

BYLAWS
OF THE
MEDICAL STAFF

ST. LUKE'S METHODIST HOSPITAL
CEDAR RAPIDS, IOWA

2011

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DEFINITIONS

"Allied Health Practitioner" or "AHP" - means an individual who is permitted by law to provide patient care services as a dependent practitioner under the direct supervision of other licensed professionals, or an independent practitioner who is not eligible for clinical privileges. Allied Health Practitioners are not members of the Medical Staff.

"Administration" - means personnel hired by the governing body to implement the directives of that body.

"Administrative Medical Director" - means the Vice President Medical Affairs, Chief Medical Officer or physician designated by Administration to function in this capacity.

"Admitting Privileges" - means the authority to admit the patient to the hospital for ongoing care, to twenty-three hour observation, or to the outpatient surgery areas for any procedure which could potentially result in admission to the hospital or which requires a general anesthetic.

"Complete Application" – a medical staff (re)application must be complete before it can be processed. Completion means the following three criteria are satisfied: (1) All blanks on the (re)application form are filled in and all necessary additional explanations are provided; (2) Verification of the information is complete; that is, all information necessary to properly evaluate the (re)applicant's qualifications has been received and is consistent with the information provided in the (re)application form; (3) Responsive letters of reference and information from past hospitals and other affiliations have been received, including letters from department chairs or other physicians who have worked with or observed the applicant (in cases of re-applicants, hospital peer review data will be collected and reviewed).

"Clinical Privileges" or "Privileges"- authority that is granted to render specific patient services without supervision, consistent with licensure, education, training and experience, and includes unrestricted access to those hospital resources which are necessary to effectively exercise privileges.

"Co-Admitting Privileges" - means the authority to admit the patient to the hospital for ongoing care, to twenty-three hour observation, or to the out-patient surgery areas for any procedure which could potentially result in admission to the hospital or which requires a general anesthetic, subject to designating a member of the Medical Staff holding admitting privileges to assume responsibility for medical evaluation, history and physical examination and overall responsibility for the patient's course of care in the hospital.

"Medical Executive Committee" or "MEC"- means the executive committee of the medical staff.

"Ex Officio" – means membership on a committee without the right to vote or attend executive sessions of the committee. Ex officio members do not count towards a quorum needed for a committee to conduct business.

"Board of Directors" or "Board"- means the Board of Directors of St. Luke's Methodist Hospital, Cedar Rapids, Iowa, which is the governing body of the hospital.

"Investigation"- means a process specifically ~~instigated~~ initiated by the Medical Executive Committee to ~~determine evaluate the validity, if any, to~~ a concern or complaint ~~raised against~~ with a medical staff member or individual holding clinical privileges, and does not include activity of the Medical Staff Wellness Committee.

"Medical Staff" - means the Medical Staff of St. Luke's Methodist Hospital, the organization of credentialed physicians, podiatrists, and dentists who have been granted medical staff membership pursuant to the bylaws of the medical staff.

"Member" - means any practitioner who is a member of the medical staff.

"Physician" - means an appropriately licensed medical physician and/or osteopathic physician.

"Practitioner"- means any dentist, oral/maxillofacial surgeon, podiatrist, or MD/DO who is a member of the medical staff or an applicant for medical staff membership and/or privileges.

"CEO or his/her representative" - means the Chief Executive Officer or appointed by the Board to act in its behalf in the overall management of the hospital.

"President of the Medical Staff" - is the chief executive of the medical staff.

"Special Notice" – means a letter sent by U.S. mail, registered with return receipt requested.

"Secret ballot"-means a written ballot that is returned in a double envelop manner to protect the identity of the person voting.

"In Good Standing"- means membership and/or privileges are not involuntarily limited, restricted, suspended, or otherwise encumbered for disciplinary reasons (excluding leaves of absence).

ARTICLE I
Purposes

It is the responsibility of the medical staff to:

1. initiate and maintain rules and regulations for self-government of the medical staff.
2. recommend to the Board qualified practitioners to the medical staff and to establish procedures governing the periodic monitoring, evaluation and review of a medical staff member's performance in the hospital.
3. provide health education for the public and to provide medical education opportunities for medical staff and hospital employees.
4. provide a forum whereby issues concerning the medical staff and the hospital may be discussed by the medical staff with the Board and the CEO.

These Bylaws, as adopted or amended, create a system of mutual rights and responsibilities between members of the Medical Staff and the Hospital, to which the Medical Staff members and the Hospital intend to be bound.

ARTICLE II
Membership

SECTION 1. NATURE OF MEDICAL STAFF MEMBERSHIP

Membership on the medical staff of St. Luke's Methodist Hospital shall be extended only to professionally competent practitioners who continuously meet the qualifications, standards and requirements set forth in these bylaws. No aspect of medical staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color or national origin.

SECTION 2. QUALIFICATIONS FOR MEMBERSHIP

- a. Applicants must provide documentation of background, current Iowa licensure, relevant training and/or experience, demonstrated competence, adherence to the ethics of their profession, good reputation, and ability to work with others sufficient to ~~provide assurance to~~ assure the medical staff and the Board that patients cared for by them in the hospital receive medical care at the professional level of quality required by the medical staff.
- b. No applicant shall be entitled to membership on the medical staff or to the exercise of particular clinical privileges in the hospital merely by virtue of the fact that the practitioner is duly licensed to practice medicine, podiatry, or dentistry in this or in any other state, or that the practitioner is a member of any professional organization, or that he/she had in the past or presently is a member of this medical staff or is employed by or under contract with this hospital. Applicants shall not be granted or denied medical staff membership or privileges because of membership on this or any other medical staff or professional organization, lack of employment by the hospital, or because of legitimate business activities that compete with the hospital or other medical staff members.

- c. The applicant must be able to respond to his/her hospitalized patients or requests for services within a reasonable time period as defined by the relevant medical staff departments.
- d. Each member of the medical staff must attest to or provide documentation that he/she has no physical or mental limitations relevant to the clinical privileges which would impair his/her ability to render quality patient care, at the time of initial application, during the pendency of the practitioner's appointment, and upon each application for additional privileges and biennial reapplication for medical staff membership and clinical privileges.
- e. Proof of current malpractice liability insurance is required for membership in amounts jointly agreed upon by the Medical Executive Committee and the Board of Directors. This coverage must be provided by an insurer licensed or approved by the Iowa State Insurance Commission. Proof of current coverage must be provided on an annual basis according to the [renewal insurance](#) date, in order to remain an associate, active, refer and follow, or adjunct member of the medical staff.
- f. All members of the medical staff must agree to subject their performance to, and ~~faithfully~~ participate in, the hospital's quality/risk management programs as the same may from time to time be in effect in accordance with the requirements of the responsible quality improvement organization and other external regulatory agencies.

SECTION 3. RESPONSIBILITIES OF MEMBERSHIP

Each member of the medical staff shall:

- a. Exercise any clinical privileges granted at the professional level of quality in an economically efficient manner as established by the medical staff taking into account patients' needs, the available hospital facilities and resources, and utilization standards in effect at the hospital. Nothing in these bylaws shall be construed to authorize the hospital to exercise any supervision or control over the practice of medicine. The practitioner shall maintain the ultimate responsibility for providing professional services to patients that are medically necessary, appropriate, and otherwise consistent with medical staff standards.
- b. Abide by the medical staff bylaws and by other policies and rules of the medical staff.
- c. Discharge such staff, department, committee, and all other functions for which the practitioner is responsible by staff category assignment, appointment, election, or other operation of these bylaws.
- d. Prepare and complete in timely fashion the medical and other required records for all patients admitted and/or cared for by the practitioner.
- e. Participate in medical staff peer review and other quality improvement activities.
- f. Abide by the ethical principles of the practitioner's profession.
- g. Provide written copy of renewed licensure documentation as requested by the Medical Staff Office.

SECTION 4. CONDITION AND DURATION OF APPOINTMENT

- a. Initial appointments and reappointments to the medical staff shall be made by the Board and shall be before a period of not more than two years. The Board shall act on appointments, reappointments, or revocation of appointments, and the delineation of setting-specific privileges only after receiving a recommendation from the medical staff as provided in these bylaws.

Any practitioner whose engagement by the hospital or by any other organization in any administrative capacity with related clinical responsibilities which require membership on the medical staff should, unless otherwise provided by agreement with the hospital, be entitled to the same procedural fairness accorded any other medical staff member when his/her medical staff privileges are terminated or otherwise adversely affected.

- b. Reappointments shall be for a period of not more than two years.
- c. Every application for staff appointment shall be signed by the applicant and shall contain the applicant's specific acknowledgment of every medical staff member's obligations to provide continuous care and supervision of his/her patients, to abide by the bylaws, rules and regulations of the medical staff, and to accept committee assignments and carry out all the responsibilities associated therewith.
- d. All members of the medical staff, except honorary members, are required to pay the annual staff dues in order to retain staff membership.

Section 5. MEMBERS' CONFLICTS OF INTERESTS

Officers, department chairs, section chiefs, medical staff representatives, and those medical staff members selected for committees represent the interests of the medical staff in improving patient care. To meet this obligation to the medical staff and to enable decision-making, every medical staff leader and candidate, and all medical staff members appointed to committees shall disclose potential conflicts of interest to the relevant medical staff authority. Membership and privileges are not affected by any conflict of interest or the declaration of any potential conflict of interest. Exercise of certain medical staff obligations and prerogatives may be affected by these conflict of interest requirements.

a. Members Subject to Disclosure Requirement

Prior to the date of election or appointment, members must disclose conflicts of interest if:

- they are asked to serve as proctors or reviewers;
- they are appointed to committees or to chair committees, including but not limited to hearing committees;
- they are asked to allow themselves to be nominated or are nominated for any leadership position.

The information is shared only with those who need the information to make an informed decision: those with a vote in the election obtain disclosure from candidates; peer review committee members obtain information from other committee members and reviewers; leaders obtain information from those who may be appointed to serve in a peer review or other decision-making capacity. Failure to disclose upon reasonable request will automatically disqualify the member from the position at issue; repeated refusal to disclose can be grounds for ~~membership termination~~ [disqualification from position in which the conflict exists](#).

b. Disclosing Financial Information

Members' financial interests are unrelated to qualifying for and maintaining medical staff membership and privileges. However, financial interests could be an issue when the member serves as a peer

reviewer, in medical staff leadership and on committees. Prior to the date of election or appointment, those financial interests that may influence or appear to influence members in certain leadership or decision-making situations must be disclosed in those circumstances in which the interests are or could be involved, include:

- Hospital contracts, employment, lease, ownership interest, joint venture, or other financial relationship with the hospital or hospital system or any management company operating the hospital
- Employment, partnership or other economic affiliation with individuals or entities involved in the subject matter of the review or other medical staff activity
- Grants, academic affiliation, research support
- Significant interest in hospital vendors, suppliers, manufacturers, or donors
- Competitive or collaborative relationships
- Economic competitors
- Any relationship that is affected by the outcome of a peer review, medical equipment selection or other decision.

c. **Disclosing Personal Information**

Members' personal affiliations and relationships are unrelated to qualifying for and maintaining medical staff membership and privileges. Personal relationships interests could be an issue when the member serves as a peer reviewer, in medical staff leadership and on committees. Those personal relationships that may influence or appear to influence members in certain leadership or decision-making situations must be disclosed in those circumstances in which the interests are or could be involved, including

- Employment, partnership or other economic affiliation
- Family relationship/Friendship
- Enmity or serious hostility

Because of the potential adverse ramification of overly broad dissemination, any personal or financial information disclosed is shared only as needed and used solely for the purpose of resolving conflicts of interest.

d. Failure to disclose the conflicts of interest may invoke corrective action and fair hearing process.

ARTICLE III
Categories of the Medical Staff

The medical staff shall be organized into active, provisional, adjunct, refer and follow, and honorary categories.

SECTION 1. THE ACTIVE MEDICAL STAFF

- a. The active staff shall consist of practitioners, each of whom:
 - i. meets the basic membership qualifications set forth in these bylaws and
 - ii. regularly admits patients to, or is otherwise regularly involved in the care of patients in the hospital.
- b. The prerogatives of the active staff members shall be:

- i. to exercise such clinical privileges as are granted to the practitioner pursuant to these bylaws
 - ii. to vote on all matters presented at general and special meetings of the medical staff and of the department and committees of which the practitioner is a member
 - iii. to hold office in the staff organization and in the department and committees of which the practitioner is a member
 - iv. to serve as members of the various diagnostic reading panels (e.g. EKG, EMG, Pulmonary Function testing, coronary CT interpretation, and others that may be developed in the future.
- c. Each member of the active staff shall:
- i. meet the basic responsibilities set forth in these bylaws
 - ii. retain responsibility within the practitioner's area of professional competence for the continuous care and supervision of each patient in the hospital for whom the practitioner is providing services, or arrange a suitable alternative for such care and supervision;
 - iii. actively participate in performance improvement, utilization review, and other evaluation and monitoring activities required by these bylaws and consultation assignments as determined by the appropriate medical staff department policies;

SECTION 2. THE PROVISIONAL MEDICAL STAFF

- a. The provisional medical staff shall consist of practitioners who are appointed initially and are being considered for advancement to membership on the active medical staff. Provisional staff members shall be assigned to a department where their performance shall be observed by the chairman of the department or representative to determine their eligibility for staff membership in other categories. They shall be ineligible to hold office in this medical staff organization. They shall satisfy the membership requirements set forth in the bylaws. Members of the provisional medical staff shall meet the requirements as set forth in Section 1 of this article for active medical staff membership.
- b. All initial appointments to the provisional medical staff shall be for a period of one year. Reappointments to provisional membership may not exceed a full year, at which time the failure to advance an appointee from provisional to another category shall be deemed an involuntary termination of staff membership and privileges. A provisional appointee whose membership is so terminated shall have the rights accorded by these bylaws to a member of the medical staff who has failed to be reappointed.

