(a) System Chief Executive Officer

(b) System Chief Medical Officer

(c) Associate Chief Medical Officer

(d) Hospital President

7.1-3 All Members of the active Medical Staff category are eligible for membership on the MEC; however, the majority of voting members of the Medical Executive Committee shall, at all times, be Physician Members of the active Medical Staff category with Privileges at the Hospital.

7.1-4 To the extent a voting member of the Medical Executive Committee, as set forth in Section 7.1-1, holds more than one position listed in Section 7.1.1, he/she shall only be entitled to one (1) vote on the MEC.

7.2 SELECTION AND REMOVAL OF VOTING MEC MEMBERS

7.2-1 Voting MEC members are selected as follows:

(a) Medical Staff officers attain their position in accordance with the procedure set forth in Section 5.4 and Section 5.5-1/5.5-2.

(b) Department Chairs attain their position in accordance with the procedure set forth in Section 6.3-1.

(c) The MEC at-large members attain their position in accordance with the procedure set forth in Section 5.5-3.

7.2-2 Voting MEC members are removed as follows:

(a) Medical Staff officers may be removed from their position in accordance with the procedure set forth in Section 5.10-1 (a)-(c).

(b) Department Chairs may be removed from their position in accordance with the procedure set forth in Section 6.8.

(c) The MEC at-large members may be removed from their position in accordance with the procedure set forth in Section 5.10-1 (d).

7.3 DUTIES AND AUTHORITY OF MEC

7.3-1 The duties of the Medical Executive Committee shall be to:

(a) Represent and act, without requirement of subsequent approval, on behalf of the Medical Staff in all matters between meetings of the Medical Staff subject only to such limitations, if any, as may be imposed by the Medical Staff governing documents.

(b) Oversee the activities and general policies of the Medical Staff Departments and Medical Staff committees.

(c) Review and act upon reports of Medical Staff committees, Departments, and other assigned activity groups and make recommendations thereon to the Board.

(d) Recommend adoption/amendment of Medical Staff Bylaws pursuant to the applicable procedure set forth in these Medical Staff Bylaws.

(e) Adopt/amend Medical Staff Policies and Rules & Regulations pursuant to the applicable procedure set forth in these Medical Staff Bylaws.

(f) Act as a liaison among the Medical Staff, the Hospital President, the System CEO, and the Board.

(g) Recommend action to the Hospital President and System CEO on medico-administrative matters including, but not limited to, issues related to Hospital operations and planning.

(h) Inform and update the Medical Staff regarding accreditation program requirements and the accreditation status of the Hospital.

(i) Implement and enforce the Medical Staff Bylaws, Policies, and Rules & Regulations

(j) Make recommendations to the Board regarding the Medical Staff structure, the process used to review credentials and delineate Privileges, the

mechanism to recommend suspension or termination of Medical Staff appointment and/or Privileges, and related Medical Staff matters.

(k) Make recommendations to the Board on requests from applicants for, as applicable, Medical Staff appointment/reappointment and/or grant/regrant and delineation of Privileges.

(l) Make recommendations to the Board on actions concerning Practitioners who hold current Medical Staff appointment and/or Privileges at the Hospital pursuant to the applicable procedures set forth in these Bylaws.

(m) Make recommendations to the Board on actions concerning APPs who hold current Privileges at the Hospital pursuant to the applicable procedures set forth in the APP Policy.

(n) Request evaluation of Practitioners and APPs granted Privileges at the Hospital in instances where there is doubt about the Practitioner's or APP's ability to perform the Privileges requested.

(o) Be responsible to the Board for the general quality of medical care rendered to patients in the Hospital by Practitioners and APPs granted Privileges at the Hospital.

(p) Review changes to quality assurance and utilization review plans applicable to medical care of patients and assure participation of the Medical Staff in the Hospital's quality and performance-improvement activities.

(q) Review reports from applicable peer review committees regarding the results of inpatient mortality/death reviews.

(r) Fulfill the functions and duties of a Credentials Committee, Nominating Committee, and Bylaws Committee.

(s) Perform such other duties as set forth in the Medical Staff governing documents or applicable accreditation standards.

7.4 MEETINGS

7.4-1 The Medical Executive Committee shall meet at least ten (10) times a year and as otherwise needed to accomplish its duties at the call of the committee chair.

7.4-2 Minutes will be maintained of each MEC meeting, copies of which shall be provided to the Board.

7.5 OTHER STANDING MEDICAL STAFF COMMITTEES

7.5-1 The composition, duties, and meeting requirements of other standing Medical Staff committees are set forth in the Medical Staff Organization Policy.

ARTICLE VIII MEETINGS OF THE MEDICAL STAFF, MEDICAL STAFF DEPARTMENTS & MEDICAL STAFF COMMITTEES

8.1 MEDICAL STAFF MEETINGS

8.1-1 Requirements with respect to Medical Staff meetings (including, but not limited, to notice and quorum requirements, manner of action, the ability to take action without a meeting, *etc.*) are set forth in the Medical Staff Organization Policy.

8.2 DEPARTMENT MEETINGS

8.2-1 Requirements with respect to Medical Staff Department meetings (including, but not limited, to notice and quorum requirements, manner of action, the ability to take action without a meeting, *etc.*) are set forth in the Medical Staff Organization Policy.

8.3 MEDICAL STAFF COMMITTEE MEETINGS

8.3-1 Requirements with respect to Medical Staff committee meetings (including, but not limited, to notice and quorum requirements, manner of action, the ability to take action without a meeting, *etc.*) are set forth in the Medical Staff Organization Policy.

