



River Park  
Hospital

# **MEDICAL STAFF BYLAWS**

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**MEDICAL STAFF BYLAWS**  
**PREAMBLE**

WHEREAS, HHC River Park, Inc. d/b/a River Park Hospital is owned and operated by Universal Health Services of Delaware, Inc. (UHS), a corporation organized under the laws of the State of Delaware;

WHEREAS, the Facility's purpose is to serve as a multi-purpose mental health facility, providing patient care, education, and research, as applicable; and

WHEREAS, one of the goals of the Medical Staff is to strive for quality treatment in the Facility;

WHEREAS, the Medical Staff must work with and is subject to the ultimate authority of the Board; and

WHEREAS, the cooperative efforts of the Medical Staff, the administration, and the Board are necessary to provide quality care.

NOW, THEREFORE, the Physicians practicing in this Facility hereby (and pursuant to an express delegation of authority by the Board) organize themselves into a Medical Staff in conformity with these Bylaws.

As used in these Bylaws, the following terms shall mean:

**ALLIED HEALTH PROFESSIONALS** or **AHP** means an individual, other than a physician, who is permitted by law, the Board, and the MEC to provide patient care services within the scope of their license, certificate, or other legal credentials in accordance with individually granted Clinical Privileges. Allied Health Professionals are not members of the Medical Staff and may not vote at meetings of the Medical Staff. Allied Health Professionals may serve on committees of the Medical Staff.

**BOARD OF DIRECTORS** means the governing authority of UHS.

**GOVERNING BOARD** means the local advisory board of the Facility.

**BYLAWS** mean these Medical Staff Bylaws.

**CEO** means the chief executive officer appointed by the Board of Directors to act on its behalf in the management of the Facility. The CEO may be designated by the Board of Directors under another title, such as, for example, Administrator, President or Executive Director.

**CLINICAL PRIVILEGES** means specified diagnostic and therapeutic services that may be exercised by authorized individuals on approval of the Trustees, based on the individual's professional license, documented current competence, experience, and judgment, and as set forth in the Facility's clinical privileging plan.

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

**FACILITY** means River Park Hospital, its services and programs.

**HIPAA** means the Health Insurance Portability and Accountability Act of 1996 and any regulations promulgated thereunder.

**MEC** means the medical executive committee appointed pursuant to these Bylaws.

**MEDICAL STAFF** or **STAFF** means the organizational component of all Members, including clinical psychologists and Advanced Nurse Practitioners, who hold an unrestricted license in this State and who are clinically privileged to provide patient care services in the Facility within the scope of their licensure and approved Clinical Privileges.

**MEDICAL STAFF MEMBER** or **MEMBER** means a physician, clinical psychologist, Advanced Nurse Practitioner, or other individual eligible to apply for Medical Staff membership who has applied for and obtained current membership with the Medical Staff. Residents, Interns, and Allied Health Professionals are not Members.

**PREROGATIVE** means a participatory right granted, by virtue of Staff category or otherwise, to a Staff appointee or AHP and is exercisable subject to the conditions imposed in these Bylaws, Rules and Regulations, and in other Facility and Medical Staff policies.

**RULES AND REGULATIONS** means the policies of the Medical Staff as defined in Article 15 and appended to these Bylaws.

**STATE** means the state of West Virginia.

**TEMPORARY PRIVILEGES** means Clinical Privileges granted to a practitioner for a specified period of time and under prescribed circumstances as defined in Article 7, Section 7.4

**ARTICLE 1  
NAME**

The name of this organization shall be the River Park Hospital Medical Staff.

**ARTICLE 2  
PURPOSE AND RESPONSIBILITIES**

**2.1 PURPOSES.**

The purposes of the Medical Staff are:

- 2.1.1 to ensure that all patients receiving treatment from the Facility receive uniform quality patient care that is provided in a highly ethical manner and that is commensurate with locally available resources;
- 2.1.2 to be the formal organizational structure through which: (1) the benefits of membership on the Medical Staff may be obtained by individual professionals, and (2) the obligations of Medical Staff membership must be fulfilled;
- 2.1.3 to serve as the primary means for accountability to the Board for the quality and appropriateness of the professional performance and ethical conduct of the Medical Staff Members, Residents, Interns and Allied Health Professionals and to strive for quality patient care efficiently delivered and maintained consistent with locally available resources and to the degree reasonably possible as determined by the state of the healing arts in the community;
- 2.1.4 to provide a means through which the Medical Staff may participate in the policy making and planning process, medication management and patient safety;
- 2.1.5 to assure that each Medical Staff Member and Allied Health Professional provides services within the scope of individual Clinical Privileges granted; and
- 2.1.6 to provide oversight of care, treatment, and services provided by practitioners with privileges, provide for a uniform quality of patient care, treatment and services, and report to and be accountable to the Governing Board.

Mission of the Medical Staff:

The Medical Staff of River Park Hospital adopts and incorporates by reference the Vision, Mission and Values of River Park Hospital which are as follows:

Vision of the Medical Staff:

The employees and medical staff of River Park Hospital strive to be recognized within the communities we serve as the leader in behavioral healthcare.

Mission & Values

It is the Mission of River Park Hospital to improve quality of life through the delivery of individualized treatment that is accessible, compassionate, effective, and affordable.

In pursuit of our Mission, we commit to the following value statements which we believe are essential in

the fulfillment of daily responsibilities.

- We recognize and affirm the unique and intrinsic worth of all individuals.
- We respect and are dedicated to protecting patient rights.
- We demonstrate sensitivity to spiritual, physical, behavioral, and emotional needs of every individual.
- We foster a team atmosphere among staff and physicians to promote mutual respect with the common goal of providing quality services.
- We are committed to continually measure, evaluate and improve care.
- We act with absolute honesty, integrity and fairness in the way we conduct our business and our lives.

## **2.2 RESPONSIBILITIES.**

The responsibilities of the Medical Staff are:

- 2.2.1 to account to the Board for the patient care processes and outcomes rendered by all Members, Residents, Interns and Allied Health Professionals authorized to practice in the Facility through the following means:
- (a) a credentialing program, including procedures for appointment and reappointment that matches verified qualifications, performance, and competence with the Clinical Privileges sought to be exercised or of specified services to be performed;
  - (b) a continuing medical education program based, in part, to the degree reasonably possible, upon the needs demonstrated through the quality management program;
  - (c) a utilization review/case management program to allocate medical and health services based upon clinical determinations of individual treatment needs;
  - (d) a procedure for monitoring patient care practices, including intake, assessment, treatment plans, treatment plan reviews, and restraint and seclusion;
  - (e) analysis of patient care processes and outcomes through a valid and reliable quality management program consistent with the requirements of the Joint Commission; and
  - (f) a procedure to ensure that each Member and Allied Health Professional provides professional services within the scope of individual Clinical Privileges granted.
- 2.2.2 to recommend to the Board action with respect to appointments, reappointments, Staff membership and status, Staff structure, service, Clinical Privileges, corrective action, hearing procedures;
- 2.2.3 to account to the Board for patient care processes and outcomes through regular reports and recommendations made concerning the results of quality management activities;
- 2.2.4 to initiate and pursue corrective action with respect to Members and Allied Health Professionals as



provided in these Bylaws;

- 2.2.5 to assist in identifying community health needs and in setting appropriate organizational goals and implementing programs to meet those needs;
- 2.2.6 to exercise the authority granted by these Bylaws as necessary to fulfill adequately the foregoing responsibilities;
- 2.2.7 to monitor, enforce, review, and, if necessary or desirable, recommend amendments to these Bylaws and Rules and Regulations and Facility policies; and
- 2.2.8 to uphold UHS, Inc.'s policies on ethical practices.

## **ARTICLE 3**

### **MEDICAL STAFF MEMBERSHIP**

#### **3.1 NATURE OF MEDICAL STAFF MEMBERSHIP.**

- 3.1.1 Membership on the Medical Staff or the exercise of Temporary Privileges is a privilege that shall be granted to and continued with only professionally qualified and currently competent Members who:
  - (a) continuously meet and satisfy the qualifications, standards, responsibilities, and requirements set forth in these Bylaws, the Rules and Regulations, and the Facility's policies and procedures;
  - (b) are professionally qualified to provide services which need to be provided at the Facility as such need is determined to exist from time to time by the Board;
  - (c) propose to provide services in one or more of the areas of patient care which the Facility offers to patients and is equipped, staffed, and licensed to offer to patients;
  - (d) comply with the provisions of these Bylaws, the Rules and Regulations, and the Facility's policies and procedures; and
  - (e) comply with the Facilities' HIPAA policies.
- 3.1.2 Appointment to and subsequent membership on the Medical Staff shall confer on the Member only such Clinical Privileges and Prerogatives as have been granted by the Board in accordance with these Bylaws and the Rules and Regulations. Appointment to and subsequent membership on the Medical Staff shall confer on the Member only such Clinical Privileges, Prerogatives, and other rights as have been granted by the Trustees in accordance with these Bylaws and the Rules and Regulations. No individual is automatically entitled to initial or continued membership on the Medical Staff or to the exercise of any Clinical Privilege in this Facility merely because he is duly licensed to practice in this or any other state, because he has previously been a member of this Medical Staff, because he had or now has membership or Clinical Privileges at this or another health care facility, or another practice setting. It is recognized that some patient care services within the Facility may be provided exclusively by a limited number of practitioners selected by the Facility, and who have been properly processed and granted Medical Staff membership and Clinical Privileges, based on the Facility's special need to meet certain objectives, including but not limited to the provision of 24-hour coverage, coordination of schedules and assignments, administrative

ease and efficiency, coordinated supervision of non-physician personnel, and quality patient care.

3.1.3 All Members of the Medical Staff exercising Clinical Privileges shall be subject to these Bylaws, the Rules and Regulations and the Facility's Policy and Procedures, and shall be subject to review as part of the Facility's quality management program.