SECTION 3. THE ADJUNCT MEDICAL STAFF

- a. The adjunct staff shall consist of practitioners, each of whom:
 - i. is not otherwise a member of the staff and meets the general qualifications of Article II, Section 2, except subsection 2(d);
 - ii. possesses adequate clinical and professional expertise.
- b. The prerogatives of the adjunct staff shall be:
 - i. to consult as reasonably requested by other members, exercising only such privileges as are specifically granted to each member pursuant to these bylaws. Adjunct staff may not hold admitting or co-admitting privileges or be solely responsible for managing a patient;
 - ii. to attend meetings of the staff and any staff or hospital education programs, but they shall have no right to hold medical staff leadership positions and may not vote.

- iii. to serve on committees as appointed.

If an adjunct staff member desires to become a member of the active staff, the adjunct member must apply for membership on the active staff as though an initial application. Membership on the adjunct staff does not ensure, guarantee or presuppose eligibility for membership on the active staff or eligibility for admitting or co-admitting privileges.

SECTION 4. REFER AND FOLLOW STAFF

The refer and follow staff shall consist of those staff members who do not have privileges but refer their patients for admission, and wish to have knowledge of their patient's care. There shall be no limitation to the number of contacts allowed to refer and follow, and they may apply for ~~other~~ [a different category of Medical Staff](#) membership at any time.

- a. The prerogatives of Refer and Follow Staff shall be to:
- Refer patients to an active staff member for admission
 - Visit and follow his/her patient while in the hospital
 - Do informational or historical charting
 - Access the medical record both remotely and at the hospital
 - Communicate with the attending
 - Attend and vote at meetings of the General Staff and of the Department and committees of which he/she is a member
 - Serve on committees of the hospital and medical staff
 - Pay dues as established by the Medical Staff
- b. Limitations of the Refer and Follow Staff. A Refer and Follow Staff member may NOT:
- Write orders
 - Do evaluations on any patient at the Hospital
 - Hold office at any level in the staff organization or be chairman of any committee or serve on the MEC
 - Provide emergency room coverage.

SECTION 5. THE HONORARY MEDICAL STAFF

- a. The honorary staff shall consist of practitioners recognized for their outstanding reputations, their noteworthy contributions to the health and medical sciences, or their previous long-standing service to the hospital.
- b. Honorary staff members are not eligible to admit patients to the hospital or to exercise clinical privileges in the hospital. They may, however, attend staff and department meetings and any staff or hospital education meetings. Honorary staff members shall not be eligible to hold office, but may serve on medical staff committees with vote.

~~ARTICLE IV~~
ARTICLE IV

Procedure for Appointment and Reappointment

SECTION 1. APPLICANT FOR INITIAL APPOINTMENT

- a. All applications for appointment to the medical staff ~~shall be~~will be in writing, ~~shall be~~ signed by the applicant, and ~~shall be~~ submitted to the Medical Staff Office on a form jointly approved by the Medical Executive Committee as well as the Board. The application ~~shall~~ requires detailed information concerning the applicant's professional qualifications, ~~shall~~ includes the name of at least three persons who have had extensive experience in observing and working with the applicant and who can provide adequate references pertaining to the applicant's professional competence and ethical character, and shall include information as to whether the applicant's membership status and/or clinical privileges have ever been revoked, suspended, reduced, or not renewed at any other hospital or institution, or his/her license for registration to practice any profession in any jurisdiction has ever been voluntary/involuntarily suspended or terminated, information about previous adverse actions against him (including judgments and settlements in malpractice suits) but also about pending challenges to his/her ability to practice competently; provide the status of his/her drug enforcement administration number and report limitations on his/her ability to practice that have been imposed by others and also instances in which the applicant voluntarily/involuntarily relinquished medical staff membership or privileges elsewhere.
- b. The applicant shall have the burden of producing adequate information for proper evaluation of his/her competence, character, ethics, current health status, data from professional practice review by an organization(s) that currently privileges the applicant (if available) and other qualifications and for resolving any doubts about such qualifications. Any intentional misrepresentation, material misstatement or omission from the application will be cause for rejection of the application. If additional information is required of the applicant to establish that he/she meets the qualifications described in these bylaws, the Administrative Medical Director/or Designee shall request it in writing. The application will not be processed until all information requested is present and current.
- c. If the applicant, subsequent to the date upon which the application was completed and during the time the application is pending, becomes aware of information that could be in any way relevant to this application, the applicant will provide such information in writing within five business days to the medical staff office in order to supplement or amend his/her application.
- d. The complete application shall be submitted to the ~~Administrative Medical Director~~Medical Staff Office. The ~~Administrative Medical Director~~Medical Staff office shall maintain a file of all applications including date of receipt and disposition. The ~~Administrative Medical Director~~ must ~~will~~ determine whether the application is complete before forwarding it to the department chairman and must advise the applicant that the application will not be considered until it is complete, including the required letters of reference. After collecting the references and other materials deemed pertinent, the ~~Administrative Medical Director~~Medical Staff Office shall ~~will~~ transmit the application and supporting materials to the department chairman for evaluation. The department chairman will review the application and make a recommendation to the Credentials Committee. The recommendation may be for approval as submitted, approval with modification or denial. Any recommendation other than for approval ~~should~~ shall be accompanied by the reason for the adverse recommendation.
- e. By applying for appointment to the medical staff, each applicant thereby agrees to appear for interviews in regard to the application; authorizes the hospital to consult with members of the medical

staff of other hospitals with which the applicant has been associated and with others who may have information bearing on his/her professional qualifications, competence, character, ethical qualifications and current health status; consents to the hospital's inspection of all records and documents that may be material to an evaluation of his/her professional qualifications and competence to carry out the clinical privileges the applicant requests; releases from any liability all representatives of the hospital and its medical staff for their acts performed in good faith and without malice in connection with evaluating the applicant and his/her credentials; and releases from any liability ~~at those~~ individuals and organizations who provide information to the hospital in good faith and without malice concerning the applicant's competence, ethics, character, and other qualifications for staff appointments and clinical privileges including otherwise privileged or confidential information.

- f. The application form shall include a statement that the applicant has received and read the bylaws, rules and regulations of the medical staff and that the applicant agrees to be bound by the terms thereof if the applicant is granted membership and/or clinical privileges and to be bound by the terms thereof without regard to whether or not the applicant is granted membership and/or clinical privileges.

SECTION 2. APPOINTMENT PROCESS

- a. The appointment and credentialing process requires the Credentials Committee to verify from the primary source or from a credentials verification organization as applicable, the following information:
- 1) the practitioner's current licensure at the time of granting privileges, renewal of privileges and expiration of privileges;
 - 2) evidence of physical ability to perform the requested privilege
 - 3) data from professional practice review by an organization(s) that currently privileges the applicant (if available);
 - 4) peer and/or faculty recommendation
 - 5) the practitioner's specific relevant training; and
 - 6) the practitioner's current competency
- b. Before granting appointment and setting-specific clinical privileges, the organized medical staff must evaluate the following:
- 1) challenges to any licensure or registration
 - 2) voluntary and involuntary relinquishment of any license or registration
 - 3) voluntary and involuntary termination of medical staff membership
 - 4) voluntary and involuntary limitation, reduction, or loss of clinical privileges
 - 5) any evidence of an unusual pattern of professional liability actions resulting in final judgment and/or settlement against the applicant
 - 6) documentation as to the applicant's current health status
 - 7) relevant practitioner-specific data as compared to aggregate data, when available, and
 - 8) performance measurement data including morbidity and mortality data, when available
- c. The Credentials Committee shall determine through information given by the practitioner, National Data Bank query response, if available, and from other sources available to the committee, including an appraisal from the clinical department chairman in which privileges are sought, whether the practitioner meets all of the qualifications for the category of staff membership and the setting-specific clinical privileges requested by him/her. Recommendations regarding staff membership and privileges

made by the Credentials Committee shall be by majority vote of all of the members of that committee present and voting at meeting when a quorum is present. Every department in which the practitioner seeks clinical privileges shall provide the Credentials Committee with specific written recommendations for delineating the practitioner's setting-specific clinical privileges, and these recommendations shall be made a part of the report. Within ninety (90 days) after receipt of the completed application for membership, the Credentials Committee shall make a written report to the Medical Executive Committee, including its recommendations that the practitioner be provisionally appointed to the medical staff, or rejected for medical staff membership, or that the application be deferred for further consideration. All recommendations to appoint must also specifically recommend conditions relating to such setting-specific clinical privileges. Any recommendation other than for approval should be accompanied by the reason for the adverse recommendation.

- d. At its next regular meeting after receipt of the application and the report and recommendation of the Credentials Committee, the Medical Executive Committee shall determine whether to recommend to the Board that the practitioner be provisionally appointed to the medical staff, that the applicant be rejected for medical staff membership, or that the applicant's application be deferred for further consideration. All recommendations to appoint must also specifically recommend the setting-specific clinical privileges to be granted, which may be qualified by probationary conditions relating to such clinical privileges.
- e. When the recommendation of the Medical Executive Committee is to defer the application for further consideration, it must be followed up within thirty (30) days with a subsequent recommendation for provisional appointment with specified setting-specific clinical privileges, or for rejection for staff membership.
- f. When the recommendation of the Medical Executive Committee is favorable to the practitioner, the Administrative Medical Director or designee shall promptly forward it, together with all supporting documentation to designated representatives of the Board. These representatives, acting on behalf of the Board, and as direct agents of the Board, are ~~given the authority~~ authorized, when necessary, to render expedited appointments and clinical privileges. All actions of the designated representatives shall be ratified by the full governing body at its first subsequent meeting.
- g. When the recommendation of the Medical Executive Committee is adverse to the practitioner, either in respect to appointment or clinical privileges, the hearing procedures as provided in these bylaws are followed. The governing body shall be advised of all adverse recommendations.
- h. At its next regular meeting, after receipt of a favorable recommendation, the Board shall act on the matter. The Board's adoption of the favorable recommendation is the final action on the application. If the Board decision is adverse to the practitioner in respect to either appointment or clinical privileges, the hearing procedures as provided in these bylaws are followed.
- i. At its next regular meeting, after all of the fair hearing procedures under these bylaws have been exhausted or waived, the Board, or its duly authorized committee, shall act on the matter. The Board's decision shall be conclusive, except that the Board may defer final determination by referring the matter back to the hearing committee for further consideration. Any such referral back shall state the reasons therefore, shall set a time limit within which subsequent recommendations to the Board shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. At its next regular meeting after receipt of such subsequent recommendation and new evidence of the matter, if any, the Board shall make a decision either to provisionally appoint the practitioner to the staff, or to reject him/her for staff membership.

- j. When the Board's decision is final, it shall send notice of such decision through the ~~Administrative Medical Director~~President of the Medical Staff to the ~~President of the Medical Staff~~, and by certified mail, return receipt requested, to the practitioner.

SECTION 3. REAPPOINTMENT PROCESS

- a. Renewal or revision of privileges shall be based on a reappraisal of the medical staff member. On or before four months prior to the date of expiration of a medical staff member's appointment, the ~~Administrative Medical Director~~Medical Staff Officer shall notify the practitioner of the date of expiration and send an application for reappointment to be completed. At least ninety (90) days prior to the expiration date, the member shall furnish, in writing, ~~on the application for reappointment;~~a completed application for reappointment including:

- i. complete information and all documents necessary to make his/her file current as listed in the notification, including current license and DEA and state controlled substances registration, professional liability insurance coverage and experience, other institutional affiliations and membership status, board certification status, disciplinary actions pending/completed, health status changes;
- ii. specific request for additions to or deletions from the clinical privileges presently held, with any basis for changes; and
- iii. requests for changes in staff category.

The staff member must sign the reappointment application and in so doing accepts the same conditions as stated in these bylaws in connection with the initial application.

If the applicant, subsequent to the date upon which the application was completed and during the time the application is pending, becomes aware of information that would be in any way relevant to this application, he or she shall provide such information in writing within five (5) working days to the medical staff office in order to supplement or amend his/her application. (For example, if there are any material changes to the status of any responses to the questions or other information provided in the application, the applicant will promptly notify the medical staff office within five (5) working days or less).