ARTICLE IX COLLEGIAL INTERVENTION, REMEDIATION, FORMAL CORRECTIVE ACTION, SUMMARY SUSPENSION, & AUTOMATIC SUSPENSION/AUTOMATIC TERMINATION

9.1 COLLEGIAL INTERVENTION & REMEDIATION

9.1-1 COLLEGIAL INTERVENTION

(a) Prior to initiating corrective action against a Medical Staff Member for professional conduct or clinical competency concerns, the Medical Staff leaders or Board (through the System CEO, the System CMO, an Associate CMO, or the Hospital President as its administrative agents) may elect to attempt to resolve the concerns collegially.

9.1-2 REMEDIATION

(a) An appropriately designated Medical Staff peer review committee may enter into a voluntary remedial agreement with a Medical Staff Member, consistent with the applicable Medical Staff Policy, to resolve potential clinical competency or conduct issues.

(b) If the affected Medical Staff Member fails to abide by the terms of an agreed-to remedial agreement, the Member may be subject to the formal corrective action procedure set forth in §9.2.

9.1-3 NO OBLIGATION; DOCUMENTATION OF INTERVENTIONS

(a) Nothing in this Section shall be construed as obligating the Hospital or Medical Staff leadership to engage in collegial intervention or remediation prior to implementing formal corrective action on the basis of a single incident.

(b) A written record of any collegial intervention and/or remediation efforts should be prepared and maintained in the Medical Staff Member's confidential peer review file.

9.2 FORMAL CORRECTIVE ACTION

9.2-1 GROUNDS

(a) Corrective action against a Medical Staff Member may be taken whenever the Member engages in conduct, either within or outside the Hospital, that is or is reasonably likely to be:

(1) Contrary to the Medical Staff Bylaws, Policies, Rules & Regulations or applicable System/Hospital policies or procedures.

(2) Detrimental to patient safety or to the quality or efficiency of patient care in the Hospital.

(3) Disruptive to Hospital operations.

(4) Damaging to the Medical Staff's or the Hospital's reputation.

(5) Unethical or below the applicable standard of care.

9.2-2 REQUEST FOR CORRECTIVE ACTION

(a) Any of the following may request that corrective action be initiated:

(1) An officer of the Medical Staff.

(2) The chair of any Department in which the Member exercises Privileges.

(3) Any standing committee of the Medical Staff (including the MEC) or chair thereof.

(4) The System CEO, Hospital President, System Chief Medical Officer, or an Associate Chief Medical Officer.

(5) The Board or Board chair.

(b) All requests for corrective action shall be submitted to the MEC in writing, which writing may be reflected in minutes. The request must be supported by reference to the specific action(s) that constitute(s) the grounds for the request. In the event the request for corrective action is initiated by the MEC, it shall reflect the basis in its minutes.

(c) The chair of the MEC shall promptly notify the System CEO, the Hospital President, and, as applicable, the System/Associate Chief Medical Officers, in writing, of all requests for corrective action and shall continue to keep him/her fully informed of all action taken in conjunction therewith.

9.2-3 MEC OPTIONS

(a) Upon receipt of a request for corrective action, the MEC shall act on the request. The MEC may:

(1) Determine that no corrective action is warranted and close the matter.

(2) Determine that no corrective action is warranted but remand the matter for collegial intervention or remediation/resolution consistent with the applicable Medical Staff governing documents.

(3) Initiate a formal corrective action investigation.

9.2-4 COMMENCEMENT OF FORMAL CORRECTIVE ACTION INVESTIGATION

(a) A matter shall be deemed to be under formal investigation upon the start of a MEC meeting at which a request for corrective action is being presented.

(b) For the sole purpose of determining whether there is a potential reportable event, the matter will be deemed to be under formal corrective action until the end of the MEC meeting at which the issue is presented; provided, however, that if the MEC determines to proceed with a formal corrective action investigation, the matter shall remain under formal investigation until such time as the MEC rejects the request for corrective action, closes the investigation, or a final decision is rendered by the Board.

(c) The affected Medical Staff Member shall be provided with written notice of a determination by the MEC to initiate a corrective action investigation.

9.2-5 FORMAL CORRECTIVE ACTION INVESTIGATION

(a) The investigation process is not a "hearing" as that term is used in the Fair Hearing Policy and does not entitle the Medical Staff Member to the procedural rights provided therein.

(b) The MEC may:

(1) Conduct such investigation itself.

(2) Assign the task to a Medical Staff officer, Department Chair, the System or an Associate Chief Medical Officer, or a standing or *ad hoc* Medical Staff committee.

(3) Refer the matter to the Board for investigation and resolution.

(c) The investigating individual/group will proceed with its investigation in a prompt manner. The investigative process may include, without limitation: a meeting with the Medical Staff Member involved who may be given an opportunity to provide information in a manner and upon such terms as the investigating individual/group deems appropriate; with the individual or group who made the request; and/or with other individuals who may have knowledge of or information relevant to the events involved.

(d) If the investigation is conducted by a group or individual other than the MEC or the Board, that group or individual shall submit a written report of its investigation, which may be reflected by minutes, to the MEC as soon as is practicable after its receipt of the assignment to investigate. The report should contain such detail as is necessary for the MEC to rely upon it

including recommendations for appropriate corrective action, or no action at all, and the basis for such recommendations.

(e) The MEC may, at any time in its discretion and shall at the request of the Board, terminate the investigative process and proceed with action as provided below.