3.1.4 Participation in an Organized Health Care Arrangement. Patient information will be collected, stored and maintained so that privacy and confidentiality are preserved. The Hospital and each member of the Medical Staff will be part of an Organized Health Care Arrangement ("OHCA"), which is defined as a clinically-integrated care setting in which individuals typically receive healthcare from more than one healthcare provider. The OHCA allows the Hospital and the Medical Staff members to share information for purposes of treatment, payment and health care operations. Under the OHCA, at the time of admission, a patient will receive the Hospital's Notice of Privacy Practices, which will include information about the Organized Health Care Arrangement between the Hospital and the Medical Staff

## **3.2 QUALIFICATIONS FOR MEMBERSHIP.**

### **3.2.1 Qualifications.**

Only applicants who comply with the following requirements shall be eligible for Medical Staff membership:

- (a) provide proof of a current, unrestricted license to practice in the State in which the Facility is located and provide documentation of their background; qualifications; professional experience; worthy character; education; relevant training; clinical judgment; physical, mental, and emotional capability as related to the performance of the Privileges requested; ability to provide, with reasonable, necessary accommodation, safe and competent care; and demonstrated current competence;
- (b) document compliance with the requirements of Section 3.1;
- (c) are determined on the basis of documented references to adhere strictly to the ethics of their profession, to work cooperatively with others, and to be willing to participate in the discharge of Medical Staff responsibilities; and
- (d) fulfill such other criteria as may be established by the Board from time to time.

3.2.2 Effect of Other Affiliations. No applicant is automatically entitled to membership on the Medical Staff or to the exercise of particular Clinical Privileges merely because he is licensed to practice in this or in any other state, or because he is a member of any professional organization, or because he is certified by any clinical Board, or because he had, or presently has, Staff membership or privileges at this or any another health care organization or in another practice setting.

3.2.3 Non-discrimination. No aspect of the decision to grant, deny, or renew Medical Staff membership or particular Clinical Privileges shall be based upon sex, race, creed, color, national origin, religion, gender identity, sexual orientation, or any physical or mental impairment if, after reasonable accommodation, the Member is able to provide safe, effective, and competent care in compliance with these Bylaws, the Rules and Regulations, and the Facility's policies and procedures.

### **3.3 GENERAL RESPONSIBILITIES OF STAFF MEMBERSHIP.**

In addition to the other obligations described in these Bylaws, each applicant by applying for or being granted any category of membership or Clinical Privileges, obligates himself to:

- 3.3.1 provide his patients with continuous care of a professionally accepted level of quality and efficiency in the community and delegate the responsibility for diagnosis or supervision of care of patients only to a Member who has Clinical Privileges to undertake that responsibility;
- 3.3.2 abide by the Medical Staff Bylaws, Rules and Regulations and by all other standards, policies, procedures, and rules of the Facility and the Board as they may exist now or in the future;
- 3.3.3 abide by all applicable federal and state laws, rules, and regulations and comply with the applicable standards of the Joint Commission;
- 3.3.4 refrain from unlawful fee splitting or unlawful inducements relating to patient referral;
- 3.3.5 actively participate in and regularly cooperate with the Medical Staff in assisting this Facility to fulfill its obligations related to patient care including but not limited to continuous quality improvement, peer review, utilization review, quality evaluation, and related monitoring activities required of the Medical Staff, and in discharging such other functions as may be required from time to time;
- 3.3.6 refrain from any unlawful harassment or discrimination against any person, including, without limitation, any patient, Facility employee, Facility independent contractor, Medical Staff Member, or visitor, on the basis of sex, age, race, creed, color, national origin, physical or mental impairment, financial status, ability to pay or source of payment, and provide all of his patients with care at the professional level of quality and efficiency as established by the Medical Staff and the Board;
- 3.3.7 obtain appropriate informed consent;
- 3.3.8 maintain a professional liability insurance policy with an approved carrier with limits of no less than \$1,000,000 per claim and \$3,000,000 aggregate per year, or such other amount as may be deemed appropriate by the Board, or participate in the applicable professional liability fund insurance plan of the state, and provide the Facility with a current certificate of insurance. The insurance must cover the types of procedures the applicant has Clinical Privileges to perform. The applicant also agrees to notify immediately the CEO of any insurance policy changes or cancellation and authorize his insurance carrier to provide immediate notice of any change to the Facility;
- 3.3.9 abide by the generally recognized ethical principles of his profession, the Medical Staff, and the Facility, to sign annually or at re-appointment and follow the Facility's policy on ethical practices, and to disclose any conflict of interest to the Facility in writing;
- 3.3.10 complete and document in a timely manner the medical and other required records for all patients he admits or in any way provides care in the Facility;
- 3.3.11 participate in a course of continuing medical education activities related to his areas of Practice;
- 3.3.12 immediately notify the CEO of any change in the information on his application for membership or Clinical Privileges;

- 3.3.13 maintain the confidentiality of all Medical Staff peer review matters pursuant to these Bylaws;
- 3.3.14 authorize the Facility to consult with Medical Staffs of other facilities and their representatives and members with which the applicant has been associated and with others who may have information bearing on his competence, skills, experience, character, ethics, and other qualifications;
- 3.3.15 authorize the disclosure and the inspection of all information, records, and documents that may be relevant to material to credentialing, privileging, or peer review activities; performing functions under these Bylaws; achieving and maintaining quality patient care; reducing morbidity and mortality; reviewing or evaluating professional performance; or contributing to medical research. Such records may include information obtained from data banks maintained on a statewide or national basis;
- 3.3.16 release from any liability, to the fullest extent permitted by law, the Medical Staff and its committees, the Board, the Facility, and their agents and representatives, and third parties for their acts performed without malice in connection with credentialing, privileging, or peer review activities; performing functions under these Bylaws; achieving and maintaining quality patient care; reducing morbidity and mortality; reviewing or evaluating professional performance; or contributing to medical research;
- 3.3.17 upon request and with the patient's consent, if necessary, provide to the Facility information and documents from his office records or from outside sources as necessary for the review of specific patients;
- 3.3.18 inform the CEO immediately of any malpractice claims, any criminal investigations, indictments, or convictions;
- 3.3.19 notify the CEO immediately if any of the following is being or has been investigated; suspended; limited; revoked; denied; placed on probation; resigned; reduced; sanctioned; excluded; relinquished; permitted to expire; or subjected to a review or a proceeding which, if adversely decided, could result in any of the foregoing; regardless of whether the action is voluntary or involuntary, together with all relevant details regarding the action: (1) staff membership, status, Prerogatives, or clinical privileges at any other healthcare facility or institution; (2) membership or fellowship in a local, state, or national professional organization; (3) specialty board certification; (4) license, certification, or other legal credentials to practice any profession in any jurisdiction; (5) Drug Enforcement Agency (DEA) or state narcotics license; (6) provider participation status or eligibility in Medicare, Medicaid, TRICARE/CHAMPUS, managed care organization or network, or any other governmental or private reimbursement plan or provider network. In addition, the Member shall immediately notify the Facility if he ceases to meet any other standards of the Facility, as set forth in these Bylaws, the Rules and Regulations, and the Facility's Policies and Procedures, for continued enjoyment of Medical Staff membership and/or Clinical Privileges;
- 3.3.20 reasonably assist the Facility in fulfilling its uncompensated or partially compensated care obligations within the areas of his professional competence and Clinical Privileges;
- 3.3.21 participate in emergency service coverage and consultation panels as may be required by the Bylaws, the Rules and Regulations, and the Facility's Policies and Procedures;
- 3.3.22 reasonably cooperate with the Facility in its efforts to comply with accreditation, reimbursement, and legal or other regulatory requirements;

- 3.3.23 supply requested information and appear for interviews regarding his membership or Clinical Privileges;
- 3.3.24 immediately notify the CEO of any change in the information on his application for membership or Clinical Privileges;
- 3.3.25 account to the Board for and discharge any Medical Staff, committee, service, and Facility functions for which he is responsible by Staff category, assignment, appointment, election or otherwise;
- 3.3.26 consent to the Facility's inspection of all records and documents that may be material to an evaluation of his professional qualifications for the Clinical Privileges he requests as well as of his moral and ethical qualifications for Medical Staff membership; and
- 3.3.27 continuously meet the qualifications for membership set forth herein.

### **3.4 TERM OF APPOINTMENT AND REAPPOINTMENT.**

- 3.4.1 Appointments and Reappointments. Initial appointments and reappointments to the Medical Staff shall be made by the Board upon a recommendation from the MEC and shall be for a period not to exceed two (2) years from the date of appointment (including any time for Provisional status). Except as otherwise determined by the Board, all initial appointments to the Medical Staff shall be Provisional.
- 3.4.2 Modification in Staff Category and Clinical Privileges. The MEC may recommend to the Board that a change in Staff category of a current Staff Member or the granting of additional Clinical Privileges to a current Staff Member be made Provisional in accordance with the procedures in Article 6 for initial appointments.

### **3.5 LEAVE OF ABSENCE.**

- 3.5.1 General Policy. A Staff Member may request a voluntary leave of absence from the Medical Staff by submitting a written request to the CEO, who shall then transmit the request to the MEC. The request shall state the reason for the request and the specific time period, which may not exceed two (2) years. The MEC and the Board must approve all leaves. By requesting a leave of absence, the Member agrees that as a condition of reinstatement, he shall bear the burden of proof to demonstrate to the MEC and the Board that he is qualified for reinstatement. During the period of the leave, the Member's Clinical Privileges and Prerogatives shall be inactive.
- 3.5.2 Procedure for Reinstatement. At least forty five (45) days prior to termination of the leave, or at any earlier time, the Member may request reinstatement of his Clinical Privileges by submitting a written notice to that effect to the CEO who shall transmit the notice to the MEC. The Member shall submit a written summary detailing any of his professional and patient care activities during the leave. The MEC shall evaluate the request and may deem it incomplete if all necessary information is not provided, may request further information from the Member, may defer action on the request, or may make a recommendation to the Board concerning the reinstatement of the Member's Clinical Privileges and Prerogatives and any conditions that should be attached. Thereafter, the procedure provided in Article 7, Section 7.2 shall apply.