- b. The staff member will have thirty (30) days upon which to complete and return the application for reappointment to the ~~Administrative Medical Director~~Medical Staff Officer. If the application is not received within thirty (30) days, the ~~Administrative Medical Director~~Medical Staff Office will send the practitioner a special notice granting the practitioner a seven-day grace period in which to submit the application or to request an extension. Failure, without good cause, ~~to provide the fully completed~~to fully complete the reappointment application with all of the above information or to request an extension prior to or within the grace period is deemed a voluntary resignation from the staff and results in an automatic termination of membership and privileges on the expiration date of the practitioner's current term. A practitioner whose appointment is so terminated is entitled to the procedural rights provided in the fair hearing plan for the sole purpose of determining the issue of good cause under this paragraph.
- c. The Medical Staff Office verifies the information provided on the reappointment application, and notifies the staff member of any information inadequacies or verification problems. This notification must be by special notice, and must indicate the nature of the additional information the staff member is to provide and the deadline for the required response. Failure, without good cause, to respond in a satisfactory manner by that date is deemed a voluntary withdrawal of the application. A practitioner

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whose appointment is so terminated is entitled to the procedural rights provided in these bylaws for the sole purpose of determining whether good cause existed for the failure to comply with the reapplication process.

- d. If the staff member's level of clinical activity at this hospital is not sufficient to permit the applicable medical staff and Board authorities to make an informed judgment as to the practitioner's competence in exercising the clinical privileges requested, the staff member shall have the burden of providing evidence of satisfactory clinical performance.
- e. The Medical Staff Office collects for each staff member's credentials file all relevant information regarding the individual's professional performance and conduct as it pertains to the quality of patient care in the hospital. Such information, which together with the information obtained above, shall form the basis for recommendations and actions shall include, without limitation:
 - i. patterns of care and utilization as demonstrated in the findings of quality review (including medication use, blood and blood component use, operative and other procedure(s), risk management and utilization management activities,
 - ii. sanctions imposed by or pending with other health care facilities or government entities,
 - iii. health status,
 - iv. timely and accurate completion and preparation of medical records,
 - v. professionalism in working with other practitioners and hospital personnel as it affects patient care,
 - vi. ethical behavior, demonstrated clinical competence, and demonstrated clinical judgment in the treatment of patients for privileges currently exercised or requested
 - vii. compliance with all applicable bylaws, policies, rules and procedures of the medical staff,
 - viii. —any other pertinent reliable information regarding clinical ability and professional ethics that may be relevant to the staff member's category and privileges at this hospital including the staff member's activities at other hospitals and medical practice outside the hospital, and
 - ix. continuing medical education requirement fulfillment
- f. The ~~Administrative Medical Director~~ Medical Staff Office transmits the reappointment application and the supporting information and the staff member's credentials file, or relevant portions thereof, with the other required information required by these bylaws to the chairman of the department in which the staff member is requesting privileges.
- g. The ~~chairman of the department~~ appropriate clinical department chair in which the staff member requests or has exercised privileges shall review the reappointment application and its supporting information. If a department chairman requires further information, he/she shall notify, through the ~~Administrative Medical Director~~ Medical Staff Office, the staff member, in writing, of the information required. The notice to the applicant must be by special notice and must include a request for the further information required and the time frame for a response. Failure without good cause to respond in a satisfactory manner by the time specified is deemed a voluntary resignation of membership and all clinical privileges. A practitioner whose appointment is so terminated is entitled to the procedural rights provided in these bylaws for the sole purpose of determining whether good cause existed for the failure to comply with the reapplication process.
- h. Each department chairman forwards to the Credentials Committee a written report with recommendations for, and any special limitations on, reappointment or non-reappointment and staff category and clinical privileges.
- i. The Credentials Committee shall review and evaluate the reappointment application and its supporting information, ~~the information gathered under 3.e above~~, reports and other relevant information available

to it. If the Credentials Committee requires further information, it shall notify, through the ~~Administrative Medical Director, Medical Staff Office~~ the staff member, in writing, of the information required. The notice to him/her must be a special notice, and must include a request for the specific information required and the time frame for response. Failure without good cause to respond in a satisfactory manner by the time specified is deemed a voluntary resignation of membership and all clinical privileges. A practitioner whose appointment is so terminated is entitled to the procedural rights provided in these bylaws for the sole purpose of determining whether good cause existed for the failure to comply with the reapplication process.

- j. The Credentials Committee shall prepare a written report with recommendations for, and special limitations on, reappointment or non-reappointment and staff category and requested clinical privileges. The Credentials Committee's report is transmitted with the chairman's report and supporting documentation as required to the Medical Executive Committee.
- k. Thereafter, the procedure provided in these bylaws relating to recommendations on applications for initial appointment shall be followed.

SECTION 4. LEAVE STATUS

To obtain a leave of absence, lasting greater than 6 months, from the medical staff, a member must submit a written request for leave to the Medical Staff Office, which will send a copy of the request to the applicant's clinical department chairperson(s) and to the Medical Executive Committee. If the leave of absence is unplanned, notification should be sent as soon as possible to the Medical Staff Office. The leave request may not be for a period of more than two years or the pending period of membership, whichever expires first. The request should state clearly the reason for the leave of absence. Upon receipt ~~arrival~~ of the leave of absence request, the Medical Staff Office will notify the member of the requirement to notify the Medical Staff Office their request to return to active practice.

At least 30 days in advance, the affected member must submit a written request for reinstatement of clinical privileges and/or medical staff membership to the Medical Staff Office, which will forward the request to the relevant department chairperson(s) and the MEC for review. The request will include a brief explanation or general description of the member's activities during the leave period. ~~For~~ The appropriate clinical department chairperson(s) will determine whether the member needs re-evaluation to renew some or all privileges, and will make a recommendation to the MEC.

A medical staff member returning from a medical leave of absence may be required to provide the following information, including but not limited to:

- Current documentation of health status
- A current physical examination may be required to affirm that the affected practitioner is physically capable of providing patient care at an expected level of quality required by the medical staff.

After consultation with the department chairperson(s) and the Credentials Committee, the MEC will make a recommendation to the hospital board concerning the reinstatement of the member's privileges and membership. If the MEC recommends denying reinstatement, or if the hospital board rejects an MEC recommendation for reinstatement, the member shall be entitled to hearing and appeal rights as provided in these bylaws.

Failure without good cause to submit the required written request for reinstatement of privileges/membership is deemed a voluntary resignation from the medical staff; however, the member is

entitled to a hearing under these bylaws for the sole purpose of determining whether good cause existed for failure to submit a request for reinstatement as required under these bylaws.

ARTICLE V Clinical Privileges

SECTION 1. NATURE OF CLINICAL PRIVILEGES

In order to be eligible for clinical privileges in the hospital, the applicant must be a physician (MD or DO), dentist, or podiatrist.

SECTION 2. NATURE OF ADMITTING PRIVILEGES

Admitting Privileges may be granted only to practitioners who are authorized to assume overall medical responsibility for ~~a patient~~care of bedded patients. This includes performing the medical evaluation, including the history and physical examination, supervising all other practitioners providing services and directing the patient's overall course of care in the hospital, and completing the patient chart upon discharge. Admitting privileges are not restricted to employees or contractors of the hospital, or with any medical specialty or society.

SECTION 3. NATURE OF CO-ADMITTING PRIVILEGES

Co-admitting Privileges – entitle the practitioner to admit a patient to the hospital for treatment within the practitioner's area of licensure, subject to designating a member of the medical staff holding admitting, and history and physical privileges to assume responsibility for the medical evaluation, history and physical examination, and overall medical responsibility for the patient's course of hospital care. Practitioners with co-admitting privileges must designate a member of the active medical staff at the time of admission ~~to~~ assume who assumes responsibility for the evaluation and care of the affected patient. Patients of allied health professionals must be admitted by a physician member of the medical staff who shall be responsible for the care of ~~any medical problem as required~~ all medical issues requiring treatment during the hospitalization.

SECTION 4. EXERCISE OF PRIVILEGES

- a. Each medical staff member is entitled to exercise only those clinical privileges specifically granted to the practitioner by the Board, consistent with these bylaws.
- b. Prior to granting new or additional privileges not currently listed on a practitioner's delineation of privilege form, the department chairman and appropriate hospital personnel will determine whether the resources necessary to support the requested privilege are currently available or are available within a specified time frame.
- c. Request for delineation of privileges forms are reviewed by the relevant section(s) and department(s), and when changes are recommended, forwarded to the Medical Executive Committee, so that the forms and privileging by the department do not conflict with the current criteria or these bylaws.

SECTION 5. BASIS FOR PRIVILEGES DETERMINATION

In all cases, the applicant ~~shall have~~ has the burden of establishing his/her qualifications and competency for each requested clinical privilege. The criteria for granting clinical privileges will be fairly and consistently applied to all applicants. The recommendation to grant or deny privileges is based upon:

- a. Primary Source Verification of applicant information, including verification of:
 - i. Current licensure
 - ii. Education
 - iii. Medical Training
 - iv. Clinical Experience(Past and Present)
 - v. Demonstrated competence to meet the credentialing and privileging standards of Centers for Medicare and Medicaid Services Conditions of Participation.
 - vi. Peer/faculty references
 - vii. Health status and physical ability to perform requested privileges
 - viii. Individual appraisal by the service in which privileges are sought
- b. Peer Recommendations – includes a written evaluation of the practitioner's:
 - i. Medical/clinical knowledge
 - ii. Technical and clinical skills
 - iii. Clinical judgment
 - iv. Interpersonal skills
 - v. Communication
 - vi. Professionalism
- c. Voluntary or involuntary changes in licensure, medical staff membership and/or clinical privileges
- d. An excessive or unusual pattern of professional liability actions resulting in a final judgment against the applicant
- e. Relevant practitioner-specific data, including morbidity and mortality data when available.
- f. Criminal background check

SECTION 6. TEMPORARY PRIVILEGES

- a. Upon receipt of completed application for medical staff membership and request for temporary privileges while the application is pending from an appropriately licensed practitioner, the chief executive officer or designee (~~Administrative Medical Director~~) may grant temporary privileges for a specified number of days, with subsequent reviews not to exceed the pendency of the application or 120 days, whichever is shorter, after receipt and verification of:
 - current licensure
 - relevant training or experience
 - current competence
 - ability to perform the clinical privileges requested
 - other criteria required by these medical staff bylaws
 - query and evaluation of National Practitioner Data Bank information
 - absence of current or previously successful challenge to licensure or registration,
 - absence of involuntary termination of medical staff membership at any hospital or other entity,

- absence of any involuntary limitation, reduction , denial or loss of clinical privileges, and
- proof of required malpractice liability coverage.

The granting of temporary privileges may be made only on recommendation of the medical staff president or authorized designee, the clinical department chair, and Chief Operating Officer or designee. In exercising such privileges, the applicant shall act under the supervision of the chairman of the department to which he/she is assigned and in accordance with the conditions specified in the granting of temporary privileges.

- Upon receipt of a request for specific temporary privileges, an appropriately licensed practitioner of documented competence, who is not an applicant for membership, may be granted temporary privileges for the care of one or more specific patients to fulfill an important patient care need. Such privileges shall be exercised in accordance with the conditions specified in the granting of temporary privileges above except that privileges may last longer than 120 days.
- Upon receipt of a request for specific temporary privileges, an appropriately licensed practitioner of documented competence who is serving as a locum tenens for a member of the medical staff and therefore serving an important patient need may, without applying for membership on the staff be granted temporary privileges for a specified number of days, with subsequent renewals not to exceed the need for the locum tenens services. Such privileges shall be limited to treatment of the patients of the practitioner for whom he/she is serving as locum tenens and shall be exercised in accordance with the conditions specified in the granting of temporary privileges.
- Special requirements of supervision and reporting may be imposed by the appropriate department chairman on any practitioner granted temporary privileges. Temporary privileges shall be immediately terminated by the Administrative Medical Director/[or designee](#) upon notice of any failure by the practitioner to comply with such special conditions. If reportable, termination of or action against temporary privileges gives rise to hearing rights under these bylaws.
- Temporary privilege holders are subject to all corrective actions under these bylaws.

SECTION 7. EMERGENCY PRIVILEGES

In any emergency, any member of the medical staff with clinical privileges to the degree permitted by his/her license and regardless of privileges, service or staff status ~~shall be~~ permitted ~~and entitled and assisted~~ to use every facility of the hospital and to do everything possible within the scope of his/her license to treat the patient . For the purpose of this section, an emergency is defined as a condition in which immediate treatment is necessary to prevent serious permanent harm to a patient, to preserve the life of a patient, or to prevent serious deterioration or aggravation of a patient's condition. When a member credentialed and privileged under these bylaws to provide the emergency treatment becomes available, and if it is otherwise feasible to do so, the member exercising emergency privileges shall promptly yield care of the patient to ~~that practitioners~~ credentialed and privileged member under these bylaws. The member exercising emergency privileges may request the privileges necessary to continue treating the patient. In the event that privileges are denied or the practitioner does not desire to request privileges, the patient shall be assigned to an appropriate member of the medical staff.