9.2-6 MEC ACTION

(a) As soon as is practicable following completion of its report (which may be reflected by minutes), or receipt of a report from the investigating individual or group, the MEC shall act upon the request for corrective action. The MEC's actions may include, without limitation, the following:

(1) A determination that no corrective action be taken.

(2) Issuance of a verbal or written warning or a letter of reprimand.

(3) Imposition of a focused professional practice evaluation period with retrospective review of cases and/or other review of clinical competence or conduct but without a requirement of prior or concurrent consultation or direct supervision.

(4) Imposition of prior or concurrent consultation or direct supervision or other form of focused professional practice evaluation that limits the Medical Staff Member's ability to continue to exercise previously exercised Privileges for a period up to fourteen (14) days.

(5) Imposition of a reduction, limitation/restriction, or suspension of all, or any part, of the Medical Staff Member's Privileges for a period up to fourteen (14) days.

(6) Other actions deemed appropriate under the circumstances that will result in a limitation or reduction of the Medical Staff Member's Privileges for a period up to fourteen (14) days.

(7) Recommendation of imposition of prior or concurrent consultation or direct supervision or other form of focused professional practice evaluation that limits the Medical Staff Member's ability to exercise previously exercised Privileges for a period in excess of fourteen (14) days.

(8) Recommendation of a limitation/restriction, reduction, or suspension of all, or any part, of the Member's Privileges for a period in excess of fourteen (14) days.

(9) Recommendation of other actions deemed appropriate under the circumstances that will result in a limitation or reduction of the Member's Privileges for a period in excess of fourteen (14) days.

(10) Recommendation of revocation of all, or any part, of the Member's Privileges.

9.2-7 EFFECT OF MEC ACTION

(a) Adverse

(1) When the MEC's recommendation is Adverse (as defined in these Bylaws and the Fair Hearing Policy) to the Medical Staff Member, the Chief of Staff shall inform the Member, by Special Notice, and the Member shall be entitled, upon timely and proper request, to the procedural rights contained in these Bylaws and the Fair Hearing Policy. The Chief of Staff shall then hold the Adverse recommendation in abeyance until the Medical Staff Member has exercised or waived the right to a hearing and appeal after which the final MEC recommendation, together with all accompanying information, shall be forwarded to the Board.

(b) Referral/Failure to Act

(1) If the MEC (i) refers the matter to the Board; or (ii) fails to act on a request for corrective action within an appropriate time as determined by the Board, the Board may proceed with its own investigation or determination as applicable to the circumstances. In the case of (ii), the Board shall make such determination after notifying the MEC of the Board's intent and allowing a reasonable period of time for response by the MEC.

(i) If the Board's decision is not Adverse to the Medical Staff Member, the action shall be effective as its final decision and the System CEO or Hospital President shall inform the Member of the Board's decision by Special Notice.

(ii) If the Board's action is Adverse to the Member, the System CEO or Hospital President shall inform the Member, by Special Notice, and the Member shall be entitled, upon timely and proper request, to the procedural rights set forth in the Medical Staff Bylaws and Fair Hearing Policy.

9.2-8 Other Action

The commencement of corrective action procedures against a Medical Staff Member shall not preclude the summary suspension or automatic suspension or automatic termination of the Medical Staff appointment and/or all, or any portion,

of the Member's Privileges in accordance with the applicable procedures set forth in this Article.

9.3 SUMMARY SUSPENSION

9.3-1 Whenever a Practitioner's conduct is of such a nature as to require immediate action to protect the life of any patient(s) or to reduce the substantial likelihood of imminent danger to the health or safety of any patient, employee, or other person present in the Hospital, any of the following have the authority to summarily suspend the Medical Staff appointment and/or all, or any portion, of the Clinical Privileges of such Practitioner:

(a) Chief of Staff

(b) Applicable Department Chair

(c) MEC

(d) System CEO or Hospital President

(e) System Chief Medical Officer or an Associate Chief Medical Officer

(f) Board or its chair

9.3-2 A summary suspension is effective immediately.

9.3-3 The person(s) or group imposing the summary suspension shall immediately inform the System CEO, Hospital President, and, as applicable, the System/Associate Chief Medical Officers of the suspension. The System CEO or Hospital President shall promptly give Special Notice thereof to the Practitioner.

9.3-4 The Chief of Staff or applicable Department Chair shall assign a suspended Practitioner's patients then in the Hospital to another Practitioner with appropriate Privileges considering the wishes of the patient, where feasible, in selecting such substitute.

9.3-5 As soon as possible, but in no event later than five (5) days after a summary suspension is imposed, the MEC, if it did not impose the summary suspension, shall convene to review the matter and consider the need, if any, for formal corrective action pursuant to §9.2. Such a meeting of the MEC shall not be considered a "hearing" as contemplated in these Bylaws or the Fair Hearing Policy (even if the involved Practitioner attends the meeting) and no procedural requirements shall apply.

9.3-6 The MEC may modify, continue, or terminate a summary suspension provided that the summary suspension was not imposed by the Board (or the System CEO, Hospital President, System CMO, or an Associate CMO).

9.3-7 In the case of a summary suspension imposed by the Board (or the System CEO, Hospital President, System CMO, or an Associate CMO) the MEC shall give its recommendation to the Board as to whether such summary suspension should be modified, continued, or terminated. The Board may accept, modify, or reject the MEC's recommendation.

9.3-8 Not later than fourteen (14) days following the original imposition of the summary suspension, the Practitioner shall be advised, by Special Notice, of the MEC's determination; or, in the case of a summary suspension imposed by the Board (or the System CEO, Hospital President, System CMO, or an Associate CMO), of the MEC's recommendation as to whether such summary suspension should be terminated, modified, or sustained.