- 3.5.3 Observation Requirement. At the discretion of the MEC, reinstatement may be made subject to an observation requirement for a period of time during which one or more designated Medical Staff Members observe the Member's clinical performance. Such routine observation shall not be considered disciplinary or adverse action and shall not entitle the Member to pursue the administrative remedies available under these Bylaws.
- 3.5.4 Requesting Reinstatement. Failure without good cause to request timely reinstatement, to supply sufficient information for the request to be deemed complete, or failure to provide a summary of professional and other activities as required above, shall constitute a voluntary resignation from the Staff and voluntary relinquishment of Clinical Privileges, effective immediately upon the determination that no good cause exists. The MEC shall, in its sole discretion, and after giving the Member an opportunity to address the MEC, determine whether good cause exists. Such voluntary resignation and voluntary relinquishment shall not be deemed an adverse action or summary professional review action and shall not entitle the Member to pursue the administrative remedies available under these Bylaws. A request for Staff membership received from a Member subsequent to a voluntary resignation shall be treated and processed as an application for initial appointment.

### **3.6 ADMINISTRATIVE AND CONTRACT PRACTITIONERS.**

- 3.6.1 Contractors With No Clinical Duties. A practitioner employed by or contracting with the Facility in a purely administrative capacity with no clinical duties or Clinical Privileges is subject to the Facility's Human Resources' policies and other terms of her conditions of employment, if employed, or to the terms of her contract with the Facility, if a contract employee. A practitioner with purely administrative duties does not need to be a member of the Medical Staff.
- 3.6.2 Contractors With Clinical Duties: Medical Administrative Officers. A Medical Administrative Officer must be a Member of the Medical Staff with delineated Clinical Privileges as set forth in these Bylaws. The effect of the expiration or termination of a contract between a Medical Administrative Officer and the Facility on the Medical Administrative Officer's Staff membership and Clinical Privileges shall be determined by the terms, if any, of the contract between the Medical Administrative Officer and the Facility. The Staff membership and Clinical Privileges of the Medical Administrative Officer shall not be contingent on her continued occupation of that position in the absence of any provision in the contract specifically providing otherwise.

## **ARTICLE 4**

### **CATEGORIES OF THE MEDICAL STAFF AND RESIDENTS AND INTERNS**

#### **4.1 CATEGORIES.**

The Staff shall be divided into Active, Provisional, Courtesy, Honorary, Advanced Nurse Practitioners, and Residents and Interns categories. Action may be initiated to change the Staff category or terminate the membership of any Member who fails to meet the qualifications or fulfill the duties described herein or in the Rules and Regulations as developed and implemented by the Facility. Changes in Medical Staff category shall not be grounds for a hearing unless they adversely affect the Member's Clinical Privileges. Each practitioner who seeks or enjoys Staff appointment must continuously satisfy the basic qualifications for membership as set forth in these Bylaws and Rules except those that are specifically waived for a particular category. The Trustees may, after recommendation from the MEC, waive any qualification in accordance with Section 4.8 of this Article 4. The Prerogatives generally available to a Medical Staff Member, subject to Staff category restrictions, are to:

- 4.1.1 Admit patients consistent with approved Clinical Privileges;
- 4.1.2 Exercise Clinical Privileges which have been approved;
- 4.1.3 Vote on any Medical Staff matter including Bylaws amendments, officer selection, and other matters presented at any general or special Staff meetings;
- 4.1.4 Hold office in the Medical Staff; and
- 4.1.5 Serve on committees and vote on committee matters.

The responsibilities which Medical Staff Members shall be expected to carry out, in addition to the basic responsibilities set forth in Article II, Section 2.2, are to:

- (a) contribute to the organizational and administrative Medical Staff activities, including quality improvement, risk management and patient safety, and utilization management, and serve in Medical Staff offices and on Facility and Medical Staff committees;
- (b) participate equitably in Staff functions at the request of the President of the Medical Staff or the Medical Director, including contributing to the Facility's medical education programs, serving the on-call roster and accepting responsibility for providing care to any patient requiring on-call coverage, proctoring practitioners, and fulfilling other Staff functions as may reasonably be required;
- (c) attend at least the minimum number of Staff meetings specified in the Bylaws or rules and regulations; and
- (d) accept for care and treatment a reasonable proportion of unassigned patients in need of emergency care who are unable to pay all or a portion of the costs of care.

## **4.2 ACTIVE STAFF.**

4.2.1 Qualifications. The Active Staff shall consist of Members, each of whom:

- (a) meets the basic qualifications set forth in Sections 3.1 and 3.2;
- (b) resides and practices close enough to the Facility's program to provide continuous and timely care to and supervision of his patients or to arrange a suitable alternative for such care and supervision but in no event more than 30 minute drive time to Facility;
- (c) is regularly involved in the care of patients in the Facility's programs. "Regularly involved," as used in this Article, means admitting a sufficient number of inpatients to enable the Medical Staff and the Facility to assess the quality of patient care provided by the Member and to assure that the Member is sufficiently involved in Facility and Medical Staff activities to hold office and vote on Medical Staff issues in an informed manner. Unless otherwise determined by the Board, this shall mean admitting the equivalent of thirteen (13) inpatients each Medical Staff year; and
- (d) has served at least one (1) year on the Provisional Staff as described in Section 4.3.

4.2.2 Prerogatives.

The Prerogatives of an Active Staff Member shall be to:

- (a) depending upon the specific Privileges granted, admit patients;

- (b) exercise such Clinical Privileges as are granted to him pursuant to Article 7;
- (c) vote on all matters presented at general and special meetings of the Medical Staff and of committees of which he is a member; and
- (d) hold office in the Staff organization and committees of which he is a member;

#### 4.2.3 Responsibilities.

Each member of the Active Staff shall:

- (a) meet the general responsibilities set forth in Section 3.3;
- (b) retain responsibility within his area of professional competence for the daily care and supervision of each patient in the Facility for whom he is providing services, or to arrange a suitable alternative for such care and supervision;
- (c) actively participate in the quality management program required of the Staff, supervise Provisional appointees of his same profession as assigned by the Medical Director, and discharge such other Staff functions as may from time to time be required;
- (d) satisfy the requirements set forth in Article 12 for attendance at meetings of the Staff and committees of which he is a member; and
- (e) perform all on call duties and assignments.

4.2.4 Automatic Transfer or Termination of Membership. An Active Staff Member who is not regularly involved in patient care shall be automatically transferred to the Courtesy Staff at the time of the next reappointment unless he does not meet the qualifications for membership for either Staff category, in which case he shall be deemed to have voluntarily resigned his membership and voluntarily relinquished his privileges, effective immediately upon determination of the failure to meet the applicable qualifications. Such voluntary resignation and relinquishment shall not constitute an adverse action or summary professional review action and shall not entitle the Member to pursue the administrative remedies available under these Bylaws.

### 4.3 **CONSULTING STAFF.**

#### 4.3.1 Qualifications.

The Consulting Staff shall consist of Members, each of whom:

Are not psychiatrists, who will provide specialized professional medical consultations and limited treatment to patients upon request of the attending physician and/or shall provide clinical interpretation or supervision which may be contracted by the Hospital (examples include, but are not limited to, radiologists, family practice, etc.)

#### 4.3.2 Prerogatives.

The Prerogatives of a Consulting Staff Member (including residents) shall be to have the professional qualifications necessary to meet the full requirements of appointment of the Active Medical Staff, with the notable exception of not being psychiatrists.

Unless otherwise expressly permitted herein, appointment to the Consulting Staff does not entitle



the appointee to admit patients, to vote, to hold office or to serve on Medical Staff committees; provided, however, that a Consulting Staff Member may be invited to participate in Medical Staff and Hospital committees, including, without exception, peer review and quality improvement activities. Unless otherwise provided in these Bylaws, Consulting Staff appointees need not attend Medical Staff meetings.

Any Member of the Consulting Staff who, during the twelve (12) months preceding his/her appointment or reappointment to Full Consulting Privileges, provides direct consultative services to twenty-five percent (25%) or more of the patients of the Hospital, including the Barboursville School Program, shall actively participate in quality assessment and improvement activities, clinical resource utilization review, assigned management functions and other required Medical Staff peer review assessment activities, as well as serve as a voting member and hold office on the Medical Executive Committee. (See Article XI, Section 3).

#### 4.3.3 Responsibilities. Each Member of the Consulting Staff shall:

Consulting Staff shall perform timely completion of consultation records as outlined in the Medical Staff Rules and Regulations.

Consulting Staff shall abide by Hospital and Medical Staff Bylaws, Rules, Regulations and policies as may be adopted by the Hospital, as well as any requirements or standard guidelines propounded by the Joint Commission, state licensing boards, and other regulatory or credentialing agencies.

## 4.4 **PROVISIONAL STAFF.**

### 4.4.1 Qualifications.

The Provisional Staff shall consist of Members, each of whom:

- (a) is being considered for advancement to Active Staff membership and will, in the ordinary course of events and unless he requests otherwise, be advanced to active Except as otherwise determined by the Board, all initial appointments to the Medical Staff shall be Provisional for six (6) months and may be renewed for two (2) additional six (6) month periods at the discretion of the MEC.

If the Provisional appointee fails within that period to furnish the certifications required, his Staff membership, status, or particular Clinical Privileges, as applicable, shall automatically terminate. Unless otherwise specified in these Bylaws, the appointee so affected shall be entitled to pursue the administrative remedies available under Article 9. Provisional status may not continue for a total period longer than eighteen (18) months; and

- (b) meets the qualifications specified in Section 4.2.1 for Members of the Active Staff.