SECTION 8 DISASTER PRIVILEGES

Disaster privileges may be granted to non-members of the medical staff when the hospital has activated its

emergency management plan and is unable to handle the immediate patient needs. The Chief Executive Officer or the President of the Medical Staff or their designee(s) may grant such privileges based upon information available which may be reasonably relied upon as evidence of personal identification and qualification. At a minimum the individual must have a current photo I.D. issued by a state or federal agency and at least one of the following:

- current valid medical license;
 - primary source verification of the license;
 - identification by current hospital or medical staff member(s) who possesses personal knowledge regarding volunteer's ability to act as a licensed independent practitioner;
 - identification indicating that the individual is a member of a DISASTER MEDICAL ASSISTANT TEAM (DMAT), or Medical Reserve Corps (MRC), or the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or groups.
 - Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances. Such authority has been granted by a federal, state, or municipal entity.
 - and/or identification that the individual has been granted authority by an appropriate entity to render emergency patient care during a disaster. Any individual who receives disaster privileges under the hospital's emergency management plan must wear at all times a means of identification and will act under the supervision of the chairperson of the department to which he/she is assigned.
- a. Verification of the credentials of a non-member of the medical staff functioning under the emergency management plan ~~will begin~~ as soon as when the emergency situation is ~~under control~~ stabilized and shall be completed within 72 hours from the time the practitioner presented to the organization. The process of verification ~~will be~~ the same as that for granting temporary privileges as described in Section ~~76~~ 76.a.
- b. All disaster privileges shall immediately terminate once the emergency condition is no longer present.

SECTION 9. HISTORY AND PHYSICALS PRIVILEGES

- a. Only those granted privileges to do so may conduct history and physicals or update histories and physicals. History and physical privileges must be carried out consistent with the requirements of these bylaws.
- b. History and physical privilege must be exercised prior to surgery or a procedure requiring anesthesia services so that each patient is provided a history and physical examination within 30 days before admission (or registration, if an outpatient procedure) or within 24 hours after admission.
- c. When the medical history and physical examination are completed within 30 days before admission, an updated examination of the patient, including any changes in the patient's condition must be completed and documented within 24 hours after admission or registration, but prior to surgery or any procedure requiring anesthesia services.
- d. Practitioners eligible for History and Physical privileges include:
1. Physicians – Physician medical staff members or physician applicants for temporary privileges may be granted privileges to conduct and update histories and physicals if they apply and are approved for such privileges through the privileging and credentialing processes.

2. Podiatrists – Podiatrists co-admit with an active staff physician who is responsible for the podiatric patient’s care and medical problem or condition that may exist at the time of admission (including performing admission history and physicals), or problems that may arise during hospitalization that is beyond the scope of the podiatrist’s license and determines the risk and effect of a proposed podiatric procedure on the total health status of the patient.

3. Dentists/Oromaxillofacial Surgeons – Dentists/Oromaxillofacial Surgeons co-admit with an active staff physician who is responsible for the dental patient’s care and medical problem or condition that may exist at the time of admission (including performing admission history and physicals), or problems that may arise during hospitalization that is beyond the scope of the dentist’s license and determines the risk and effect of a proposed dental procedure on the total health status of the patient.

SECTION 11. TELEMEDICINE PRIVILEGES –

- a. All licensed medical staff members who have either total or shared responsibility for the patient’s care, treatment, and services via telemedicine link are credentialed and privileged to do so at the originating site (the site where the patient is located at the time the service is provided) through one of the following mechanisms:
 - 1) the originating site fully privileges and credentials the practitioner according to standards set forth above in these bylaws,
 - (a) ~~a-~~the originating site may use the distant site’s credentialing packet for privileging purposes if the distant site is a Medicare Participating Facility, ~~but and~~ the privileging decision remains with the originating site
 - (~~b-~~) ~~site~~the privileging process will review complaints concerning a potential applicant from the distant site.-

- b. The Medical Executive Committee, based on department recommendations will recommend approval or disapproval of a request for telemedicine privileges to the Board ~~which~~for clinical services ~~that~~are appropriately ~~delivered-provided~~ by the medical staff members through telemedicine links.

- c. The clinical services offered via telemedicine link will be consistent with the quality standards set forth at the originating site.

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SECTION 12. FOCUSED REVIEW OF INITIAL PRIVILEGES

All privileges initially granted to new members, held as temporary privileges, or granted as additional privileges to a current member, are subject to focused review.

- a. The relevant department or section chair will assign a proctor to conduct the focused review. Where proctoring is not feasible, focused review may include chart review, monitoring clinical practice patterns, simulation, external peer review and discussion with other individuals involved in the care of the member’s patients. The department chair is responsible for monitoring the focused review and communicating with the practitioner.

- b. At the end of the evaluation period, or sooner if deviations from professional competence or conduct standards occur, the department or section chair assesses the proctoring reports as part of this peer review process.

- c. Where the practitioner has demonstrated acceptable performance in the requested privileges specifically requested, the relevant department chair will forward a recommendation to the credentials committee, and then forward to the Medical Executive Committee.

- d. Where the focused review identifies either individual, department or system wide deficiencies, further performance monitoring, corrective action, or other measures may be recommended by the department chair to the credentials committee and then forward to the Medical Executive Committee.
- e. At any time during the focused review period a member may voluntarily withdraw the request for additional privileges without penalty or reporting obligation to NPDB.

SECTION 13. ONGOING PROFESSIONAL PRACTICE EVALUATION

All privileges are subject to ongoing professional practice evaluation. Ongoing professional practice evaluation is a peer review program that allows the medical staff to identify professional practice trends that impact on quality of care and patient safety on an on-going basis. The program includes:

1. ~~The An~~ evaluation of ~~an~~ individual practitioner’s professional performance and includes opportunities to improve care based on standards established and maintained by the relevant department, based on recognized standards. It differs from other quality improvement processes in that it evaluates the strengths and opportunities of an individual practitioner’s performance and competence related to their privileges rather than appraising the quality of care rendered by a group of professionals or by a system.
2. ~~Multiple Practice evaluation using~~ sources of information including but not limited to the review of individual cases; the review of aggregate data; and satisfaction of the medical staff’s clinical standards;
3. Individual evaluation, based on standards established and maintained by the relevant department, which are based on generally recognized standards of care. The process provides practitioners with feedback for personal improvement or confirmation of personal achievement related to the effectiveness of their professional and technical and interpersonal skills in providing patient care.
4. ~~The type of data to be collected~~ Clinical and performance data that is determined by individual departments and approved by the Medical Executive Committee.
5. Information resulting from the ongoing professional practice evaluation is used to determine whether to continue, limit, or revoke any existing privileges(s), and/or changes in systems operating in the section, department, medical staff or hospital to improve patient safety and care.

**ARTICLE VI
Corrective Action**

These bylaws contain the exclusive means for review of and action regarding medical staff membership or privileges. Whenever there is reasonable grounds to believe the professional competence, or personal conduct of any member of the organized medical staff is considered below the standards set by the medical staff, a corrective action may be requested by any officer of the medical staff, the chief of any clinical department, by the chairperson of any standing committee of the medical staff, by the hospital Chief Executive Officer or designated representative, or by the hospital board.

All requests for corrective action shall be in writing and presented either to the president of the medical staff, the relevant department chair, or to the Medical Staff Office/~~Chief Medical Officer/~~Administrative Medical Director/or designee.

SECTION 1. PROFESSIONAL CONDUCT REVIEW - includes review of actions which may or may not implicate a change in membership or privileges.

a. Appropriate Conduct

Medical staff members are responsible for reporting errors that impact on the quality of care. For this reason, the following kinds of conduct by members are appropriate and therefore not restricted by these bylaws:

- i. Discussing quality of care concerns
- ii. Advocating for patients
- iii. Input that is meant to improve care
- iv. Input that is respectfully and constructively provided

b. Actionable Conduct

Actionable conduct may lead to restriction of privileges or loss of medical staff membership.

Members' conduct is actionable under these bylaws if it includes but is not limited to the following:

- i. harassment on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, age, marital status, sex or sexual orientation, and/or
- ii. verbal or physical abuse, directed against another person in their capacity as medical staff member, allied health professional, or house staff or privileges holder; hospital employee, contractor or volunteer, or patient.
- iii. abuse of process includes but is not limited to:
 - i. Member retaliation against complainants or those implementing this process, failure or refusal to cooperate with this process, even if the underlying accusation is found to be untrue, and abuse of the complaint process to harass other members ~~are~~ is subject to corrective action under these bylaws. Abuse of the complaint process by employees, Board members or contractors is subject to discipline under hospital administrative policies

SECTION 2. PROFESSIONAL CONDUCT REVIEW PROCEDURE

The conduct of everyone working in the hospital is subject to review. For members of the organized medical staff, the medical staff bylaws are the exclusive means for professional review. For hospital employees, including administrative personnel, nursing staff, and other business associates, conduct review, disciplinary procedures are established under existing hospital policy. Complaints of actionable conduct by a member of the medical staff are made in writing, and referred to any one of the following:

- a. Clinical department chair
- b. President of the medical staff
- c. Any officer of the medical staff
- d. Administrative Medical Director

- a. Initial Complaint Screening – All written complaints shall be received by the Medical Staff Office/Administrative Medical Director. The AMD may, after review of the complaint in collaboration with the President of the medical staff, if both agree, determine that a complaint does not warrant a corrective action. If the AMD is not available to review the complaint in a timely manner, the medical staff President and appropriate department chair will review the complaint and determine if a valid complaint exists.
- b. Complaint Review Committee – Except for written complaints discharged through the initial complaint screening described above, all written complaints will be evaluated by a complaint

committee comprised of the appropriate clinical department chairperson, president of the medical staff, and if available, the AMD. This committee will evaluate all written complaints to determine whether the complaint is credible, valid, and whether it warrants further evaluation, formal corrective action, or should be rejected. The committee may, by a majority vote, elect to refer the subject of the complaint to the Medical Staff Wellness Committee.

- c. Non-actionable Conduct – Complaints not rising to the level of actionable conduct will be tracked for a period of 12 months by the Medical Staff Office
- d. Actionable Conduct – Where a written complaint establishes a valid basis for formal review of professional competency or personal conduct, the following procedure will be initiated:
 - i. A request for formal corrective action will be presented to the president of the medical staff.
 - ii. Within 14 days of receiving a request for corrective action, the president of the medical staff, in concert with the administrative medical director, will formally notify the affected member, by special notice, that a corrective action complaint has been received.
 - iii. The subject of the complaint, may within 14 days of being notified of the corrective action complaint, provide a written response to the president of the medical staff.
 - iv. Either upon receiving the written response from the affected member, or the passage of 14 days, the president of the medical staff will formally notify the MEC that a request for corrective action has been received.
 - v. The MEC may elect to appoint an ad hoc committee to review the complaint, or act on the complaint itself. IF an ad hoc committee is appointed, it will investigate the complaint and provide a written report of its investigation to the MEC within 30 days of its formation.
 - vi. The affected member and the MEC (or ad hoc committee if appointed by MEC) will meet within 7 days informally for the purpose of discussing the complaint, and determine whether a valid complaint/request for corrective action exists. This meeting does not constitute a hearing, will be preliminary in nature, and none of the procedural rules provided in these bylaws ~~shall apply~~applies. A written record of this meeting will be made.
 - vii.
 - i. e. The MEC shall take action upon receipt of the request for corrective action. Such actions may include, without limitation: to reject the corrective action
 - ii. to impose appropriate corrective action as follows
 - (a) to issue a warning letter, a letter of admonition, or a letter of reprimand. These actions do not entitle the practitioner to a formal hearing.
 - (b) To impose a focused review for a specified period of time without loss of privileges. Any such focus professional practice review will be supported by findings and reported to the member by the MEC, specifying the standards at issue, deviations identified, and steps that should be taken and are recommended for future compliance and remediation, as appropriate under clinical department standards of performance and monitoring.

- (c) To impose terms of probation that would not invoke automatic reporting to the national practitioner databank.
 - (d) To suspend the practitioner's membership or clinical privileges
- iii. That an already imposed summary suspension of clinical privileges be terminated, modified, or sustained temporarily in order to obtain further information necessary to take more definitive action or
- iv. To recommend to the board:
- (a) Reduction, limitation, modification (which may include a requirement for consultation), or revocation of clinical privileges and/or membership.
- f. Any recommendation by the MEC for reduction, suspension, or revocation of clinical privileges, or for expulsion from the medical staff shall entitle the affected practitioner to the fair hearing rights provided in these bylaws.
- g. The president of the medical staff shall promptly notify the ~~administrative~~ Administrative medical-Medical director/Director/or designee in writing of all requests for corrective action received by the MEC, and shall continue to keep the AMD/~~or desingee~~ fully informed of all actions taken. When the recommendation of the MEC is favorable to the practitioner, the ~~AMD-President of the Medical Staff acting on behalf of the medical staff~~ shall promptly forward it, together with all supporting documentation to the designated representatives of the board for review and approval at its next regular meeting.
- h. Any practitioner whose engagement by the hospital in an administrative capacity with related clinical responsibilities which require membership on the medical staff shall be entitled to the same hearing rights accorded any other medical staff member when his/her medical staff privileges are terminated or otherwise adversely affected.
- i. A request for corrective action is considered to have been officially received at the time of the first formal MEC meeting following the submission in writing of a request for corrective action to the president of the medical staff.