9.3-9 If a summary suspension remains in place for more than 14 days, the Practitioner shall be advised, by Special Notice, of the Practitioner's rights, if any, pursuant to these Bylaws and the Fair Hearing Policy.

9.4 AUTOMATIC SUSPENSION

9.4-1 GROUNDS FOR AUTOMATIC SUSPENSION/LIMITATION

The following events shall result in an automatic suspension (or limitation) of a Practitioner's Medical Staff appointment and/or Privileges, as applicable, without recourse to the procedural due process rights set forth in the Fair Hearing Policy.

(a) License Suspension/Expiration

(1) Whenever a Practitioner's license is suspended by the applicable licensing entity or expires (subject to §9.5-1(a)), his/her Medical Staff appointment and Clinical Privileges shall be automatically suspended.

(b) License Restriction

(1) Whenever a Practitioner's license is limited or restricted by the applicable licensing entity, his/her Medical Staff appointment and Clinical Privileges will be similarly automatically limited or restricted.

(c) DEA Registration Suspension

(1) Whenever a Practitioner's DEA registration (or other authorization to prescribe controlled substances) is suspended, his/her Medical Staff appointment and Privileges shall be automatically suspended.

(d) DEA Registration Restriction

(1) Whenever a Practitioner's DEA registration (or other authorization to prescribe controlled substances) is limited or restricted, his/her right to prescribe medications covered by the registration will be similarly automatically limited or restricted.

(e) Federal Healthcare Program Suspension

(1) Whenever a Practitioner is suspended from participating in a Federal Healthcare Program, his/her Medical Staff appointment and Privileges shall be automatically suspended.

(f) Failure to Satisfy Professional Liability Insurance Requirements

(1) If a Practitioner's Professional Liability Insurance coverage lapses, falls below the required minimum, is terminated, or otherwise ceases to be in effect, in whole or in part, the Practitioner's Medical Staff appointment and Privileges shall be automatically suspended until Professional Liability Insurance coverage is restored or the matter is otherwise resolved pursuant to §9.5-1(c) below.

(2) The Medical Staff Services Department must be provided with a certified copy of the insurance certificate from the insurance company and a written statement explaining the circumstances of the Practitioner's non-compliance with the Hospital's Professional Liability Insurance requirements, any limitation on the new policy, and a summary of relevant activities during the period of non-compliance.

(3) For purposes of this section, the failure of a Practitioner to provide proof of Professional Liability Insurance shall constitute failure to meet the requirements of this provision.

(g) Failure to Complete Required Education/Training

(1) Failure by a Practitioner to complete Hospital training (*e.g.,* EPIC, safety, *etc.*) in accordance with the requirements set forth in an applicable Medical Staff Policy, as such policies may be amended from time to time, shall result in automatic suspension of the Practitioner's Medical Staff appointment and Privileges.

(h) Failure to Pay Dues

(1) Failure to pay dues in accordance with the requirements set forth in the Medical Staff Credentials Policy shall result in an automatic suspension of a Practitioner's Medical Staff appointment and Privileges.

(i) Vaccinations/Immunizations/Health Screenings

(1) Failure to provide documentation of required vaccinations, immunizations, and/or health screenings (or an approved qualified exemption therefrom); failure to comply with vaccination exemption conditions; or failure to otherwise take a leave of absence (when applicable) in accordance with the requirements set forth in the applicable System, Hospital, and/or Medical Staff policies will result in an automatic suspension of the Practitioner's appointment and Privileges subject to §9.5-1 (f) below.

(j) Delinquent Medical Records

(1) Failure by a Practitioner to complete medical records (or components thereof), as provided for in the Delinquent Medical Records Policy, shall result in an automatic suspension of the Practitioner's Clinical Privileges.

9.4-2 EFFECT OF AUTOMATIC SUSPENSION

(a) During such period of time when a Practitioner's Medical Staff appointment and/or Privileges are automatically suspended or limited pursuant to §9.4-1 (a)-(i), he/she may not, as applicable, exercise any Prerogatives of appointment including, but not limited to, any Privileges at the Hospital, participate in on-call coverage, schedule surgery, admit patients, or otherwise provide care, treatment, and/or services at the Hospital.

(b) A Practitioner whose Privileges are automatically suspended or limited pursuant to §9.4-1 (j) for delinquent medical records is subject to the same limitations except that such Practitioner may, as applicable:

(1) Conclude the management of any patient under his or her care in the Hospital at the time of the effective date of the automatic suspension/limitation of Privileges.

(2) Attend an obstetrical patient who has been under his or her care and management and who is admitted to the Hospital.

(3) Attend to the management of patients requiring emergency care and intervention.

(4) Perform surgery for any patient under his/her care whose admission or outpatient procedure was scheduled prior to the effective date of the automatic suspension.

9.4-3 ACTION FOLLOWING AUTOMATIC SUSPENSION

(a) Following imposition of an automatic suspension or limitation, the MEC shall convene, as necessary, to determine if corrective action is necessary in accordance with §9.2.

(b) The lifting of the action or inaction that gave rise to an automatic suspension or limitation of the Practitioner's Medical Staff appointment and/or Privileges shall result in the automatic reinstatement of such appointment and/or Privileges; provided; however, that the Practitioner shall be obligated to provide such information as the Medical Staff Services Department shall reasonably request to assure that all information in the Practitioner's credentials file is current

9.5 AUTOMATIC TERMINATION

9.5-1 GROUNDS FOR AUTOMATIC TERMINATION

The following events shall result in an automatic termination of the Practitioner's Medical Staff appointment and Privileges without recourse to the procedural due process rights set forth in the Fair Hearing Policy.