### 4.4.2 Prerogatives.

The Prerogatives of a Provisional Staff Member shall be to:

- (a) admit, depending upon the specific Privileges granted to the Member, patients;
- (b) exercise such Clinical Privileges as are granted to him pursuant to Article 7; and

- (c) Provisional Staff Members may serve on Medical Staff committees, but they shall not be eligible to hold office in the Medical Staff but shall be eligible to vote at meetings of the Medical Staff at six months

4.4.3 Responsibilities. Each Member of the Provisional Staff shall:

- (a) meet the general responsibilities set forth in Section 3.3;
- (b) retain responsibility within his area of professional competence for the daily care and supervision of each patient in the Facility for whom he is providing services, or to arrange a suitable alternative for such care and supervision;
- (c) actively participate in the quality management program required of the Staff, supervise Provisional appointees of his same profession as assigned by the Medical Director, and discharge such other Staff functions as may from time to time be required;
- (d) satisfy the requirements set forth in Article 12 for attendance at meetings of the Staff and committees of which he is a member; and
- (e) perform all on call duties and assignments.

Failure to discharge such responsibilities shall constitute grounds for denial of advancement to Active Staff membership. Each Provisional Staff Member shall be supervised by a Member of the Active Staff, who shall be selected by the Medical Director. The required nature and frequency of such supervision will be written in the Privilege description.

## 4.5 COURTESY STAFF.

4.5.1 Qualifications.

The Courtesy Staff shall consist of Members, each of whom:

- (a) meets the basic qualifications set forth in Sections 3.1 and 3.2;
- (b) resides and practices his profession, within the discretion of the Board, close enough to the Facility's program to provide continuous care to and supervision of his patients or arrange a suitable alternative for such care and supervision;
- (c) is not "regularly involved", as that phrase is defined in Section 4.2.1(c), in patient care in the Facility; and
- (d) may be a Member of the Active or Provisional Staff of another organization in which his regular participation in quality improvement activities is documented and his performance evaluated. Courtesy Staff Members shall provide satisfactory evidence to the MEC of such membership, participation, and evaluation;

4.5.2 Prerogatives. The Prerogatives of a Courtesy Staff Member shall be to:

- (a) depending upon the specific privileges granted to the Member and within the limitations provided in Section 4.4.1(c), admit patients. Members of the Active and Provisional Staffs shall have preference over Courtesy Staff Members in the admission of patients on an elective basis;

- (b) exercise such Clinical Privileges as are granted to him pursuant to Article 7; and
- (c) courtesy Staff Members may serve on Medical Staff committees, but they shall not be eligible to hold office in the Medical Staff or to vote at Medical Staff meetings.

4.5.3 Responsibilities. Each Member of the Courtesy Staff shall be required to:

- (a) discharge the general responsibilities specified in Section 3.3;
- (b) retain responsibility within his area of professional competence for the daily care and supervision of each patient in the Facility for whom he is providing services, or to arrange a suitable alternative for such care and supervision;
- (c) actively participate in the quality management program required of the Staff and discharge such other Staff functions as may from time to time be required;
- (d) satisfy the requirements set forth in Article 12 for attendance at meetings of the Staff committees of which he is a member; and
- (e) perform all on-call duties and assignments.

#### **4.6 HONORARY STAFF.**

4.5.1 Qualifications. The Honorary Staff shall consist of Members recognized for their outstanding reputations, their noteworthy contributions to the health and medical sciences, or their previous long-standing service to the Facility. Honorary Staff Members shall not be entitled to treat patients in the Facility, to hold office, vote or serve as a Member of the MEC.

#### **4.7 RESIDENTS AND INTERNS.**

Residents providing weekend, holiday and vacation coverage shall be Members of the Medical Staff and shall be granted Clinical Privileges as approved by the credentialing and Medical Executive Committee. They shall be entitled to any rights afforded to Practitioners, including the hearing and appeal rights under these bylaws. These Residents are not under training agreements through any curriculum.

Residents and Interns that are assigned for clinical rotations under a training agreement shall not be members of the Medical Staff and will not be granted Clinical Privileges. They will not be entitled to any rights afforded other Clinical Practitioners, including the hearing and appeal rights under these Bylaws.

All Residents and Interns shall comply with the Medical Staff Bylaws, Medical Staff rules and regulations, and applicable Hospital policies.

#### 4.7.1 Qualifications.

Residents providing coverage for Medical Staff are permitted to provide care specified in the credentialing process.

Residents and Interns enrolled in a residency or internship training program approved by the MEC and the Board may be permitted to provide patient care services within RPH. Such participation by Residents and Interns shall be governed exclusively by the terms and conditions of the written agreement and applicable RPH policies. Training rotations are assigned by the training program and credentials will be verified by the Training Program.

Residents and Interns may perform only those services set forth in the protocols developed by the applicable training program to the extent that such services do not exceed or conflict with the rules and regulations of the Medical Staff, or Hospital policies. Residents and Interns, or the institution which they are affiliated, must have a separate agreement with RPH.

Residents and Interns shall be responsible and accountable at all times to Members of the Medical Staff identified as supervisors under the agreement with the training program. All documentation by Residents and or Interns in the training programs and functioning under specified curriculum will be co-signed by the supervising physician.

#### 4.7.2 Prerogatives.

Residents and Interns may attend Medical Staff meetings if required and may be appointed to Medical Staff committees, but shall have no voting rights. Residents and Interns functioning under a training program agreement may not admit patients without the supervision of a Member of the Medical Staff.

The supervisory Medical Staff will report any issues or concerns related to the training program to the Medical Executive Committee immediately. In addition, the supervisory Medical Staff will provide quarterly reporting to the Medical Executive Committee.

Payment of Staff Dues is not required.

#### 4.7.3 Responsibilities.

- (a) Participation in a residency or internship training program shall be governed exclusively by the terms and conditions of the written agreement, the Bylaws, the Rules and Regulations, and Facility's Policies and Procedures.
- (b) Residents and Interns shall be responsible and accountable to an assigned Member of the Medical Staff at all times and shall be under the supervision and direction of the Medical Staff.
- (c) Satisfy the requirements set forth in Article 12 for attendance at Staff meetings that he is requested to attend and meetings of the Staff committees of which he is a member.
- (d) Residents and Interns shall comply with the Medical Staff Bylaws, Rules and Regulations, and applicable Facility policies.

## 4.8 ADVANCED NURSE PRACTITIONERS.

4.8.1 Qualifications. The Advanced Nurse Practitioner Staff shall consist of Members, each of whom:

- (a) meets the basic qualifications set forth in Sections 3.1 and 3.2;
- (b) resides and practices close enough to the Facility's program to provide continuous and timely care to and supervision of his patients or to arrange a suitable alternative for such care and supervision but in no event more than 30 minute drive time to Facility;
- (c) is regularly involved in the care of patients in the Facility's programs. "Regularly involved," as used in this Article, means co-attending a sufficient number of inpatients to enable the Medical Staff and the Facility to assess the quality of patient care provided by the Member and to assure that the Member is sufficiently involved in Facility and Medical Staff activities to hold office and vote on Medical Staff issues in an informed manner; and

4.8.2 Prerogatives.

- (a) Advanced Nurse Practitioners must apply for privileges if they provide patient care at the Hospital. The Advanced Nurse Practitioner must have a collaborative agreement with one or more physicians at the Hospital and must demonstrate such clinical capabilities as the MEC shall deem appropriate.
- (b) Applicants for appointments as an Advanced Nurse Practitioner must complete a written application and provide documentation of their education, training, experience, current clinical competence and licensure.
- (c) Applicants must also provide a written statement as to the duties and responsibilities for which they are applying.
- (d) Applicants for appointment and reappointment must provide a Certificate of Insurance evidencing current professional liability insurance coverage with an insurance company licensed to do business in West Virginia and domiciled in the United States, with an A.M. Best rating of no less than B+, in amounts satisfactory to the Hospital. There shall also be "tail coverage" in amounts satisfactory to the Hospital to assure coverage upon resignation or termination of privileges, or upon switching from one insurance carrier to another when "prior acts" coverage is not provided.
- (e) Applicants for appointment and reappointment must also demonstrate good reputation and character, show mental and emotional stability and have the ability to work harmoniously with others as necessary for good patient care and effective hospital operations and administration.
- (f) The Governing Board shall determine the level of privileges granted to an Advance Nurse Practitioner. An Advance Nurse Practitioner shall only be allowed to participate in direct patient care under the supervision of a Medical Staff Member (if supervision by a physician is required under licensure or other regulatory guidelines or standards), within the limitation of the Advance Nurse Practitioner's licensure or certification, within the demonstrated ability and competency of the Advance Nurse Practitioner and within a demonstrated service need of the Hospital for the community it serves.

#### 4.8.3 Responsibilities.

- (a) May perform only those services commensurate with advanced education, training and experience to the extent that such services do not exceed or conflict with the Bylaws, the Rules and Regulations, the Hospital Policies and Procedures, and West Virginia Standards for Professional Nursing Practice.
- (b) May admit patients only with the supervision and co-admission of a Member of the Medical Staff.
- (c) Are approved and permitted by the MEC and the Board to provide co-attending practitioner services in the Hospital, in conjunction with, and under the supervision of a co-attending physician.
- (d) Shall serve as members of the Medical Staff. They may serve on Staff committees, as assigned.
- (e) Participation as a co-attending practitioner shall be governed by the terms and conditions of the collaborative agreement, the Bylaws, the Rules and Regulations, and Hospital's Policies and Procedures.
- (f) Advanced Nurse Practitioners shall be responsible and accountable to an assigned Member of the Medical Staff at all times and shall be under the supervision and direction of the Medical Staff.
- (g) Satisfy the requirements set forth in Article 10, 2.1.7 for attendance at Staff meetings that he is requested to attend and meetings of the Staff committees of which he is a member.
- (h) Advanced Nurse Practitioners shall comply with the Medical Staff Bylaws, Rules and Regulations, and applicable Hospital policies.
- (i) Advanced Nurse Practitioners shall actively participate in quality assurance and improvement activities, clinical resource utilization review, management and clinical functions, and other Medical Staff activities as assigned.