SECTION 4. FOCUSED PROFESSIONAL PRACTICE REVIEW -

Complaints or other concerns raised about a member's practice are referred to the appropriate section or department chief to determine if the complaint or concern is baseless, if focused review is warranted, or to refer the subject member immediately for evaluation and possible resolution. The subject of review is included early in the review process and as appropriate throughout, to promote the sharing of information. All recommendations are supported by findings and reported to the member and the Medical Executive Committee, specifying the standards at issue, deviations identified and steps that should have been taken and are recommended for future compliance and remediation. If appropriate under department standards, performance monitoring, corrective action or other measures are implemented or recommended.

SECTION 5. SUMMARY SUSPENSION

- a. The chairman of the clinical department(s) in which the practitioner has privileges, or any of the Medical Staff Officers, ~~or the Administrative Medical Director~~ if available shall have authority,

whenever action must be taken, because of imminent danger to the health of any person, to summarily suspend all or any portion of the clinical privileges of a practitioner, and such summary suspension shall become effective immediately upon imposition.

- b. A practitioner whose clinical privileges have been summarily suspended shall be entitled to request that the Medical Executive Committee hold a meeting on the matter within such reasonable time period thereafter as the Medical Executive Committee may be convened. The suspended practitioner shall be permitted to attend to present information and respond to questions of the Medical Executive Committee members, but the meeting shall not be considered a hearing, nor shall procedural rights established under these bylaws apply to such a meeting.
- c. The Medical Executive Committee may modify, continue, or terminate the terms of the summary suspension. If, as a result of such meeting, the Medical Executive Committee does not terminate the summary suspension, the affected practitioner ~~shall be is~~ entitled to request a hearing and an appellate review, but the terms of the summary suspension as sustained or as modified by the Medical Executive Committee shall remain in effect pending a final action on the matter by the Board.
- d. Immediately upon the imposition of a summary suspension, the President of the Medical Staff, responsible department chairman, or the Administrative Medical Director/ ~~or designee~~ shall have authority to provide for alternative medical coverage for the patients of the suspended practitioner still in the hospital at the time of such suspension. The wishes of the patients shall be considered in the selection of such alternative practitioner.

SECTION 6. AUTOMATIC ACTION LIMITING OR REVOKING PRIVILEGES

Except as noted below, any action arising from this section does not create the right to hearing and appeal under these bylaws, and does not create an obligation to report these automatic actions to the NPDB.

- a. **Medical Records.** A temporary suspension of a practitioner's admitting privileges, effective until medical records are completed, shall be imposed automatically after a written warning of delinquency, for failure to complete medical records in a timely fashion.
- b. **Malpractice Insurance.** For failure to maintain the amount of professional liability insurance required of the practitioner by these bylaws, a practitioner's medical staff membership and clinical privileges shall be immediately suspended until he/she shows proof that the proper amount of professional liability insurance is in force.
- c. **License and DEA Status**
 - i. **License** – Whenever a practitioner's license, certificate, or any other legal basis for authorizing the practitioner to practice is revoked, restricted, or suspended, the affected practitioner's membership status and/or clinical privileges so affected will be immediately and automatically modified to fully comply with any such change in legal licensure status, subject to further action as may be taken under subsection iii. ~~(e)~~ of this section.
 - ii. **Changes in DEA Status** – Whenever a practitioner's DEA number is revoked or suspended the member will be immediately and automatically subject to the same restrictions as it pertains to their rights to prescribe medications. ~~DEA probation will not produce any immediate action, other than to invoke section (e) below.~~

- iii. ~~Medical Executive Committee deliberatio~~MEC Review and Possible Action – Any change in licensure or DEA status will require the Medical Executive Committee to convene a special meeting as soon as practical for the purpose of reviewing the factual circumstances, including any official reports from the relevant licensing body or DEA leading to the change in licensure or DEA status of a practitioner. ~~the MEC may, consistent with state law and confidentiality protection laws, seek clarification of restrictions and - The Medical Executive Committee may recommend additional corrective actions which may produce changes in membership and/or clinical privileges, thus invoking hearing and appeal rights under these bylaws. subject the rights of hearing and rights provided under these bylaws.~~
- iv. Reinstatement – Should a practitioner’s license or DEA number be reinstated by the appropriate board prior to the practitioner’s next application for reappointment to the medical staff, the practitioner must follow the biennial reappointment process for reinstatement of lost privileges or membership.

**ARTICLE VII
Hearing and Appellate Review Procedure**

The right to a hearing or appeal arises any time when a practitioner entitled to the hearing and appeal process under these bylaws is notified either by the Medical Executive Committee or by the Board of actions that could result in a change in membership status or a change in their current clinical privileges. All hearings and appellate reviews are in accordance with the procedural safeguards set forth in this Article. As used in these provisions for hearing and appeal rights, “member” and “practitioner” includes applicants and temporary privileges holders.

SECTION 1. RIGHT TO HEARING AND TO APPELLATE REVIEW

- a. When any practitioner receives notice of a recommendation of the Medical Executive Committee that, if ratified by decision of the Board, will adversely affect the practitioner's appointment to or status as a member of the medical staff or exercise of clinical privileges, the practitioner shall be entitled to a hearing before an ad hoc committee of the Medical Staff. If the recommendation of the ad hoc committee to Medical Executive Committee following such hearing is ~~still~~ adverse to the affected practitioner, the practitioner shall be entitled to an appellate review by the Board, before prior to a final~~the Board makes a final~~ decision on the matter.
- b. The practitioner is entitled to a hearing or appellate review when he or she receives a:
 - i. notice of a decision by the Board affecting the practitioner’s appointment to or status as a member of the medical staff,
 - ii. notice of reduction in the practitioner’s exercise of clinical privileges, or
 - iii. decision by the Board overturning in whole or in part a favorable recommendation by the Medical Executive Committee
- c. All hearings and appellate reviews shall be in accordance with the procedural safeguards set forth in this Article.

SECTION 2. NOTICE OF ADVERSE RECOMMENDATION AND REQUIREMENT TO RESPOND

- a. Notice to the Member - The ~~Administrative Medical Director~~ President of the Medical Staff ~~is~~ shall be responsible for giving prompt special notice of an adverse recommendation or decision to any affected practitioner who is entitled to a hearing. This notice shall:
 - i. inform the applicant of the reasons for the proposed action and his/her right to a hearing and/or appellate review pursuant to these bylaws,
 - ii. specify that he/she shall have thirty (30) days following the date of receipt of such notice within which to request a hearing,
 - iii. state that failure to request a hearing within the specified time period shall constitute the waiver of the practitioner's right to same,
 - iv. state that upon timely receipt of the practitioner's request, the practitioner will be notified of the date, time, and place for a hearing and the grounds upon which the adverse action is based, and
 - v. inform him/her of the rights under these bylaws.

SECTION 3. WAIVER OF HEARING OR APPEAL RIGHTS

A practitioner who fails without good cause to appear and proceed at such hearing ~~shall be~~ is deemed to have waived his/her rights and to have accepted the adverse recommendation or decision involved, and the same shall thereupon become and remain in effect as otherwise provided in these bylaws for waivers. Waiver extinguishes any other hearing or appeal rights under these bylaws and is considered the same as affirming a final adverse Board decision against the practitioner. A practitioner waives his/her rights to a hearing or appeal whenever:

- a. The practitioner fails, without good cause, to request in writing a hearing or appeal within the time limits set forth in these bylaws.
- b. A practitioner fails, without good cause, to appear at a scheduled hearing. A practitioner who fails, without good cause, to appear and proceed at such hearing shall be deemed to have waived his/her rights.

SECTION 4. NOTICE OF HEARING

- a. Practitioners not under suspension – Within seven (7) days after receipt of a request for hearing from a practitioner entitled to the same, the Administrative Medical Director, consistent with these bylaws shall schedule and arrange for such a hearing to take place within thirty (30) days from the date of receipt of the request for hearing.
- b. Practitioners who are under suspension – A hearing for a practitioner who is under suspension which is then in effect shall be held as soon as arrangements therefore may be reasonably be made, but not later than seven (7) days from the date of receipt of such a practitioner's request for a hearing unless extended by the practitioner.
- c. The ~~Administrative Medical Director~~ President of the Medical Staff shall notify the practitioner by special notice of the following:
 - i. the time, place, and date of the hearing,

- ii. (in concise language) a detailed description of the evidence of acts or omissions considered in making the adverse recommendation or decision,
- iii. a list of specific or representative charts that are the subject of, or relevant to the hearing process,
- iv. the list of witnesses (if any) expected to testify at the hearing on behalf of the professional review body. In turn, the practitioner shall provide a list of witnesses expected to testify on behalf of the practitioner within fifteen (15) days, if not under suspension, or within 4 days if under suspension.

SECTION 5. COMPOSITION OF HEARING COMMITTEE

- a. Every hearing shall be conducted by an ad hoc committee of not less than three (3) members of the medical staff appointed by the President of the Medical Staff, who are not in direct competition with the affected practitioner. All members are subject to the conflict of interest rules of these bylaws. These are the sole voting members of the hearing committee. An alternate committee member may be chosen to attend the hearing as well to assist with the completion of the hearing process. Voting rights will be delegated to the three members appointed unless due to scheduling conflicts the alternate needs to replace one of the three assigned members.
- b. No staff member who has actively participated in the consideration of the adverse recommendation shall be appointed a member of this hearing committee.
- c. The hearing officer – The hearing officer will be selected by the President of the Medical Staff and approved by the Medical Executive Committee from a list of individuals with documented experience in the hearing process. The hearing officer may not be selected from a law firm or an organization regularly utilized by the hospital, the medical staff, or the affected medical staff member or applicant for membership.
- d. The physician advocate – The affected practitioner shall be entitled to be accompanied by and/or represented at the hearing by an attorney and/or other person of his/her choice.
- e. The Medical Executive Committee advocate – The Medical Executive Committee, when its action has prompted the hearing, shall appoint one of its members to represent it at the hearing to present the facts in support of its adverse recommendation and to examine witnesses. The Medical Executive Committee may also be represented by an attorney. The Board, when its action has prompted the hearing, shall appoint one of its members to represent it at the hearing, to present the facts in support of its adverse decision and to examine witnesses. The Board may be represented by an attorney.

SECTION 6. CONDUCT OF HEARING

- a. The hearing officer – shall preside over the hearing to determine the order of procedure during the hearing, to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence, and to maintain decorum.
- b. Procedural rules -
 - i. Rules of evidence – The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible over objection in civil or criminal action. The practitioner for whom the hearing is being held shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of procedure or of fact, and such memoranda shall become a part of the hearing record.

- ii. Rights of the parties – To call and examine witnesses, to introduce written evidence, to cross-examine any witness on any matter relevant to the issue of the hearing, to challenge any witness, and to rebut any evidence. If the practitioner does not testify in his/her own behalf, the practitioner may be called and examined as if under cross examination.
- c. Attendance – All members of the hearing committee must be present at all times when the hearing takes place, and no member may vote by proxy.
- d. Personal appearance of the practitioner – The personal presence of the practitioner for whom the hearing has been scheduled is required.
- e. The burden of proof –
 - i. Except in the case of an initial applicant denied membership and privileges on the medical staff, it shall be the obligation of the Medical Executive Committee (or Board, if its action is the reason for the hearing) to persuade the hearing committee, by a preponderance of the evidence presented, that its recommendation is reasonable and warranted. The affected practitioner shall thereafter be responsible for supporting his/her challenge to the adverse recommendation or decision by showing that the Medical Executive Committee (or Board if it has initiated the hearing) has not met its burden of proof, or that such basis or any action thereon is either arbitrary, unreasonable, or capricious.
 - ii. New applicant – In the case of an initial applicant denied privileges and membership on the medical staff, the applicant shall bear the burden of persuading the hearing committee, by a preponderance of the evidence, of the applicant’s qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning the applicant’s current qualifications for membership and privileges.
- f. Hearing Recess – The hearing committee may at its own discretion and without prior notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation.
- g. Recordkeeping – An accurate record of the hearing must be kept. The mechanism shall be established by the ad hoc committee and may be accomplished by use of a court reporter or electronic recording unit.
- h. Closing the hearing process – Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. Both parties shall have the right to submit a written statement at the close of the hearing. The hearing committee may thereupon, at a time convenient to itself, conduct its deliberations in private.
- i. Final hearing committee report and recommendations – Within twenty (20) days after closure of the hearing, the hearing committee shall make a written report and recommendation approved by the majority of the committee, based upon evidence produced at the hearing and shall forward the same together with the hearing record and all other documentation to the practitioner, and the Medical Executive Committee or the Board, whichever recommended the adverse action. The report may recommend confirmation, modification or rejection of the original adverse recommendation of the Medical Executive Committee or decision of the Board. Together with the report, recommendation, hearing record, and other documentation, the President of the Medical Staff shall inform the affected practitioner, by special notice, in writing of their rights to appeal and in the appeals process. A minority report may be also submitted by any voting member(s) of the hearing committee. The

hearing officer will attest, by signature, that the record and the final recommendation represents a fair and complete record.