(a) License Termination/Expiration

(1) Whenever a Practitioner's license to practice is revoked by the applicable licensing entity or a Practitioner (whose Medical Staff appointment and Privileges were automatically suspended pursuant to §9.4-1 (a) for an expired license) fails to renew his/her license within thirty (30) days of its expiration, his/her Medical Staff appointment and Privileges shall be automatically terminated.

(b) Revocation of DEA Registration

(1) Whenever a Practitioner's DEA registration (or other authorization to prescribe controlled substances) is revoked, his/her Medical Staff appointment and Privileges shall be automatically terminated.

(c) Failure to Satisfy Professional Liability Insurance Requirements

(1) If a Practitioner's Professional Liability Insurance coverage lapses, falls below the required minimum, is terminated, or otherwise ceases to be in effect for a period greater than sixty (60) days, the Practitioner's Medical Staff appointment and/or Privileges shall automatically terminate as of the sixty-first (61st) day.

(2) For purposes of this provision, the failure of a Practitioner to provide proof of Professional Liability Insurance shall constitute a failure to meet the requirements of this provision.

(d) Federal Healthcare Program Exclusion

(1) Whenever a Practitioner is excluded from participating in a Federal Healthcare Program, his/her Medical Staff appointment and Privileges shall be automatically terminated.

(e) Felony/Other Designated Offenses

(1) If a Practitioner pleads guilty to, is found guilty of, or pleads no contest to a felony, the Practitioner's Medical Staff appointment and Privileges shall be automatically terminated.

(2) If a Practitioner pleads guilty to, is found guilty of, or pleads no contest to an offense that involves: (i) violence or abuse upon a person; (ii) conversion, embezzlement, or misappropriation of property; (iii) fraud, bribery, evidence tampering, or perjury; or, (iv) drugs, the Practitioner's Medical Staff appointment and Privileges shall be automatically terminated.

(f) <u>Vaccinations/Immunizations/Health Screenings</u>

(1) In the event that documentation of required vaccinations, immunizations, and/or health screenings (or an approved qualified exemption therefrom) is not provided; or, such other identified deficiency is not corrected within thirty (30) days following the date of an automatic suspension of Medical Staff appointment and Privileges pursuant to §9.4-1 (i), the Practitioner's appointment and Privileges shall automatically terminate as of the thirty-first (31st) day.

9.6 CONSISTENCY OF ACTIONS AT HOSPITAL AND AFFILIATE HOSPITALS

9.6-1 So that there is consistency between the Hospital and Affiliate Hospitals regarding corrective action and the status of medical staff appointment and privileges considering that the Hospital and the Affiliate Hospitals are part of the same Health System, and that the Hospital and the Affiliate Hospitals have agreed to share information regarding appointment and/or privileges, the following automatic actions shall occur:

(a) With the exception of an automatic suspension for delinquent medical records, if a Practitioner's appointment and/or privileges are automatically suspended or automatically terminated, in whole or in part, at an Affiliate Hospital(s), the Practitioner's appointment and/or Privileges at this Hospital shall automatically and immediately become subject to the same action without recourse to the procedural rights set forth in these Bylaws and the Fair Hearing Policy.

(b) If a Practitioner's appointment and/or privileges are summarily suspended or if a Practitioner voluntarily agrees not to exercise privileges while undergoing an investigation at an Affiliate Hospital(s), such summary suspension or voluntary agreement not to exercise privileges shall automatically and equally apply to the Practitioner's appointment and/or Privileges at this Hospital and shall remain in effect until such time as the

Affiliate Hospital(s) render(s) a final decision or otherwise terminate(s) the process.

(c) If a Practitioner's appointment and/or privileges are limited, suspended, or terminated at an Affiliate Hospital, in whole or in part, based on professional conduct or clinical competency concerns, the Practitioner's appointment and/or Privileges at this Hospital shall automatically and immediately become subject to the same decision without recourse to the procedural rights set forth in these Bylaws and the Fair Hearing Policy unless otherwise provided in the final decision at the Affiliate Hospital(s).

(d) If a Practitioner resigns his/her medical staff appointment and/or privileges or fails to seek reappointment and/or regrant of privileges at an Affiliate Hospital(s) while under investigation or to avoid investigation for professional conduct or clinical competency concerns, such resignation shall automatically and equally apply to the Practitioner's Medical Staff appointment and/or Privileges at this Hospital without recourse to the procedural rights set forth in these Bylaws and the Fair Hearing Policy.

(e) If a Practitioner withdraws an initial application for Medical Staff appointment and/or privileges at an Affiliate Hospital(s) for professional conduct or clinical competency concerns, such application withdrawal shall automatically and equally apply to applications for Medical Staff appointment and/or Privileges at this Hospital without recourse to the procedural rights set forth in these Bylaws and the Fair Hearing Policy.

ARTICLE X HEARING & APPEAL PROCEDURES

10.1 OVERVIEW

10.1-1 Unless otherwise provided in the Medical Staff Bylaws or Fair Hearing Policy, when a Practitioner receives notice of an Adverse recommendation of the MEC, the Practitioner shall be entitled to a hearing and appellate review, if applicable, in accordance with the procedures set forth in the Fair Hearing Policy.