#### **4.9 LIMITATION OF PREROGATIVES.**

The Prerogatives set forth under each Staff category are general in nature and may be subject to limitation by special conditions, by other sections of these Bylaws, the Rules and Regulations and the Facility's Policies and Procedures.

### **ARTICLE 5 ALLIED HEALTH PROFESSIONALS**

#### **5.1 QUALIFICATIONS.**

##### 5.1.1 General Qualifications.

To be eligible for Prerogatives, Allied Health Professionals must meet the following requirements:

- (a) hold a current, unrestricted license, certificate, or other appropriate legal credentials in a

category of Allied Health Professionals that the Board has identified as eligible for Prerogatives;

- (b) provide documentation of background; qualifications; relevant training; education; experience; current competence; judgment; character; physical, mental, and emotional capability as related to the performance of the Privileges requested; and ability to provide, with reasonable, necessary accommodation, safe and competent care. Documentation must be sufficiently adequate to demonstrate that patient care services will be provided by the Allied Health Professional at the professional level of quality and efficiency established by the Staff and the Facility;
- (c) are professionally qualified to provide services which need to be provided to patients as such need is determined to exist from time to time by the MEC and the Board;
- (d) provide services in one or more of the areas of patient care which the Facility offers to patients and is equipped, staffed, and licensed to offer to patients;
- (e) resides and practices his profession within the discretion of the Board, close enough to the Facility's program to provide continuous care to and supervision of his patients or to arrange a suitable alternative for such care and supervision;
- (f) provide documentation of strict adherence to the ethics of the Medical Staff and the Allied Health Professional's respective profession, his ability to work cooperatively with others in the Facility setting, and his willingness to commit to and regularly assist the Facility in fulfilling its obligations related to patient care, within the areas of the Allied Health Professional's competence and credentials;
- (g) maintain a professional liability insurance policy with a carrier approved by the Board with policy limits of \$1,000,000 per claim and \$3,000,000 aggregate per year, or such other amount as may be deemed appropriate by the Board, or participate in the applicable professional liability fund insurance plan of the state, and provide the Facility with a current certificate of insurance. The insurance must cover the types of procedures the applicant has Prerogatives to perform. The applicant also agrees to notify immediately the CEO of any insurance policy changes or cancellation and authorize his insurance carrier to provide immediate notice of any change to the Facility;
- (h) continuously meet and satisfy the qualifications, standards, responsibilities, and requirements of these Bylaws, the Rules and Regulations, and the Facility's Policies and Procedures;
- (i) comply with the provisions of these Bylaws, the Rules and Regulations, and the Facility's Policies and Procedures; and
- (j) fulfill such other criteria as may be established by the Board from time to time.

5.1.2 Particular Qualifications. The MEC, with approval of the Board, may establish particular qualifications required of members of a specific category of Allied Health Professionals.

## 5.2 PROCEDURE FOR GRANTING PREROGATIVES AND CLINICAL PRIVILEGES.

- 5.2.1 Applications. Applications for appointment, reappointment, and Privileges for Allied Health Professionals shall be submitted and processed in the same manner provided in Articles 6 and 7 for Medical Staff membership and Clinical Privileges. However, Allied Health Professionals shall not be entitled to pursue administrative remedies available under those or any other Articles of these Bylaws, and an Allied Health Professional's remedy for the denial, suspension, termination or any other action adversely affecting the Allied Health Professional's privileges, whether requested or existing, shall be limited to that set forth in Section 5.6 below. Allied Health Professionals shall only be granted Privileges appropriate to their background; qualifications; relevant training; education; experience; current competence; judgment; character; physical, mental, and emotional capability as related to the performance of the Privileges requested; and ability to provide, with reasonable, necessary accommodation, safe and competent care. Privileges shall be granted for a period not to exceed two (2) years.
- 5.2.2 Effect of Other Affiliations. No Allied Health Professional is automatically entitled to appointment, reappointment, or to Clinical Privileges merely because he is licensed to practice in this or in any other state, or because he is a member of any professional organization, or because he is certified by any agency, or because he had, or presently has, Prerogatives or privileges at this or any another health care organization or in another practice setting.
- 5.2.3 Non-discrimination. No aspect of the decision to grant, deny, or renew applications for appointment, reappointment, or for particular Clinical Privileges shall be based upon sex, race, creed, color, national origin, or any physical or mental impairment if, after reasonable accommodation, the Allied Health Professional is able to provide safe, effective, and competent care in compliance with these Bylaws, the Rules and Regulations, and the Facility's Policies and Procedures.

## 5.3 Prerogatives.

The Prerogatives of an Allied Health Professional shall be to:

- 5.3.1 exercise, under the supervision or direction of a Medical Staff Member, granted Privileges; within the scope of his license, certificate or other legal credentials; and in accordance with these Bylaws, the Rules and Regulations, and the Facility's Policies and Procedures;
- 5.3.2 write orders within scope of his license, certificate, or other legal credentials and in accordance with these Bylaws, the Rules and Regulations, and the Facility's Policies and Procedures;
- 5.3.3 serve on committees to the extent assigned thereto;
- 5.3.4 exercise such other Prerogatives as may be accorded to Allied Health Professionals as a group or to any particular category of Allied Health Professionals by resolution or written policy as adopted by the Staff or by the CEO and approved by the Board; and
- 5.3.5 only Licensed Psychologists, Licensed Masters Social Workers, Licensed Professional Counselors, Registered Nurses, Nurse Practitioners, Licensed Chemical Dependency Counselors, Licensed Marriage and Family Counselors, (collectively, "Qualified Mental Health Professionals") and Physician Assistants shall have the Prerogative to perform assessments as appropriate to their license and Privileges. All Qualified Mental Health Professionals and Physician Assistants may perform pre-admission assessments. Final determination of the need for services may be assessed by appropriately privileged Staff Members only.



#### 5.4 Responsibilities.

Each Allied Health Professional shall:

- 5.4.1 met the same general responsibilities as required by Section 3.3 for Medical Staff Members;
- 5.4.2 retain appropriate responsibility within his area of professional competence for the care and supervision of each patient for whom he is providing services, or arrange a suitable alternative for such care and supervision;
- 5.4.3 participate as appropriate in the quality management program required of the Staff, supervise Provisional appointees of his same profession, and discharge such other Staff functions as may from time to time be required; and
- 5.4.4 satisfy the requirements set forth in Article 12 for attendance at meetings which he is requested to attend of the Staff and committees of which he is a member.

#### **5.5 TERMINATION OF PREROGATIVES AND CLINICAL PRIVILEGES.**

An Allied Health Professional's appointment and/or Clinical Privileges shall be terminated, effective immediately, by the CEO upon the occurrence of the following:

- 5.5.1 termination of the Medical Staff membership or Clinical Privileges of any supervising Member;
- 5.5.2 termination of the relationship between the Allied Health Professional and the supervising Member;
- 5.5.3 suspension, revocation, expiration, voluntary or involuntary restriction, termination, or the imposition of terms of probation by the applicable licensing or certifying agency of the Allied Health Professional's license, certificate, or other legal credential which authorizes the Allied Health Professional to provide health care services;
- 5.5.4 failure of the Allied Health Professional to perform properly assigned duties;
- 5.5.5 conduct by the Allied Health Professional which interferes with or is detrimental to the provision of quality patient care or which may result in imminent danger to the health of any individual;
- 5.5.6 termination of the supervising Member's contract or other relationship with the Facility, for any reason;
- 5.5.7 failure to meet, satisfy, or comply with the qualifications, criteria, standards, responsibilities, and requirements of these Bylaws, the Rules and Regulations, and the Facility's Policies and Procedures; or
- 5.5.8 any other reasonable ground for supporting the belief that action is appropriate or necessary.

#### **5.6 GRIEVANCE PROCESS.**

Nothing contained in these Bylaws nor any permission to participate in the provision of patient care services shall be interpreted to entitle an Allied Health Professional to the administrative remedies available under these Bylaws. However, an Allied Health Professional may challenge any action by

filing a written grievance within fifteen (15) days of the action, with the CEO. Upon receipt of the grievance, the CEO shall initiate an investigation and afford the Allied Health Professional an opportunity for an interview with the MEC.<sup>1</sup> The CEO or his designee shall participate in any such interview. The interview shall not constitute a “hearing” as established in these Bylaws and shall not be conducted according to the procedural rules applicable to such hearings. Before the interview, the Allied Health Professional shall be informed of the general nature of the circumstances giving rise to the action. The Allied Health Professional may present relevant information and documents at the interview. The MEC shall submit a written decision and recommendation to the Board regarding the challenged action, and the Board shall take up the matter at its next regularly scheduled meeting and make a written decision which shall be final and communicated to the Allied Health Professional by the CEO.

## **5.7 CONFIDENTIALITY, IMMUNITY, AND RELEASES.**

Allied Health Professionals shall be subject to the provisions of Article 13.

## **5.8 TERMINATION OF FACILITY EMPLOYEES.**

Nothing in these Bylaws shall be construed in such a way as to interfere with the Facility’s right to terminate Facility employees, including Allied Health Professionals and Members, in accordance with the Facility Human Resources policies.

# **ARTICLE 6 PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT**

## **6.1 GENERAL PROCEDURE.**

The Medical Staff, through its committees and officers, shall investigate and consider each complete application for appointment or reappointment, and each request for modification of appointment, and shall adopt and transmit recommendations thereon to the Board. The Medical Staff shall also perform these same investigation, evaluation, and recommendation functions in connection with any applicant who is not eligible for Medical Staff Membership, but who seeks to exercise Prerogatives or Clinical Privileges. A separate record will be maintained for each individual who has or applies for Clinical Privileges.