- j. Copies of the proceedings – The affected practitioner has a right to one written copy of the record made of the proceedings, additional written copies of which may be obtained by the practitioner upon payment of any reasonable charges associated with the preparation thereof. A permanent copy of the proceedings will be securely maintained and stored by the Medical Staff Office.

SECTION 7. APPEAL TO THE BOARD

The Board or its appointed appellate review committee shall act as the appellate body. It shall review the record created in the proceedings and shall consider the written statements submitted pursuant to these bylaws for the purpose of determining whether the adverse recommendation or decision against the affected practitioner was reasonable and warranted.

- a. Request for appellate review – Within ten (10) days after receipt of a notice of an adverse recommendation or decision by a hearing committee the practitioner or Medical Executive Committee may, by special notice to the Board, request an appellate review by the Board. Such notice may request that the appellate review be held only on the record on which the adverse recommendation or decision is based, as supported by the parties’ written statement provided for below, or may also request that an oral argument be permitted as part of the appellate review.
- b. Waiving the right to appeal – If such appellate review is not requested as specified in these bylaws, the parties shall be deemed to have waived the right to the same, and to have accepted such recommendation or decision. If the recommendation or decision upholds a Board action, that action becomes final if not appealed.
- c. Schedule – Within seven (7) days after receipt of such notice of request for appellate review, the Board shall schedule a date for such review, including a time and place for oral argument if such has been requested, and shall, through the ~~Administrative Medical Director~~ President of the Medical Staff by special notice notify the parties of the same.
 - i. Practitioners under suspension – When the practitioner requesting the appellate review is under a suspension which is then in effect, such review shall be scheduled as soon as the arrangements for it may reasonably be made, but not more than seven (7) days from the date of the receipt of such notice unless extended by the practitioner.
 - ii. Practitioners not under suspension – The date of the appellate review shall not be less than fifteen (15) days, nor more than forty-five (45) days from the date of receipt of the notice of request for appellate review.
- d. Conduct of the appellate review – The appellate review shall be conducted by the Board or by a duly appointed appellate review committee of the Board of not less than three members subject to the conflict of interest policy of the Board. New or additional matters not raised during the original hearing or in the hearing committee report, nor otherwise reflected in the record, shall be introduced at the appellate review only under unusual circumstances, and the Board or the committee thereof appointed to conduct the appellate review shall, in its sole discretion, determine whether such new matters shall be accepted.

- e. Access to the record – All parties shall have access to the report, record, and transcription of the hearing committee and all other material, favorable or unfavorable, that was considered in making the adverse recommendation or decision.
- f. The right to submit a written report to the Board – All parties have the right to submit a written statement containing objections to the findings of fact, conclusions and procedural rulings together with the reasons therefore, and addressing any matters raised at any step in the hearing process. The statement shall be submitted to the appellate review body through the ~~Administrative Medical Director~~President of the Medical Staff at least ten (10) days prior to the scheduled date of the review, unless the time limit is waived by the review body. The ~~Administrative Medical Director~~President of the Medical Staff shall provide a copy to the other party immediately upon receipt of the statement, or as soon as practicable thereafter.
- g. Oral arguments – If oral argument is requested as part of the review procedure, the affected practitioner shall be present at such appellate review, shall be permitted to speak against the adverse recommendation or decision, and shall answer questions put to him/her by any member of the appellate review body. The Medical Executive Committee shall also be represented by an individual who shall be permitted to present oral arguments before the Board or appellate body. Both the practitioner and the Medical Executive Committee may be represented by an attorney.
- h. If the appellate review is conducted by the Board, the Board may affirm, modify, or reverse the recommendation of the hearing committee, or in its own discretion, refer the matter back to the hearing committee for further review and recommendations. Such referral may include a request that the hearing committee conduct further hearings to resolve specified disputed issues within a reasonable period.

SECTION 8. FINAL DECISION BY BOARD

- a. Timing. For matters in which the Board conducted the appellate review, within five days after the conclusion of the appellate review, the Board shall make its decision on the appeal. For matters in which an appellate review committee conducted the appellate review, the appellate review committee must submit their report to the board within five days after the conclusion of the appellate review. The Board shall make its decision within five days after receipt of the written report of the appellate review committee. The action of the Board is final.
- b. Notice of final action. When the decision is final, the affected practitioner and the Medical Staff President shall be sent by special notice of the final decision within five working days by the Board, including a statement of the basis for the decision. The Medical Executive Committee will receive a report of the action at its next meeting.
- c. Reporting. When a final decision on a corrective action matter ~~listed in Article VII~~ adversely affects a practitioner, reports shall be sent to the relevant Boards of Medicine and the National Practitioner Data Bank as required by law. The reports will be written by the Medical Staff Office with assistance from the medical staff legal counsel.
- d. Review of Report. Whenever action is taken pursuant to these Bylaws which action requires a report to be made to the Board of Medicine or the National Practitioner Data Bank, such report shall be reviewed for accuracy by the ~~Administrative Medical Director~~Medical Staff legal counsel, the chairman of the department in which the practitioner is associated, and the President of the Medical Staff prior to filing the report.

SECTION 9. ALLIED HEALTH PRACTITIONER REVIEW PROCESS

~~Whenever the Medical Executive Committee or the Board makes a recommendation or takes an action to deny an Allied Health Professional's application, to terminate or summarily suspend an Allied Health Professional's Delegated Activities, or to restrict any or all Delegated Activities for more than thirty days, the Administrative Medical Director provides the Allied Health Professional written notice of the recommendation or action, the reasons for it, and the time period within which the Allied Health Professional can request a hearing. If a hearing is requested, the Administrative Medical Director appoints a committee of comprised of at least three unbiased medical staff members and Allied Health Professionals with clinical privileges to hear the Allied Health Professional's objections to the proposed action or recommendation. The hearing is scheduled no sooner than thirty days from the date of the request, and the Allied Health Professional and his/her supervising Medical Staff member, if any, are notified of the date, time and place of the hearing. A record of the hearing is made. The committee provides a written report of its recommendations and the reasons therefor, based on the information presented at the hearing, to the Administrative Medical Director for prompt dissemination to the Allied Health Professional, the Medical Executive Committee, and the Board. The Allied Health Professional and the Medical Executive Committee have the right to appeal the hearing committee's recommendation by a submitting written statement of the reasons for the appeal to the Board, within thirty days of receiving the hearing committee report. The Board, or a Board committee, reviews the written appeal, and the hearing committee report. If the appeal is reviewed by a committee, it promptly provides the parties and the Board with its recommendation. The Board considers the appeal, the recommendation and the report and takes final action. The Administrative Medical Director provides all parties with the Board's decision, and the reasons there for, in writing. Final actions regarding Allied Health Professionals are not reported to the National Practitioner Data Bank~~

.Whenever the Medical Executive Committee or the Hospital Board of Directors make a recommendation or take actions to restrict or deny an allied health professional's delegated activities, the allied health professional has a right to a fair hearing.

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1. Whenever the Medical Executive Committee or the Hospital Board of Directors make a recommendation or takes an action to deny an allied health professional's membership or delegated Activities, or to restrict any or all delegated activities for more than 30 days, the Administrative Medical Director, or designee, will provide the allied health professional special written notice containing the following items:

- recommendation or action from the Medical Executive Committee or the Hospital Board of Directors;
- the reasons for it;
- and the deadline of thirty (30) days within which the allied health professional can request a hearing

2. When the allied health professional is employed by the hospital, the supervising nursing director and the medical director of the service line shall be notified.

Comment [WS11]: This is not in bylaws but I think they are entitled to be informed of potential employment issues.

3. An allied health professional who fails to request a hearing automatically waives the right to review. The practitioner will be notified by special written notice that the recommended actions will be forwarded to the Hospital Board of Directors for final recommendation.

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4. If a hearing is requested by the allied health professional, the Administrative Medical Director, or Designee, appoints a hearing committee of comprised of at least three (3) unbiased medical staff members and allied health professionals with clinical privileges to hear the allied health professional's objections to the proposed action or recommendation. At least one-third of the hearing committee will be represented by an allied health professional currently privileged to practice at the hospital.
5. The hearing will be scheduled within thirty (30) days from the date of the hearing request by the allied health professional.
6. The hearing notification will be sent by special written notice to the allied health professional and his/her supervising physician.
7. An official record will be made of the hearing.
8. The hearing committee will provide a written report of its recommendations and the reasons therefor, based on the information presented at the hearing. The Administrative Medical Director, or Designee, will send the report by special written notice to the allied health professional and his/her supervising physician. The Administrative Medical Director, or Designee, will also promptly disseminate the report to the Medical Executive Committee, and the Hospital Board of Directors or Board Committee.
9. The allied health professional and the Medical Executive Committee may appeal the hearing committee's recommendation by submitting a written statement of the reasons for the appeal to the Hospital Board of Directors or Board Committee, within 30 days of receiving the hearing committee's report.
10. The Hospital Board of Directors, or a Board Committee, may review the written appeals, and the Hearing Committee's report. Upon receiving the written request for appeal the Hospital Board of Directors may as a body review the request to appeal or appoint a committee representing the Board to review the request.
11. If the appeal is reviewed by a Board Committee, it will promptly provide the parties and the Hospital Board of Directors with its written recommendation within five (5) business days after the conclusion of the review.
12. The Hospital Board of Directors will provide all parties with their final decision, and the reason therefor in special written notification within five (5) days of their decision.
13. Final actions regarding the allied health professional shall be reported to the National Practitioner Data Bank.

Comment [WSJ2]: We are not required by NPDB to report these actions. NPDB rules available.

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ARTICLE VIII
Medical Staff Officers, Representatives, and Administrative Staff

SECTION 1. OFFICERS OF THE MEDICAL STAFF

- a. The officers of the medical staff shall be:
 - i. President
 - ii. Vice President (President-elect)
 - iii. Immediate Past President
 - iv. Secretary-Treasurer

SECTION 2. QUALIFICATIONS OF OFFICERS

Officers must be members of the active medical staff at the time of nomination and election and must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

SECTION 3. ELECTION OF OFFICERS

SECTION 3. ELECTION OF OFFICERS

- a. Officers ~~will be~~ elected at the annual meeting of the medical staff. Only voting members of the active, Refer & Follow medical staff ~~will be~~ eligible to vote.
 - b. The nominating committee will consist of the available most immediate past three presidents of the medical staff. The committee will offer one or more nominees.
 - c. The slate of candidates ~~will be~~ reviewed and approved by the MEC the month prior to the annual meeting. ~~The medical staff office will prepare a secret ballot, send it to the medical staff by mail, and collect proxy votes sent back prior to the annual meeting.~~
 - d. Voting and Quorum:
 - i. The medical staff members, if possible, should attend the annual medical staff meeting to vote.
 - ii. Medical staff members may vote by submitting a secret written ballot prior to the meeting. This ballot will be prepared by the medical staff office and sent to the members prior to the meeting. Medical staff members may vote by attending the annual medical staff meeting or by submitting secret ballot prior to the annual meeting.
 - iii. A Medical Staff Member may vote by proxy-giving his/her vote to a member that is attending the meeting.
- ~~d.~~ A quorum at the annual meeting is 30% of the medical staff either present at the general medical staff meeting ~~or, by proxy, or~~ by written ballot. Officers will be elected by a majority vote.

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SECTION 4. TERM OF OFFICE

All officers shall serve a one year term from the election date or until a successor is elected. Officers shall take office on January 1. Removal of an officer during his/her term of office may be initiated by a majority vote of all active-voting members of the medical staff. Removal of an officer shall be for just cause. Just cause may include but is not limited to the following:

- a. Failure to uphold the interests of the medical staff.
- b. Failure to carry out the duties of the office.
- ~~b.c.~~ Failure to adhere to the standards in the Medical Staff Bylaws.

An Officer may resign, effective immediately or upon a date specified, by writing, or verbally stating, to another medical staff officer the intent to resign. Any verbal resignation shall be immediately documented by the Officer receiving the resignation, with a copy to the resigning Officer. Failure to withdraw the resignation within five days serves as confirmation of the resignation.

SECTION 5. VACANCIES IN OFFICE

Vacancies in office, except for the presidency, shall be filled by action of the Executive Committee of the medical staff. If there is a vacancy in the office of the President, the Vice President (President-elect) shall serve out the remaining term. The vacancy thereby created in the office of Vice President shall be filled by the Executive Committee of the medical staff. That appointed Vice President shall serve out the remainder of the term, but shall not automatically ascend to hold the office of the President of the Medical Staff. Instead, the office of President shall be filled at the next regular medical staff election of officers.

SECTION 6. DUTIES OF OFFICERS

During their terms of office, medical staff officers are supplied with access to work and meeting space, medical staff support staff, and email and intranet as available to the hospital administration, for the sole purpose of carrying out the duties of their offices.