10.1-2 Unless otherwise provided in the Medical Staff Bylaws or Fair Hearing Policy, when a Practitioner receives notice of an Adverse recommendation or action of the Board, and such decision is not based upon a prior Adverse recommendation of the MEC with respect to which the Practitioner was entitled to a hearing, the Practitioner shall be entitled to a hearing and appellate review, if applicable, in accordance with the procedures set forth in the Fair Hearing Policy.

10.2 SCHEDULING OF HEARING

10.2-1 Upon receipt of a timely and proper request therefore, a hearing shall be scheduled by the Chief of Staff, if the request for hearing was prompted by an Adverse recommendation of the MEC; or, by the Board chair, if the request for hearing was prompted by an Adverse recommendation or action of the Board.

10.3 HEARING OFFICER OR PANEL

10.3-1 The hearing shall be conducted by either a hearing officer or a hearing panel, as determined by the body whose Adverse recommendation or action triggered the request for the hearing.

(a) A hearing officer may be a Practitioner, an individual from outside the Hospital, such as an attorney, or other individual qualified to conduct the hearing. The hearing officer is not required to be a Medical Staff Member.

(b) A hearing panel shall consist of not less than three (3) individuals. The panel members may either be Practitioners, individuals from outside of the Hospital, or a combination thereof.

10.4 CONDUCT OF HEARING/APPEAL

10.4-1 The hearing shall be conducted in a manner consistent with the then current requirements of the Health Care Quality Improvement Act, as amended from time to time, and as further detailed in the Fair Hearing Policy.

ARTICLE XI MISCELLANEOUS

11.1 MEDICAL HISTORY & PHYSICAL EXAMINATION; OUTPATIENT ASSESSMENTS

11.1-1 Patients shall, as applicable, have a medical history and physical examination (H&P) completed and documented no more than thirty (30) days prior to, or within twenty-four (24) hours after, registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. For an H&P that was completed within thirty (30) days prior to registration or inpatient admission, an update documenting any changes in the patient's condition shall be completed within twenty-four (24) hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services.

11.1-2 In lieu of an H&P, an assessment for designated outpatients may be completed and documented after registration but prior to surgery or a procedure requiring anesthesia services provided that the conditions set forth in the Medical Staff Rules & Regulations are met.

11.1-3 The H&P or outpatient assessment, as applicable, shall be completed and documented by a Physician, an Oral Maxillofacial Surgeon, or other qualified licensed individual in accordance with State law and Hospital/Medical Staff policy.

11.1-4 Additional requirements regarding completion and documentation of the H&P or outpatient assessment, as applicable, are set forth the Medical Staff Credentials Policy and the Medical Staff Rules & Regulations.

ARTICLE XII CONFIDENTIALITY, IMMUNITY, AND RELEASES

12.1 SPECIAL DEFINITIONS

12.1-1 For purposes of this Article only, the following definitions shall apply:

(a) Information means documentation of proceedings, minutes, interviews, records, reports, forms, memoranda, statements, investigations, examinations, hearings, meetings, recommendations, findings, evaluations, opinions, conclusions, actions, data, and other disclosures or communications, whether in written or oral form, relating to any of the subject matter specified in §12.5.

(b) Representative means the Board of the Hospital and any trustee/director or committee thereof; the System CEO, Hospital President, System Chief Medical Officer, Associate Chief Medical Officers; the Hospital and authorized Hospital employees; the Medical Staff, its Departments, committees, and any Medical Staff officer, chair, or member thereof; and agents authorized by any of the foregoing to perform specific information gathering, analysis, use, or disseminating functions.

(c) Third Parties means both individuals and organizations providing information to any Representative.

12.2 AUTHORIZATIONS AND CONDITIONS

12.2-1 By submitting an application for Medical Staff appointment/reappointment and/or grant/regrant of Clinical Privileges and at all times that a Practitioner holds Medical Staff appointment and/or Clinical Privileges at the Hospital, a Practitioner:

(a) Authorizes Representatives and Third Parties, as applicable, to solicit, provide, and act upon Information bearing on his/her qualifications for Medical Staff appointment and/or Clinical Privileges.

(b) Agrees to be bound by the provisions of this Article and to waive all legal claims against Representatives and Third Parties who act in accordance with the provisions of this Article.

(c) Acknowledges that the provisions of this Article are express conditions to his/her application for and, as applicable, acceptance and continuation of Medical Staff appointment and/or Clinical Privileges at the Hospital.

12.3 CONFIDENTIALITY OF INFORMATION

12.3-1 All Information submitted, collected, or prepared by any Representative of this Hospital or by any other health care facility or organization or medical staff for the purpose of:

(a) Reviewing, evaluating, monitoring, or improving the quality and efficiency of patient care;

(b) Reducing morbidity and mortality;

(c) Evaluating qualifications (including, but not limited to, current clinical competence) for medical staff appointment and/or clinical privileges;

(d) Contributing to teaching or clinical research;

(e) Determining that health care services are professionally indicated and performed in accordance with the applicable standards of care;

(f) Enforcing guidelines to help keep health care costs within reasonable bounds;

shall, to the fullest extent permitted by law, be confidential.

12.3-2 Dissemination of such Information shall only be made where expressly required by law or authorized by applicable Hospital/Medical Staff policies including, but not limited to, sharing of information policies. Such confidentiality shall also extend to Information of like kind that may be provided by Third Parties. This Information shall not become part of any particular patient's record. It is expressly acknowledged by each Practitioner that violation of the confidentiality provisions provided herein is grounds for corrective action pursuant to these Bylaws.