## **6.2 APPLICATION FOR INITIAL APPOINTMENT.**

6.2.1 Application Form. Each application shall be submitted to the CEO on the prescribed form, and signed by the applicant. No application shall be deemed complete (and, therefore, ready for transmission to the Medical Staff for consideration) until all requisite information and materials are provided. When an applicant is provided an application, he shall be given a copy of these Bylaws, the Rules and Regulations and applicable policies.

6.2.2 Content.

The application form shall include but not be limited to:

- (a) detailed information concerning the applicant's qualifications, including information in satisfaction of the basic qualifications specified in Sections 3.1, 3.2, or 5.1, as is applicable, and of any additional qualifications specified in these Bylaws;

- (b) A valid picture ID issued by a state or federal agency (e.g., driver's license or passport); The picture ID will be used to verify the identity of the practitioner who is applying for privileges.
- (c) specific requests stating the appointment status and Clinical Privileges for which the applicant wishes to be considered;
- (d) the names of at least three (3) persons who have worked with the applicant and observed his professional performance in the recent past and who can provide reliable information based on significant personal experience as to the applicant's medical and clinical knowledge, technical and clinical skills, clinical judgment, interpersonal and communication skills, professionalism, and other qualifications for eligibility under these Bylaws. Two of the names provided shall, whenever possible, be that of a person with the same professional specialty as that of applicant;
- (e) information as to whether the following is being or has been investigated; suspended; limited; revoked; denied; placed on probation; resigned; reduced; sanctioned; excluded; relinquished; permitted to expire; or subjected to a review or a proceeding which, if adversely decided, could result in any of the foregoing; regardless of whether the action is voluntary or involuntary, together with all relevant details regarding the action: (1) staff membership, status, or clinical privileges at any other healthcare facility or institution; (2) membership or fellowship in a local, state, or national professional organization; (3) specialty board certification; (4) license, certification, or other legal credentials to practice any profession in any jurisdiction; (5) Drug Enforcement Agency (DEA) or state narcotics license; (6) provider participation status or eligibility in Medicare, Medicaid, TRICARE/CHAMPUS, managed care organization or network, or any other governmental or private reimbursement plan or provider network;
- (f) information regarding any charges, indictments, or convictions of misdemeanors (other than minor traffic violations) and felonies, and whether a related proceeding is pending;
- (g) a statement that the applicant carries at least \$1,000,000/\$3,000,000 of professional liability insurance coverage as required by these Bylaws and information on his malpractice claims history and experience, including a consent to the release of information by his present and any past malpractice insurance carriers and a waiver of any privilege relating thereto. If the application is for Staff status as an Allied Health Professional and the applicant is an employee of a Staff Member, the application shall include an indemnification of the Facility signed by such Staff member and indemnifying the Facility against all claims and losses arising out of the acts or omissions of the applicant;
- (h) statements notifying the applicant of the scope and extent of the authorization, confidentiality, immunity and release provisions of Section 6.3 and Article 13;
- (i) a statement that no health problems exist that could affect the applicant's ability to perform the privileges requested. In instances where there is doubt about an applicant's ability to perform the privileges requested, an evaluation by an external or internal source may be required by the MEC; and
- (j) a statement whereby the applicant agrees that, when an adverse ruling is made with respect to his Staff status and/or Clinical Privileges, he will exhaust the administrative remedies afforded by these Bylaws before resorting to legal action.

6.2.3 Refusal. The CEO may refuse to furnish an application form upon proper request only if one (1) or more of the following applies:

- (a) not licensed - the applicant is not licensed in this State to practice in a field of health care eligible for appointment to the Staff;
- (b) privileges denied or terminated - within two (2) years immediately preceding the request, the applicant has had an application for an appointment to the Staff denied, has resigned his or her Staff appointment at the Facility during the pendency of an active investigation which could have led to revocation of the appointment, or has had his or her appointment revoked or terminated at the Facility;
- (c) exclusive contract - the applicant practices a specialty which is the subject of a current written exclusive contract for coverage with the Facility;
- (d) inadequate insurance - the applicant does not have the liability insurance coverage required by these Bylaws; or
- (e) exclusion from Federal Health Program - the applicant has been excluded from any health care program funded in whole or in part by the federal or state government, including, without limitation, Medicare or Medicaid.

The CEO's refusal to provide an application form for any of the above reasons shall not entitle the applicant to any further procedural rights under the Bylaws.

6.2.4 Requests for Further Information. Any individual charged with the responsibility of reviewing an application for appointment, reappointment, or Clinical Privileges, may request further documentation or clarification from the applicant. The applicant has sixty (60) days from the date of service of the request to provide the requested information or documents. Failure to do so will result in the discontinuance of the processing of the application, and the applicant shall be so notified in writing. Any further application submitted by this applicant shall be processed as an initial application under these Bylaws. Notwithstanding any other provision of these Bylaws, the discontinuance of the processing of an application pursuant to this Section shall not constitute a summary professional review action, as discussed in Section 8.3.3, or an adverse action, as discussed in Section 9.2, and shall not entitle the applicant to pursue the administrative remedies available under these Bylaws.

### **6.3 EFFECT OF APPLICATION.**

By applying for appointment or reappointment to the Medical Staff, or Clinical Privileges, the applicant:

- 6.3.1 signifies his willingness to appear for interviews in regard to his application;
- 6.3.2 authorizes the Medical Staff and its committees, the Board, the Facility, and their agents and representatives to consult with others who may have information that may be relevant to credentialing, privileging, or peer review activities; performing functions under these Bylaws; achieving and maintaining quality patient care; reducing morbidity and mortality; reviewing or evaluating professional performance; or contributing to medical research; and authorizes persons to provide such information;
- 6.3.3 authorizes the disclosure and the inspection of all information, records, and documents that may be

relevant or material to credentialing, privileging, or peer review activities; performing functions under these Bylaws; achieving and maintaining quality patient care; reducing morbidity and mortality; reviewing or evaluating professional performance; or contributing to medical research. Such records may include information obtained from data banks maintained on a statewide or national basis;

- 6.3.4 releases from any liability to the fullest extent permitted by law, the Medical Staff and its committees, the Board, the Facility, and their agents and representatives, and third parties for their acts performed without malice in connection with credentialing, privileging, or peer review activities; performing functions under these Bylaws; achieving and maintaining quality patient care; reducing morbidity and mortality; reviewing or evaluating professional performance; or contributing to medical research;
- 6.3.5 agrees to be bound by the authorization, confidentiality, immunity, and release provisions of Article 13;
- 6.3.6 represents and warrants that all information provided by him is true, correct, and complete in all material respects and certifies that he will immediately report to the CEO any changes in the information provided;
- 6.3.7 agrees that, when an adverse ruling is made with respect to his Staff membership, status, and/or Privileges, he will exhaust the administrative remedies available under these Bylaws before resorting to legal action;
- 6.3.8 releases from any and all liability all individuals and organizations, to the fullest extent permitted by law, who provide information regarding the applicant including otherwise privileged or confidential information to Facility representatives;
- 6.3.9 agrees that the Facility and Medical Staff may share information with a representative or agent from another organization, including information obtained from other sources, and releases each person and entity who received the information and each person and entity who disclosed the information from any and all liability, including any claims of violations of any federal and state law including the laws forbidding restraint of trade, that might arise from the sharing of information, provided that such information was shared in good faith and without malice, and agrees that the Facility and any and all other organizations may act upon such information; and
- 6.3.10 consents to undergo and to release the results of a medical, psychiatric, or psychological examination by a practitioner acceptable to the MEC, at the applicant's expense, if deemed necessary by the MEC.

#### **6.4 PROCESSING THE APPLICATION.**

6.4.1 Applicant's Burden. The applicant shall have the burden of providing accurate, adequate, and complete information for a thorough evaluation of his qualifications; education; character; experience; background; relevant training; ability; utilization history; current licensure; current competence; professional ethics; physical, mental, and emotional capability as related to the performance of the Privileges requested; and to resolve any doubts about these or any of the other relevant qualifications. Failure to provide accurate, adequate, and complete information or to report immediately any change in the information may result in the application's being deemed incomplete, in the denial of membership, status, or Clinical Privileges, or in disciplinary action.

6.4.2 Review of the MEC. The MEC shall review and analyze all relevant information regarding the

requesting practitioner's current licensure status, training, experience, current competence, and ability to perform the requested privileges, and such other information available to it that may be relevant to the consideration of the applicant's qualifications for the status, membership, and/or Clinical Privileges requested

6.4.3 MEC Action. After the MEC has completed its review, the MEC shall then forward to the Board the application, related documentation, relevant information, and a written report and recommendation as to status, membership, Clinical Privileges, and any special conditions. The MEC may also defer action on the application for a period not to exceed thirty (30) days.

6.4.4 MEC Recommendations.

- (a) Favorable Recommendation: When the recommendation of the MEC is favorable to the applicant, the CEO shall promptly forward it, together with the application and all related documentation, to the Board.
- (b) Adverse Recommendation: When the recommendation (including those made after deferral) of the MEC is adverse, as that term is described in Section 9.2, to the applicant, the CEO shall serve upon the applicant notice pursuant to Section 9.2.3, and the applicant shall be entitled to the pursue the administrative remedies available under Article 9.