- a. President. The president shall serve as the chief administrative officer of the medical staff to:
 - i. act in coordination and cooperation with the CEO or his/her representative in all matters of mutual concern within the hospital;
 - ii. call, preside at, and be responsible for the agenda of all general meetings of the medical staff;
 - iii. serve as chairman on the Medical Executive Committee;
 - iv. serve as ex officio member of all other medical staff committees;
 - v. be responsible for the enforcement of medical staff bylaws, rules, and regulations, for implementation of sanctions where these are indicated, and for the medical staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner;
 - vi. appoint committee members to all standing, special, and multi-disciplinary medical staff committees except the Executive Committee;
 - vii. represent the views, policies, needs, and grievances of the medical staff to the Board and to the CEO;
 - viii. receive and interpret the policies of the Board to the medical staff and report to the Board on the performance and maintenance of quality with respect to the medical staff's delegated responsibility to provide medical care;
 - ix. be responsible for the educational activities of the medical staff, and
 - x. be the spokesman for the medical staff in its external professional public relations.
- b. Vice President (President-elect). In the absence of the president, he/she shall assume all duties and have the authority of the president. The vice president shall be a member of the Executive Committee of the medical staff. Except as provided for in Section 5 of this Article, he/she shall automatically succeed the president when the president's term expires or when the latter steps down from office for any reason.
- c. Secretary-Treasurer. He/she shall be a member of the Executive Committee of the medical staff. The secretary shall keep accurate and complete minutes of all medical staff meetings, call medical staff

meetings on order of the president, attend to all correspondence, and perform such other duties as ordinarily pertain to his/her office.

~~e.~~ The immediate past president of the medical staff shall continue to serve on the Credentials Committee and the Nominating Committee for three years. They will serve on the Quality of Care Committee of the Hospital Board for one year.

SECTION 7. Board Representatives

In addition to the President of the Medical Staff and the Vice President of the Medical Staff, if the Board requests additional Medical Staff appointments, they will be elected at the annual meeting of the Medical Staff from the membership at large.

SECTION 8. Medical Staff Administrative Staff

Medical staff administrative staff includes the Administrative Medical Director/[designee](#) and support staff. Although they are hospital employees, they carry out the administrative roles as outlined in these bylaws.

a. Job Descriptions

Job descriptions for the medical staff administrative staff are reviewed by the Medical Executive Committee which serves in an advisory role to hospital administration, to maximize cooperation between the hospital and the medical staff.

b. Selection

The CEO shall coordinate candidate interviews for the Administrative Medical Director/[designee](#) with representatives of the medical staff leadership, who provide feedback to the CEO on all candidates.

c. Removal

The Medical Executive Committee or the medical staff by a majority vote for identified cause, may recommend to the CEO the removal of the Administrative Medical Director/[designee](#) from his/her position due to a lack of confidence or failure to perform the duties as outlined in these bylaws. Prior to removing the Administrative Medical Director/[designee](#), the CEO shall meet and discuss the action with the Medical Executive Committee.

ARTICLE IX Clinical Departments

SECTION 1. ORGANIZATION OF CLINICAL DEPARTMENTS AND SECTIONS

Departments of the medical staff shall be as follows: Anesthesiology, Cardiovascular Medicine, Dental-Oral Surgery, Dermatology, Emergency Medicine, Family Medicine, Internal Medicine, Obstetrics-Gynecology, Ophthalmology, Orthopedics, Pathology, Pediatrics, Physical Medicine and Rehabilitation, Podiatry, Psychiatry, Radiology, Surgery and Urology. Each department shall be organized separately and shall elect a chairman responsible for its clinical work.

All departments may divide into subspecialty sections but a minimum of three (3) members are required to form such sections. Any subspecialty section with ten (10) or more members may request recognition as a separate department of the medical staff with representation on the Medical Executive Committee as set forth in Article X, Section 2. If membership of a department drops below ten (10), Medical Executive Committee representation is forfeited, effective the beginning of the next year except for those departments with less than ten members that existed prior to 2007.

SECTION 2. QUALIFICATIONS, SELECTION, AND TENURE OF DEPARTMENT CHAIRMAN AND SECTION CHIEFS

- a. Each chairman or chief shall be a member of the active staff qualified by training, experience and demonstrated competence for the position. Every chairman or chief will be board certified by an appropriate specialty board or be determined by the Medical Executive Committee to have comparable competence.
- b. Each chairman or chief shall be elected by a simple majority of the department or section for a two-year term.
- c. Removal of the chairman or chief during his/her term of office may be initiated by a majority vote of all active staff members of the department. Grounds for removal shall be the same as required for removal of medical staff officers in Section 4 of Article VIII.

SECTION 3. ROLES & RESPONSIBILITIES OF DEPARTMENT AND SECTION LEADERSHIP

Each chairman shall:

- a. be responsible for implementing a process for the continuous assessment and improvement of the quality of care and services provided by the department/service, assuring that quality control programs are maintained, and participates in the evaluation, and assures the continuing surveillance of, the professional performance of all individuals with clinical privileges in the department;
- b. be a member of the Medical Executive Committee, giving guidance on the overall medical policies of the hospital, making specific recommendations and suggestions regarding his/her own department in order to assure quality patient care, and working to assure the department's integration into the primary functions of the organization.
- c. be responsible for enforcement of the medical staff bylaws, rules and regulations within his/her department;
- d. be responsible for implementation within his/her department of actions taken by the Medical Executive Committee;
- e. transmit to the Medical Executive Committee his/her department's recommendations concerning the staff classification, reappointment, and the delineation of clinical privileges for all practitioners in his/her department;
- f. determine the qualifications and competence of all department and section personnel, including allied health professionals, who provide patient care, treatment and services.

- g. recommend to the Medical Executive Committee the criteria for clinical privileges in the department, and the space and other resources needed by department;
- h. be responsible for the orientation of all persons in the department, and the teaching, educational, and research program in his/her department;
- i. participate in every phase of administration of his/her department through cooperation with the nursing service and the hospital administration in matters affecting patient care, including personnel, space, supplies, special regulations, standing orders and techniques;
- j. assess and recommend to the hospital off-site sources for needed patient care, treatment and service not provided within the department or the hospital;
- k. assist in the preparation of such annual reports, including budgetary planning, pertaining to his/her department as may be required by the Medical Executive Committee;
- l. be responsible for the coordination and integration of interdepartmental and intradepartmental services;
- m. be responsible for developing and implementing policies and procedures that guide and support the provision of care, treatment and services;
- n. call and chair department meetings; and
- o. carry out other duties as assigned by the Medical Executive Committee.

Each chief shall:

- a. call and chair section meetings; and
- b. carry out other duties as assigned by the department chair or Medical Executive Committee.

SECTION 4. FUNCTIONS OF DEPARTMENTS

- a. Each clinical department shall establish its own criteria, consistent with the bylaws, rules, regulations and policies of the medical staff for granting clinical privileges and for the holding of office in the department. No clinical department may make a policy which affects the medical practice of members of another department without the approval of the affected department.
- b. Each department:
 - i. determines how its members will be obligated to provide on-call service to the Emergency Department, or may provide services on a voluntary basis, and will provide the Emergency Department with a call rotation, based on its determinations and resources, if any or all department members serve on-call and report to the Medical Executive Committee;
 - ii. identifies the important aspects of care for the department;
 - iii. identifies the indicators used to monitor the quality and appropriateness of the important aspects of care; and
 - iv. evaluates through departmental peer review committees the quality and appropriateness of care provided by department members.

- c. Each department shall determine its own meeting frequency to review and analyze on a peer-group basis the clinical work of the department.
- d. A report shall be submitted periodically, but no less than quarterly, to the Medical Executive Committee detailing such departmental analysis of patient care.

ARTICLE X
Committees

SECTION 1. TYPES AND OPERATIONS OF COMMITTEES

- a. Committees shall be standing and special. All committees other than the Medical Executive Committee shall be appointed by the President of the Medical Staff. No policies of any committee shall be final until approved by the Medical Executive Committee.
- b. Standing committees shall be:
 - i. Medical Executive Committee
 - ii. Medical Staff Wellness Committee
 - iii. Credentials Committee
 - iv. Bylaws Committee
 - v. Performance Improvement Committee
 - vi. Pharmacy and Therapeutics Committee
 - vii. Physician Peer Review Committee
 - viii. Clinical Management Committee
- c. Special committees will be ad hoc committees appointed by the President of the Medical Staff, or the Medical Executive Committee. Special committees shall confine their work to the purpose for which they were appointed and should report to the Medical Executive Committee. The Medical Executive Committee shall review the need and purpose(s) of each special committee at least annually and modify the charge and/or membership of the committee, or terminate the committee, as may be warranted after conducting the review. The functions, composition, staff and accountabilities of each special committee shall be stated in the minutes of the Medical Executive Committee when announced to or appointed by the Medical Executive Committee.
- d. Any general medical staff member can request a change in personnel on a committee which he/she feels is not functioning properly or fairly. This request should be made to the Medical Executive Committee which will consider the request. The decision of the Medical Executive Committee is final.
- e. Complete and accurate minutes for all committee meetings shall be kept by a designated recorder who is acceptable to both the medical staff and to the administration.
- f. A committee member may resign for any reason from the Committee, effective immediately or upon a date specified, by writing, or verbally stating, to an officer or the committee chairman the intent to resign. Any verbal resignation shall be immediately documented by the person receiving the resignation, with a copy to the resigning member. Failure to withdraw the resignation within five days serves as confirmation of the resignation.
- g. Executive Session. At the call of its chairman, any medical staff committee or department, or the staff as a whole, may meet in executive session, with attendance restricted to medical staff members,

a recording secretary, and such advisors or other attendees as the chairman may specifically request to attend.

SECTION 2. MEDICAL EXECUTIVE COMMITTEE

- a. **Composition.** The members of the Medical Executive Committee are fully licensed physician members of the active medical staff. It shall consist of the officers of the medical staff, the chief of each clinical department, the director of medical education, and the immediate past three presidents of the medical staff. Each member of the Medical Executive Committee shall have one vote. Removal of a member may be initiated by a majority vote of all active members of the medical staff. Removal of a member shall be for just cause. Just cause may include but is not limited to the failure to uphold the interests of the medical staff and failure to carry out the duties of the office.
- b. **Duties.** The duties of the Medical Executive Committee shall be:
- i. to act on all matters of medical staff business between meetings of the general medical staff, except for election of general staff officers, removal of medical staff officers, and adoption of amendments of these medical staff bylaws;
 - ii. to represent and to act on behalf of the medical staff, subject to such limitations as may be imposed by these bylaws;
 - iii. to coordinate the activities and general policies of the various departments;
 - iv. to receive reports and takes action on quality management findings or direct other action-taking officials or components of medical staff to act on and/or further evaluate quality management findings; monitor substance, timeliness and effectiveness of actions taken;
 - v. to report to the Board on the quality of care delivered as demonstrated in the quality management activities;
 - vi. to receive and act upon committee and department reports;
 - vii. to coordinate, or oversee coordination of, the activities of and policies adopted by the staff, departments and other clinical units and committees;
 - viii. to implement and monitor policies of the medical staff, or monitor that such policies are implemented by the departments and other clinical units;
 - ix. to provide liaison between medical staff and the CEO and the Board;
 - x. to recommend action to the CEO on matters of a medico-administrative nature;
 - xi. to make recommendations on hospital management matters to the Board through the CEO or designee;
 - xii. to fulfill the medical staff's accountability to the Board through the CEO;
 - xiii. to ensure that the medical staff is kept abreast of the accreditation program and informed of the accreditation status of the hospital;
 - xiv. to provide for the preparation of all meeting programs, either directly or through delegation to a program committee or other suitable agent;
 - xv. to review the credentials of all applicants and to make recommendations for staff membership, assignments to department, and delineation of clinical privileges to the Board;
 - xvi. to review periodically all information available regarding the performance and clinical competence of staff members and other practitioners with clinical privileges and, as a result of such reviews, to make recommendations for re-appointments and renewal or changes in clinical privileges;
 - xvii. to take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all members of the medical staff, including the initiation of and/or participation in medical staff corrective or review measures when warranted;
 - xviii. to report at each general staff meeting; and
 - xix. performs other functions as required by the Medical Staff Bylaws.

- a. Meetings. The Medical Executive Committee shall meet at least once a month and maintain a permanent record of its proceedings and actions.
- b. Procedure to overturn an action of the Medical Executive Committee. Except for actions of the Medical Executive Committee related to peer review, under these bylaws, any action or recommendation of the Medical Executive Committee may be overturned by a majority vote of the active medical staff through the following procedure:
 - i. Any member of the medical staff may request a vote to overturn actions or recommendations of the Medical Executive Committee. Any such request will be made in writing to the President of the Medical Staff no later than 180 days from the Medical Executive Committee action that is the subject of the controversy.
 - ii. The request to vote to overturn an Medical Executive Committee action must be approved by either a majority vote of active and refer and follow medical staff members present at any regular or special meeting, or by a petition signed by at least 25% of the active and refer and follow medical staff.
 - iii. If the request is approved, a vote to overturn a Medical Executive Committee action may be undertaken at any regular or special meeting of the medical staff.
 - iv. At least 15 days before any such meeting to overturn a Medical Executive Committee action, all active and refer and follow members of the medical staff will be given written notice of the meeting which will include the time and place of the meeting, and will include a written proxy.
 - v. All voting will be either in person or by delivering the signed written proxy to the Medical Staff Office prior to the meeting.
 - vi. A vote to overturn a Medical Executive Committee action will require ~~the~~ an affirmative vote to overturn by a majority of the members of the active and refer and follow medical staff where there is a quorum (30%) as defined by these bylaws.