12.4 IMMUNITY FROM LIABILITY

12.4-1 FOR ACTION TAKEN

No Representative or Third Party, as applicable, shall be liable to a Practitioner for damages or other relief for any decision, opinion, action, statement, or recommendation made within the scope of his/her duties as a Representative or Third Party provided that such Representative or Third Party does not act on the basis of false information knowing it to be false as provided for in the Health Care Quality Improvement Act of 1986 ("HCQIA"), 42 U.S.C. §11101, *et seq*.

12.4-2 FOR GATHERING/PROVIDING INFORMATION

No Representative or Third Party, as applicable, shall be liable to a Practitioner for damages or other relief by reason of providing Information, including otherwise privileged or confidential information, concerning said Practitioner provided that such Representative or Third Party is acting within the scope of his/her duties and does not act on the basis of false information knowing it to be false as provided for in the Health Care Quality Improvement Act of 1986 ("HCQIA"), 42 U.S.C. §11101, *et seq.*

12.5 ACTIVITIES AND INFORMATION COVERED

12.5-1 ACTIVITIES

The confidentiality requirements and immunity provided by this Article apply to all Information in connection with the activities of this Hospital or any other health care facility or organization or medical staff concerning, but not limited to:

(a) Applications for appointment or clinical privileges.

(b) Periodic reappointment or regrant of clinical privileges.

(c) Corrective actions.

(d) Hearings and appellate reviews.

(e) Quality/peer review program activities.

(f) Utilization review and management activities.

(g) Other Hospital, committee, Department, or Medical Staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

12.5-2 INFORMATION

The Information referred to in this Article may relate to a Practitioner's qualifications for Medical Staff appointment and/or Clinical Privileges (including, but not limited to, clinical competency, judgment, character, ability to exercise the Privileges requested with or without a reasonable accommodation, professional ethics, *etc.*) or any other matter that might directly or indirectly affect patient care.

12.6 RELEASES

Each Practitioner shall, upon request of the Hospital, execute general and specific releases in accordance with the tenor and import of this Article, subject to applicable state and federal laws. Execution of such releases is not a prerequisite to the effectiveness of this Article.

12.7 CUMULATIVE EFFECT AND SEVERABILITY

Provisions in these Bylaws and in application forms relating to authorizations, confidentiality of Information, and immunities from liability are in addition to other protections provided by relevant state and federal laws and not in limitation thereof. A finding by a court of law or administrative agency with proper jurisdiction that all or any portion of any such provision is not enforceable shall not affect the legality or enforceability of the remainder of such provision or any other provision.

ARTICLE XIII ADOPTION & AMENDMENT OF MEDICAL STAFF BYLAWS, POLICIES, AND RULES & REGULATIONS

The following procedures shall be followed in adopting and amending the Medical Staff Bylaws, Policies, and Rules & Regulations. Subject to the provisions set forth below, neither the Board nor the Medical Staff may unilaterally amend the Medical Staff Bylaws, Policies, or Rules & Regulations.

13.1 MEDICAL STAFF AUTHORITY AND RESPONSIBILITY

13.1-1 The Board holds the Medical Staff responsible for the development, adoption, amendment, and periodic review of Medical Staff Bylaws, Policies, and Rules & Regulations all of which must be consistent with Hospital policies, applicable laws, rules, regulations, and accreditation requirements.

13.1-2 The Medical Staff, in turn, delegates to the MEC responsibility for adoption and amendment of Medical Staff Policies and Rules & Regulations.

13.2 METHODOLOGY

13.2-1 MEDICAL STAFF BYLAWS

(a) The Medical Staff Bylaws, or proposed amendments thereto, shall be referred first to the Medical Executive Committee for review.

(b) The Medical Executive Committee shall report on such Medical Staff Bylaws (or amendments thereto), either favorably or unfavorably, at the next regular meeting of the Medical Staff or at a special meeting called for such purpose.

(c) The Medical Staff Bylaws, or amendments thereto, shall be made available for review by the voting Members of the Medical Staff, at least fourteen (14) days prior to adoption or amendment.

(d) Adoption or amendment of the Medical Staff Bylaws shall occur in one of the following ways:

(1) By a majority affirmative vote of those Medical Staff Members eligible to vote who are present and voting at a Medical Staff meeting at which a quorum is present; OR,

(2) By ballot, without a Medical Staff meeting. In such event, ballots shall be distributed to each Medical Staff Member eligible to vote. Completed ballots shall be returned within the time period specified and according to the instructions that accompany the ballot. Ballots received after the stipulated date shall not be counted. Adoption or amendment of the Bylaws shall require a majority affirmative vote of the total votes returned by the stipulated date.

(e) The adoption or amendment of the Medical Staff Bylaws shall be effective when approved by the Board.

(f) If the Board proposes to make any changes to the Medical Staff's recommendations, the Board shall submit such changes to the MEC. The MEC may thereafter solicit input from the Medical Staff and/or otherwise provide comment(s) to the Board.

(g) If there is disagreement between the Board and the Medical Staff regarding adoption or amendment of the Medical Staff Bylaws, the matter shall be referred to the Joint Conference Committee for review and recommendation. Upon receipt of the Joint Conference Committee's recommendation, the Board may then render its final decision.

13.2-2 **MEDICAL STAFF POLICIES AND RULES & REGULATIONS**

(a) Subject to subsections (1) through (4) below, adoption or amendment of Medical Staff Policies and Rules & Regulations shall be by vote of the MEC subject to approval by the Board.