6.4.5 Board Action.

- (a) Favorable MEC Recommendation: Within 60 days of receipt of the MEC's recommendation, the Board shall adopt or reject a favorable recommendation of the MEC, or refer the recommendation back to the MEC for further consideration, stating the reasons for such referral back and setting a reasonable time limit within which a subsequent recommendation shall be made. The Board shall make specific findings as to the applicant's satisfaction of the requirements of experience, ability, and current competence as set forth in Section 6.4.2.<sup>2</sup>If the Board adopts the MEC's recommendation, it shall become the final action of the Facility. If the Board's action is adverse, as defined in Section 9.2, to the applicant, the CEO shall serve upon the applicant notice pursuant to Section 9.2.3, and the applicant shall be entitled to pursue the administrative remedies available under Article 9. If the Board refers the matter back to the MEC, the MEC shall, as appropriate, review the case and relevant documentation and shall promptly forward its subsequent recommendation to the Board.
- (b) Expedited Credentialing: To expedite appointment, reappointment, or renewal or modification of Clinical Privileges, the Board may delegate authority to render those decisions to a sub-committee consisting of at least two governing body members. Following a positive recommendation from the MEC on an application, the sub-committee of the Board reviews and evaluates the qualifications and competence of the practitioner applying for appointment, reappointment, or renewal of modification of clinical privileges and renders its decision. A positive decision by the sub-committee results in the status or privileges requested. The sub-committee shall meet as often as necessary as determined by its chairperson. The full Board considers and, if appropriate, ratifies all positive sub-committee decisions at its next regularly scheduled meeting. If the sub-committee's decision is adverse to an applicant, the matter is referred back to the MEC for further evaluation. An applicant is ineligible for the expedited process if at the time of appointment, or if since the time of reappointment, any of the following has occurred: (1) the applicant

submits an incomplete application; (2) the MEC makes a final recommendation that is adverse or with limitation; (3) there is a current challenge or a previously successful challenge to licensure or registration; (4) the applicant has received an involuntary termination of medical staff membership at another organization; (5) the applicant has received involuntary limitation, reduction, denial or loss of clinical privileges; or (6) there has been a final judgment adverse to the applicant in a professional liability action.

- (c) Adverse MEC Recommendation: In the case of a recommendation for adverse action, as defined in Section 9.2, the Board shall take action in accordance with the provisions of Article 9.

6.4.7 Reapplication after Adverse Appointment Decision. An applicant who has received a final adverse decision regarding appointment or Clinical Privileges shall not be eligible to reapply for a period of two (2) years. Any such reapplication shall be processed as an initial application.

## **6.5 DENIAL FOR ACCOMMODATION REASONS.**

A recommendation by the MEC or a decision by the Board shall not constitute a professional summary review, as defined in Section 8.3.3 or an adverse action, as defined in Section 9.2, and shall not entitle the applicant to pursue the administrative remedies available under these Bylaws if it is based on any of the following reasons:

- 6.5.1 the Facility does not then provide adequate resources for the applicant and his patients for any reason including but not limited to utilization levels then existing or services not then offered;
- 6.5.2 the inconsistency with the Facility's plans with respect to its development, including but not limited to the mix of patient care services currently or to be provided in the future; or
- 6.5.3 the Facility has an exclusivity policy as described in Section 6.9.

## **6.6 PROVISIONAL STATUS.**

6.6.1 Time Limitations. Except as otherwise determined by the Board, all initial appointments to the Medical Staff shall be Provisional for six (6) months and may be renewed for two (2) additional six (6) month periods at the discretion of the MEC. If the Provisional appointee fails within that period to furnish the certifications required, his Staff membership, status, or particular Clinical Privileges, as applicable, shall automatically terminate. Unless otherwise specified in these Bylaws, the appointee so affected shall be entitled to pursue the administrative remedies available under Article 9. Provisional status may not continue for a total period longer than eighteen (18) months.

- 6.6.2 Proctoring. Each Provisional appointee shall be proctored by one or more appropriate Members as determined by the Medical Staff President for the number of cases or procedures specified by the Medical Staff President. The care observed shall be relevant to the Clinical Privileges granted. The purpose of observation is to determine the individual's eligibility for non-Provisional status in the Staff category to which he was appointed and for exercising the Clinical Privileges provisionally granted. The proctor shall complete a proctoring report with his comments on the appointee's performance. At the end of the initial Provisional period, the appointee must qualify for and be advanced to non-Provisional status or be extended on Provisional status for an additional period not to exceed twelve (12) months, at the end of which time he shall be reevaluated for advancement.
- 6.6.3 Initial Appointment Monitoring by Medical Director. Each Provisional appointee shall be observed by the Medical Director of the Facility to determine his eligibility for regular Staff membership in the Staff category to which he was provisionally appointed and for exercising the Clinical Privileges provisionally granted. An initial appointment and renewals thereof shall remain Provisional until the appointee has furnished to the CEO:
- (a) a statement signed by the Medical Director of the Facility that the appointee meets all of the qualifications, has discharged all of the responsibilities, and has not exceeded or abused the Prerogatives of the Staff category to which he was provisionally appointed; and
  - (b) a statement signed by the Medical Director of the Facility that the appointee has demonstrated the ability to exercise the Clinical Privileges provisionally granted to him.
- 6.6.4 Failure to Complete Required Number of Cases. Unless excused by the MEC and the Board for good cause, a Provisional appointee's failure to complete the required number of proctored cases shall be deemed a voluntary resignation of membership and voluntary relinquishment of Clinical Privileges, effective immediately upon determination of non-compliance. Such voluntary resignation and relinquishment shall not constitute an adverse action, as defined in Section 9.2, or a summary professional review action, as defined in Section 8.3.3, and shall not entitle the Provisional appointee to pursue the administrative remedies available under these Bylaws.
- 6.6.5 Failure to Receive a Favorable Recommendation. Unless the Provisional status is extended, failure of a Provisional appointee to receive a favorable recommendation for advancement to non-provisional status shall result in automatic termination of membership and Clinical Privileges. Unless otherwise expressly provided in these Bylaws, the Provisional appointee shall be entitled to the pursue the administrative remedies available under these Bylaws.
- 6.6.5 Modification in Staff Category and Clinical Privileges. The MEC may recommend to the Board that a change in Staff category of a current Staff Member or the granting of additional Clinical Privileges to a current Staff Member be made Provisional in accordance with the procedures in Article 6 for initial appointments.
- 6.6.7 No Additional Credentialing. If the Provisional appointee satisfies all conditions set forth herein, he shall be re-categorized in the appropriate category of the Medical Staff without further credentialing.

## **6.7 REAPPOINTMENT PROCESS.**

- 6.7.1 Reappointment Form. At least ninety (90) days prior to the expiration date of the present appointment of each person holding same, the CEO shall provide such person with a



Reappointment/Recredentialing application form for use in considering reappointment. Within thirty (30) days after service of the application, each such person who desires reappointment shall send the completed Reappointment/Recredentialing application form to the CEO. Failure to return timely the form shall be deemed a voluntary resignation from appointment status and voluntary relinquishment of Clinical Privileges, effective at the expiration of such person's current term. Such voluntary resignation and relinquishment shall not constitute an adverse action, as defined in Section 9.2, or a summary professional review action, as defined in Section 8.3.3, and shall not entitle the applicant to pursue the administrative remedies available under these Bylaws.

6.7.2 Requests for Further Information. Any individual charged with the responsibility of reviewing an application for reappointment or Clinical Privileges, may request further documentation or clarification from the applicant. The applicant has fifteen (15) days from the date of service of the request to provide the requested information or documents. Failure to do so will result in the discontinuance of the processing of the application, and the applicant shall be so notified in writing. Any further application submitted by this Member or Allied Health Professional shall be processed as an initial application under these Bylaws. Notwithstanding any other provision of these Bylaws, the discontinuance of the processing of an application pursuant to this Section shall not constitute a summary professional review action, as defined in Section 8.3.3, or an adverse action, as defined in Section 9.2, and shall not entitle the applicant to pursue the administrative remedies available under these Bylaws.

6.7.3 Content of the Reappointment/Recredentialing Application Form. The Reappointment/Recredentialing Application Form shall be a prescribed form and, when completed, shall contain information necessary to maintain, as current, the Medical Staff's file including, without limitation, the following information about:

- (a) objective evidence of the individual's clinical competence based on peer review, quality improvement, physician profile data activities, and other activities designed to monitor the efficient and effective delivery of patient care.
- (b) evidence of the individual's support of the Medical Staff and Facility through, for example, medical record delinquency status, meeting attendance, committee service, satisfaction of minimum patient care requirements to maintain Staff category, and compliance with the Bylaws, Rules and Regulations, and the Facility's Policies and Procedures;
- (c) continuing training, education, and experience that qualifies the reappointment applicant for the status and/or Privileges sought on reappointment;
- (d) current physical and mental health status only to the extent necessary to determine the practitioner's ability to perform the functions of staff membership or to exercise the privileges requested;
- (e) whether any of the following is being or has been investigated; suspended; limited; revoked; denied; placed on probation; resigned; reduced; sanctioned; excluded; relinquished; permitted to expire; or subjected to a review or a proceeding which, if adversely decided, could result in any of the foregoing; regardless of whether the action is voluntary or involuntary, together with all relevant details regarding the action: (1) staff membership, status, or clinical privileges at any other healthcare facility or institution; (2) membership or fellowship in a local, state, or national professional organization; (3) specialty board certification; (4) license, certification, or other legal credentials to practice any profession in any jurisdiction; (5) Drug Enforcement Agency

(DEA) or state narcotics license; (6) provider participation status or eligibility in Medicare, Medicaid, TRICARE/ CHAMPUS, managed care organization or network, or any other governmental or private reimbursement plan or provider network. In addition, the Member shall immediately notify the Facility if he ceases to meet any other standards of the Facility, as set forth in these Bylaws, the Rules and Regulations, and the Facility's Policies and Procedures, for continued Medical Staff membership and/or Clinical Privileges;

- (f) membership, awards or other recognitions conferred, granted, limited, suspended, reduced, placed on probation, or revoked by any professional health care societies, institutions, or organizations or voluntarily or involuntarily relinquished by the reappointment applicant;
- (g) sanctions of any kind imposed or proposed to be imposed by any other health care organization, professional health care organization, utilization review, third party payor, or licensing or drug control authority, or the voluntary or involuntary relinquishment of any registration or licensure to a licensing or drug control authority;
- (h) complete details about malpractice claims experience, and information related to the reappointment applicant's professional liability insurance coverage;
- (i) the reappointment applicant's current home and office addresses and telephone numbers;
- (j) any request for modification of Staff status or Privileges, which the reappointment applicant may desire to make;
- (k) proof of current licensure, certification, or other legal credentials, and, if applicable, DEA registration and certification;
- (l) information regarding the applicant's clinical practice during the previous appointment;
- (m) evidence of a query sent to the National Practitioner Data Bank;
- (n) information regarding any charges, indictments, or convictions involving misdemeanors (other than minor traffic violations) and felonies; and
- (o) a valid Hospital picture ID card, or a valid picture ID issued by a state or federal agency (e.g., driver's license or passport); and
- (p) such other specific information about the reappointment applicant's professional ethics, qualifications, and ability as the Board or the MEC may require.