SECTION 3. MEDICAL STAFF WELLNESS COMMITTEE

The Medical Staff Wellness Committee exists to provide a non-punitive approach to assist medical staff with matters of individual physical and mental health. Furthermore, it serves to proactively maintain a healthy medical staff. The Wellness Committee seeks to maintain the ability of all practitioners to practice with reasonable skill and safety not limited by physical or mental disorders or disabilities.

The Committee will consist of the Administrative Medical Director/designee and two additional members of the medical staff as chosen by the President of the Medical Staff. At least one individual should have experience in behavioral health and/or substance abuse evaluation and treatment. The term of service will be determined by the Medical Executive Committee. No member of the Wellness Committee shall serve on other peer review or quality committees.

SECTION 4. CREDENTIALS COMMITTEE

The Credentials Committee will consist of seven members of the active medical staff, including the immediate 5 past presidents, if available, and additional members appointed by the President of the Medical Staff. The Committee will review and evaluate the qualifications and evaluations of and recommendations for each practitioner applying for initial appointment or reappointment, and initial, modified, or continuing clinical privileges. The Committee will submit reports and information on the qualifications of each practitioner applying for staff membership or clinical privileges, including recommendations for appointment, membership, category of membership, department affiliation, clinical privileges, and special conditions. Membership, privilege, and all other forms needed by the medical staff, its departments and divisions. The

Committee will meet at least bimonthly. A record of its proceedings and actions will be maintained by the medical staff offices and reported to the Medical Executive Committee.

SECTION 5. BYLAWS COMMITTEE

The Bylaws Committee will consist of seven members of the medical staff. The current and immediate past president of the organized medical staff will serve on the Bylaws Committee. Five other members will be chosen by the current bylaws chairperson after consulting with the president of the medical staff. Members will be selected to reflect a broad range of clinical expertise, and ideally have past experience with reviewing and revising bylaws documents. The committee will perform an annual review of the medical staff bylaws, rules and regulations, and medical policies. Recommendations for changes in these documents are made to the Medical Executive Committee in order to support best medical practices and to comply with state and federal regulations and existing hospital accreditation standards. The Bylaws Committee will meet as often as necessary at the call of its chair, but at least semi-annually. A record of its proceedings and actions will be maintained by the Medical Staff Office and the Medical Executive Committee. The bylaws chairman will serve for a maximum of three years, a term which may be extended annually for a maximum of three additional years, if approved by the Medical Executive Committee. Members of the Bylaws Committee will serve for no more than five years, and it is preferable that committee terms are staggered to allow continuity in committee membership.

SECTION 6. PERFORMANCE IMPROVEMENT COMMITTEES

The medical staff has a responsibility to participate in quality improvement activities of the hospital. The physician Peer Review Committee includes a member from each clinical department and is chaired by the Vice-president of the Medical Staff. The Committee performs primary peer review. The Clinical Management Committee provides a forum for collaboration between the medical staff and hospital operational leaders to review and improve system processes that affect the quality of patient care... The Committees meets at least bimonthly. A record of their proceedings and actions will be maintained by the medical staff offices and reported to the Medical Executive Committee.

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SECTION 7. PHARMACY AND THERAPEUTICS COMMITTEE

The Pharmacy and Therapeutics Committee – this is a joint committee of St. Luke’s Hospital and Mercy Medical Center. The committee consists of representatives from each hospital pharmacy. Other members include 4 members of the active medical staff. The Committee meets at least bimonthly to review hospital formulary issues and all medication-related concerns, especially related to safe and appropriate use of medications. Medication safety concerns are reviewed and recommendations for system improvements are made. A record of its proceedings and actions will be maintained by the medical staff offices and reported to the Medical Executive Committee.

ARTICLE XI
Meetings

SECTION 1. MEDICAL STAFF MEETINGS

- a. **Annual Meetings.** The annual staff meeting will be held in December of each year. At this meeting the retiring officers shall make such reports as deemed necessary; the officers for the ensuing year shall be elected.
- b. **Regular Meetings.** The Medical Executive Committee may provide for the holding of regular meetings of the Medical Staff by resolution, for the purpose of transacting such business as may come before the meeting. All regular meetings of the Medical Staff shall be held at such day and hour as designated by the President in the call for such meeting.
- c. **Special Meetings.**
 - i. The President or the Medical Executive Committee may call a special meeting of the Medical Staff at any time. The president shall, within seven days, issue a call for a special meeting after receipt of a written request for same, signed by not less than one-fourth of the active staff and stating the purpose of such meeting. The Medical Executive Committee shall designate the time and place of any special meeting. Written or printed notice stating the place, day, and hour of any special meeting of the medical staff shall be delivered, either personally or by U.S. mail, to each member of the active staff not less than two and not more than fourteen (14) days before the date of such meeting, by or at the direction of the president (or other persons authorized to call the meeting). If mailed, the notice of the meeting shall be deemed delivered when deposited, postage prepaid, in the United States mail addressed to each staff member at his/her address as it appears on the records of the hospital. The attendance of a member of the medical staff at a meeting shall constitute a waiver of notice of such meeting. No business shall be transacted at any special meeting except that stated in the notice calling said meeting.
- d. **Executive Session.** At the call of the President of the Medical Staff or on motion and vote of the staff as a whole, the Medical Staff may meet in executive session, with attendance restricted only to active medical staff members, a recording secretary (who may be a medical staff member), and such advisors or other attendees as the President or Medical Staff may specifically request to attend.
- e. **Quorum and Action**

No formal action may be taken by the medical staff at any annual, regular or special meeting unless a quorum is present. Unless otherwise specifically stated, a quorum requires the presence of at least 30% of all voting members of the organized medical staff who must be present in person or by proxy. Written ballots shall be sent out with notice of the meeting and shall include the matters to be voted upon at the meeting. A written ballot must be signed and delivered to the President of the Medical Staff or the Medical Staff Office prior to or at the meeting. All written ballots must be counted at the time of the regular meeting. Formal action may only be taken on the affirmative vote of a majority of voting members present when there is a quorum.
- f. **Procedural Rules.**

Every meeting of the Medical Staff shall be conducted according to the then-current edition of Robert's Rules of Order. In the event of conflict between said Rules and any provisions of these

bylaws, the bylaws shall supersede said Rules. However, technical or not-substantive departures from those Rules shall not invalidate an action taken.

SECTION 3. CLINICAL DEPARTMENT AND COMMITTEE MEETINGS

a. Regular Meetings

Committees may, by resolution, provide the time for holding regular meetings without notice other than such resolution. Departments shall hold regular meetings in accordance with departmental policy to review and evaluate the clinical work of practitioners with privileges in the department.

b. Special Meetings

- i. A special meeting of any committee or department may be called by or at the request of the chairman or chief thereof, by the President of the Medical Staff, or by one-third of the group's then members, but not less than two members.
- ii. Written or oral notice stating the place, day, and hour of any special meeting, or of any regular meeting not held pursuant to resolution, shall be given to each member of the committee or department, not less than five business days before the time of such meeting by the person or persons calling the meeting. If mailed, the notice of the meeting shall be deposited, postage prepaid, in the United States mail no later than seven business days before the meeting, addressed to the member at his/her address as it appears on the records of the hospital. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

c. Quorum. Thirty percent (30%) of the active medical staff members of a committee or department, but not less than two members, shall constitute a quorum at any meeting of a committee or department.

d. Executive Session. At the call of its chairman, any medical staff committee or department, may meet in executive session, with attendance restricted to medical staff members, a recording secretary (who may be a medical staff member), and such advisors or other attendees as the chairman may specifically request to attend.

SECTION 4. MANNER OF ACTION

The action of a majority of the members present in person or by proxy at a meeting in which a quorum is present shall be the action of the committee or department. Action may be taken without a meeting by unanimous written consent signed by each member entitled to vote on the matter.

SECTION 5. MINUTES

Minutes of each regular and special meeting of a committee or department shall be prepared and shall include a written record of the attendance of members and the vote taken on each matter. The minutes shall be signed by the presiding officer and copies thereof shall be promptly submitted to the attendees for approval, and after

such approval is obtained, forwarded to the Medical Executive Committee. Each committee and department shall maintain a permanent file of the minutes of each meeting.

SECTION 6. DEPARTMENT MEMBER PERFORMANCE OR CONDUCT REVIEW

Each department shall evaluate the professional practice activities of its members and respond to questions of professional competency or personal conduct consistent with these bylaws.

- a. Where a practitioner is required to provide information about specific case management or professional activities, the department chair or their designated representative will notify the affected practitioner in writing of the need to have the member attend a department meeting for the purpose of discussing individual case management or personal conduct matters.
- b. The department chair or their representative will schedule a meeting for the purpose of discussing the professional practice or conduct issues leading to this meeting. The affected member will be provided with detailed information about the nature of any complaint or practice issue leading to the meeting.
- c. The department chair may delay or postpone such a meeting for no more than 30 days upon written request by the affected member which provides a reasonable, good faith explanation for such a postponement.
- d. Department members are expected to assist in the timely resolution of any such performance or conduct issues.
- e. Failure to make a good faith effort to assist the department's peer review and quality of care efforts that are fundamental to the performance and conduct review process represents potential actionable conduct against a member and is subject to the corrective action process of these bylaws, and may result in a change in membership status or loss of privileges.

ARTICLE XII Immunity from Liability

The following shall be express conditions of any practitioner's application for, or exercise of, Medical Staff membership or clinical privileges at this hospital.

- a. That any act, communication, report, recommendation, or disclosure, with respect to any such practitioner, performed or made in good faith and without malice and at the request of any authorized representative of this or any other health care facility for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged to the fullest extent permitted by law.
- b. That such privilege shall extend to members of the hospital's Medical Staff and of its Board, its other practitioners, CEO, and to third parties who supply information to any of the foregoing authorized to receive, release, or act upon the same. For the purpose of this Article XII, the term "third parties" means both individuals and organizations from whom information has been requested by an authorized representative of the Board or of the medical staff.
- c. That there shall, to the fullest extent permitted by law, be immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure by any person or body listed in paragraph b. of this Article, even where the information involved would otherwise be deemed privileged.

- d. That such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care institution's activities related, but not limited to:
 - i. applications for appointment or clinical privileges;
 - ii. periodic reappraisals for reappointment or clinical privileges;
 - iii. corrective action, including summary suspension;
 - iv. hearings and appellate reviews;
 - v. medical care evaluations;
 - vi. utilization reviews; and
 - vii. other hospital, department, section, or committee activities related to quality patient care and inter professional conduct.
- e. That the acts, communications, reports, recommendations, and disclosures referred to in this Article may relate to a practitioner's professional- qualifications, clinical competency, character, mental or physical condition, ethics, or any other matter that might have an effect on patient care.
- f. That in furtherance of the foregoing, each practitioner shall, upon request of the hospital, execute releases in accordance with these bylaws in favor of the individuals and organizations specified in paragraph b, subject to such requirements, including those of good faith, absence of malice, and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of this state.
- g. That the consent, authorizations, releases, rights, privileges, and immunities provided by these bylaws for the protection of this hospital's practitioners, other appropriate hospital officials, personnel, and third parties, in connection with applications for initial appointment and for reappointment, shall also be fully applicable to the activities and procedures covered by this Article.
- h. The Hospital shall defend, indemnify, and hold all Medical Staff officers, department chairs, committee chairs, committee members and other participating medical staff members harmless for good faith actions taken when acting in the course and scope of their official Medical Staff duties and responsibilities.

ARTICLE XIII

Rules and Regulations

The organized medical staff shall adopt such rules and regulations as may be necessary to implement the principles embodied within these bylaws. The rules and regulations shall relate to the organization and function of the organized medical staff and are a part of the medical staff bylaws. Rules and regulations may be amended or repealed by a majority vote of all voting members physically present or voting by written ballot at any regular meeting in which a quorum is present, and notice given to all voting members of the organized medical staff. All written ballots must be counted at the time of the regular meeting. Any such change shall become effective when approved by the governing body. The Rules and Regulations will be reviewed by the Bylaws Committee and the Board on an annual basis.

**ARTICLE XIV
Amendments**

These bylaws may be amended after submission of the proposed amendment at any regular or special meeting of the medical staff. A proposed amendment shall be referred to the Bylaws Committee which shall report on it at the next regular meeting of the Medical Staff or at a special meeting called for such purpose. To be adopted, an amendment shall require a secret ballot using a two envelope system, and requiring an affirmative two-thirds vote of the active medical staff submitting ballots. Amendments so made shall be effective when approved by the Board. Neither the organized medical staff nor the Board may unilaterally amend the medical staff bylaws or rules and regulations.

**ADOPTED BY ST. LUKE'S ACTIVE MEDICAL STAFF
____, 2011**

President of the Medical Staff

Secretary of the Medical Staff

**APPROVED BY ST. LUKE'S BOARD OF DIRECTORS
____, 2011**

Secretary of the Board of Directors