(1) If the MEC proposes to adopt a Rule or Regulation, or an amendment thereto, it shall first communicate the proposal to the Medical Staff prior to an MEC vote.

(2) When the MEC adopts a Medical Staff Policy, or an amendment thereto, the MEC shall communicate such Policy, or amendment, to the Medical Staff following Board approval.

(3) In the event the voting members of the Medical Staff propose to adopt a Medical Staff Rule/Regulation or Policy, or an amendment thereto, the Medical Staff shall first communicate its proposal to the MEC.

(4) In the event of a documented need for an urgent amendment to a Medical Staff Rule or Regulation necessary to comply with law or regulation, the MEC may provisionally adopt and the Board may provisionally approve such urgent amendment without prior notice to the Medical Staff. In such event, the Medical Staff shall thereafter be immediately notified by the MEC and shall be provided with the opportunity for retrospective review of, and comment on, the provisional amendment. If the Medical Staff agrees with the MEC's action, the provisional amendment shall stand. If the Medical Staff disagrees with the MEC's action, a meeting of the MEC and Medical Staff shall be held and, if necessary, a revised amendment shall be submitted to the Board for action.

(b) Adoption or amendment of Medical Staff Policies or the Rules & Regulations shall occur in one of the following ways:

(1) By a majority affirmative vote of those MEC members eligible to vote who are present and voting at an MEC meeting at which a quorum is present; OR,

(2) By ballot, without an MEC meeting. In such event, ballots shall be distributed to each MEC member eligible to vote. Completed ballots shall be returned within the time period specified and according to the instructions that accompany the ballot. Ballots received after the stipulated date shall not be counted. Adoption or amendment of the a Medical Staff Policy or the Rules & Regulations shall require a majority affirmative vote of the total votes returned by the stipulated date.

(c) If the Board proposes any changes to the MEC's recommendations, the Board must submit its proposed changes to the MEC for review and subsequent recommendation.

(d) If there is disagreement between the Board and the MEC regarding adoption or amendment of a Medical Staff Policy or the Rules & Regulations, the matter shall be referred to the Joint Conference Committee for review and recommendation. Upon receipt of the Joint Conference Committee's recommendation, the Board may then render a final decision.

(e) New or amended Medical Staff Policies and Rules & Regulations will become effective upon approval by the Board.

13.3 TECHNICAL AND EDITORIAL AMENDMENTS

13.3-1 The MEC shall have the power to adopt such amendments to the Medical Staff Bylaws Policies, and Rules & Regulations as are, in its judgment, technical modifications or clarifications, reorganization or renumbering, or amendments made necessary because of punctuation, spelling, or other errors of grammar or expression, inaccurate cross-references, or to reflect changes in committee names.

13.3-2 Such amendments shall be effective immediately and shall be permanent if not objected to by the Medical Staff (as applicable) or the Board within ninety (90) days of adoption by the MEC. The action to amend may be taken by motion acted upon in the same manner as any other motion before the MEC. After approval, such amendments shall be communicated to the Medical Staff and to the Board.

13.4 ACTION BY MEDICAL STAFF MEMBERS

Any active Medical Staff Member may raise a challenge to any Medical Staff Policy established by the MEC and approved by the Board. In order to raise such challenge, the Member must submit to the MEC a petition signed by not less than two-thirds (2/3rds) of the Members Staff Members eligible to vote. Upon receipt of the petition, the MEC shall either (a) provide the petitioners with information clarifying the intent of such Medical

Staff Policy; and/or (b) schedule a meeting with the petitioners to discuss the issue. In the event that the issue cannot be resolved to the satisfaction of the petitioners, the matter shall be brought before the Medical Staff for vote subject to final review and action by the Board.

13.5 MEDICAL STAFF/MEC CONFLICT RESOLUTION

In the event of a conflict between the MEC and the Medical Staff (on issues other than those involving individual Practitioners or APPs), as reflected by a signed petition of not less than two-thirds (2/3rds) of the Medical Staff Members eligible to vote, a special meeting of the Medical Staff and MEC shall be convened to discuss issues of concern and seek resolution of the conflict. In the event that the conflict cannot be resolved to the mutual satisfaction of the parties, the matter shall be brought before the Medical Staff for vote subject to final review and action by the Board.

13.6 RESOLUTION OF CONFLICTS BETWEEN DOCUMENTS

13.6-1 All reasonable efforts shall be made to assure that the Medical Staff Bylaws, Policies, and Rules & Regulations, the Hospital's governing documents, and applicable Hospital policies are compatible with each other and compliant with applicable laws, rules, regulations, and accreditation standards.

13.6-2 If there is a conflict between the Hospital's governing documents or policies and the Medical Staff Bylaws, Policies, and/or Rules & Regulations, the Hospital's governing documents/policies shall control; provided, however, that such conflict shall then be referred to the Joint Conference Committee for recommendation to the Board as to how such conflict can be resolved.

13.6-3 If there is a conflict between the Medical Staff Bylaws and a Medical Staff Policy or the Medical Staff Rules & Regulations, the Medical Staff Bylaws shall control; provided, however, that such conflict shall then be referred to the Medical Staff and MEC for resolution of the conflict.

13.7 COMMUNICATION OF CHANGES

A copy of the current Medical Staff Bylaws, Policies, and Rules & Regulations, and any amendments thereto, shall be made available to all Practitioners and Advanced Practice Providers with Clinical Privileges at the Hospital.

CERTIFICATION OF ADOPTION AND APPROVAL

Adopted by the Medical Staff on _______________, 2023

Approved by the Board on _______________, 2023