6.7.4 Verification of Information. The CEO shall, in timely fashion, seek to collect or verify the information made available on each Reappointment/Recredentialing application form and to collect any other materials or information deemed pertinent. When collection and verification is accomplished, the application for reappointment shall be considered complete, and the CEO shall transmit the Reappointment/Recredentialing application form and related materials to the MEC.

6.7.5 Reappointment Applicant's Burden. The applicant shall have the burden of providing accurate, adequate, and complete information for a thorough evaluation of his qualifications; education; character; experience; background; relevant training; ability; utilization history; current licensure; current competence; professional ethics; physical, mental, and emotional capability as related to the performance of the Privileges requested; and to resolve any doubts about these or any of the other relevant qualifications. Failure to provide accurate, adequate, and complete information or to

report immediately any change in the information may result in the application's being deemed incomplete, in the denial of membership, status, or Clinical Privileges, or in disciplinary action.

- 6.7.6 MEC Review. The MEC shall review and analyze all relevant information regarding the requesting practitioner's current licensure status, training, experience, current competence, and ability to perform the requested privileges, and such other information available to it that may be relevant to the consideration of the applicant's qualifications for the Staff membership, status, and/or Clinical Privileges requested.<sup>3</sup>
- 6.7.7 MEC Action. After the MEC has completed its review, it shall forward to the Board the application, related documentation, relevant information, and a report and recommendation that appointment be either renewed, renewed with modified Staff status and/or Clinical Privileges, renewed with special conditions, or terminated. The MEC may also defer action for a period not to exceed thirty (30) days.
- 6.7.8 Final Processing and Board Action. Thereafter, the procedures provided in Sections 6.4.4 through 6.4.6 shall be followed. For purposes of reappointment, the terms "applicant" and "appointment" as used in those sections shall be read, respectively, as "reappointment applicant" and "reappointment." However, Allied Health Professionals shall not be entitled to pursue the administrative remedies available under these Bylaw, but they may pursue the grievance process set forth in Section 5.6.
- 6.7.9 Basis for Recommendations and Determinations. Each recommendation concerning the reappointment and Clinical Privileges to be granted upon reappointment, and the determinations made with respect thereto, shall be based upon an evaluation of the considerations described in Section 6.3(o) as they impact upon determinations regarding the<sup>4</sup> the applicant's professional ability; demonstrated current competence; and clinical judgment in the treatment of patients; character; professional ethics; meeting and fulfilling of the qualifications and responsibilities for Staff status; information contained in practitioner specific performance profiles, developed and approved by the medical staff, in the areas of medical assessment and treatment of patients, use of medications, procedures, appropriateness of clinical practice patterns, significant departures from established patterns of clinical practice, sentinel events, and patient safety as compared to aggregate information; discharge of obligations hereunder; compliance with the Medical Staff Bylaws, Rules, and Regulations, and Facility and Board Policies, including utilization policies; cooperation with other healthcare providers and with patients; disruption, if any, of Facility operations; physical, mental and emotional capability as related to the Privileges requested; ability to provide, with reasonable, necessary accommodation, safe and competent care; ability and willingness to contribute to good patient care practices, including ability and willingness to cooperate and work in harmony with the Facility's employees; and other relevant matters.
- (a) When insufficient practitioner specific information is available, peer recommendations are used to recommend individuals for reappointment to, or termination from, the medical staff and for the renewal, revision, or revocation of clinical privileges
- 6.7.10 Time Periods for Processing. Transmittal of the Reappointment/Recredentialing application form to a reappointment applicant and his return of it shall be carried out in accordance with Section 6.7.1. Thereafter and, except for good cause, each person, and committee required by these Bylaws to act thereon shall complete such action in timely fashion such that all reports and recommendations concerning reappointment for its consideration and action and to the Board for its consideration and action, are prior to the expiration date of the appointment of the reappointment applicant.

## **6.8 REQUESTS FOR MODIFICATION OF APPOINTMENT.**

A Member or Allied Health Professional may, either in connection with reappointment or at any other time, request modification of his membership, status, or Privileges by submitting a written application to the CEO on the prescribed form. Such application shall be processed in the same manner as provided in Section 6.7 for reappointment.

## **6.9 CLOSED STAFF OR EXCLUSIVE CONTRACTS.**

6.9.1 Policy. The Board may determine, as a matter of policy from time to time, that certain services and programs may be used only on an exclusive basis in accordance with written contracts between the Facility and qualified professionals selected by the Board. Such a policy may be based on the Facility's need to meet certain objectives, including but not limited to the provision of 24-hour coverage, coordination of schedules and assignments, administrative ease and efficiency, coordinated supervision of non-physician personnel, and quality patient care. Applications for initial appointment, reappointment, or for Clinical Privileges related to those Facilities and services specified in such contracts shall not be accepted for processing unless submitted with confirmation from the CEO that they are from applicants that have an existing or proposed contract with the Facility.

6.9.2 Qualifications. Those providing contract services pursuant to this Section must meet the same qualifications, must be processed for appointment, reappointment, and Clinical Privilege delineation in the same manner and must fulfill all of the obligations for his Staff membership, status, and Clinical Privileges. The right to provide services and programs on an exclusive basis is automatically terminated when Staff membership expires or is terminated, or if he leaves the physician group that holds the exclusive contract. Similarly, the right to render services under the contract is automatically terminated to the extent that the relevant Clinical Privileges are reduced, restricted, or terminated.

6.9.3 Effect of Termination. The effect upon a Staff membership, status, and Clinical Privileges of the expiration or other termination of a contract shall be governed solely by the terms of the contract. If the contract is silent on the matter, then contract expiration or termination shall not affect Staff membership, status, or Clinical Privileges, except that Clinical Privileges for which the Facility has made exclusive contractual arrangements with another may not thereafter be exercised.

6.9.4 Conversion to Exclusive Service. From time to time, the Board may determine that a service or program not previously offered on an exclusive basis shall, in the future, be offered on an exclusive basis. When the Board makes such a determination, it shall:

- (a) document the reasons for the conversion;
- (b) adopt an appropriate resolution stating that the service shall be offered only on an exclusive basis;
- (c) enter into an exclusive contract with a qualified professional or group of professionals; and
- (d) notify any person offering such services prior to the effective date of such exclusive contract that their Clinical Privileges to offer such services shall be terminated on the effective date of such exclusive contract.

6.9.5 Termination or Reduction in Privileges. The denial, termination, or reduction of Clinical Privileges as the result of the Board's action authorized hereunder shall not constitute a summary professional review action, as defined in Section 8.3.3, or an adverse action, as defined in Section 9.2, and shall not entitle the Member, or Allied Health Professional to pursue any administrative remedies available under these Bylaws. A Member or Allied Health Professional shall be entitled to thirty (30) days written notice prior to the termination or reduction of Clinical Privileges pursuant to this Section.

## **6.10 TELEMEDICINE.**

Practitioners who provide health care services by means of electronic technology to Facility's patients shall not provide such services without first being granted Clinical Privileges. Application for such Clinical Privileges shall be made as provided in these Bylaws, except that such privileges may be granted based on credible documented evidence that the Member enjoys the same or similar privileges at a hospital that is accredited by the Joint Commission. This Section 6.10 shall not be construed as requiring the Staff and Board of Directors to appoint or grant privileges to any practitioner of telemedicine.

## **ARTICLE 7 DETERMINATION OF CLINICAL PRIVILEGES**

### **7.1 EXERCISE OF PRIVILEGES.**

Every Member, and Allied Health Professional providing direct patient services by virtue of his Staff status shall, except as provided in Sections 7.4, be entitled to exercise only those Clinical Privileges specifically granted to him by the Board. Regardless of the Clinical Privileges granted, each Member, or Allied Health Professional shall obtain consultation when necessary for proper patient care or when required by these Bylaws, the Rules or Regulations, and the Facility Policies and Procedures.

### **7.2 DELINEATION OF PRIVILEGES IN GENERAL.**

7.2.1 Requests. Each application for appointment and reappointment must contain a request for the specific Clinical Privileges desired by the applicant. A request pursuant to Section 6.8 for a modification of privileges must be supported by documentation of training and education and/or experience supportive of the request.

7.2.2 Basis for Privileges Determinations. Requests for Clinical Privileges shall be evaluated on the basis of the Member's, or Allied Health Professional's education; course work; training; treatment results; experience; character; peer recommendations; and demonstrated judgment and ability to provide, with reasonable accommodation, safe and competent care; and physical, mental, and emotional capability, as related to the performance of the Privileges requested. In addition, those practitioners seeking new, additional or renewed<sup>5</sup> clinical privileges (except those seeking emergency privileges) must meet all criteria for Medical Staff membership as described in these Bylaws, including a query of the National Practitioner Data Bank.<sup>6</sup> Consideration must be given to observed clinical performance and the documented results of quality management activities conducted at the Facility, as well as pertinent information concerning clinical performance obtained from other sources, especially other organizations and health care settings where a professional exercises or has exercised Clinical Privileges. Information regarding (a) previously successful or currently pending challenges to any licensure or registration (state, district, or Drug Enforcement

Administration) or the voluntary relinquishment of such licensure or registration; and (b) voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary limitation, reduction, or loss of Clinical Privileges at another organization shall also be used to evaluate requests for Clinical Privileges, and any other relevant matters. This information shall be added to, and maintained in, the file established for a Staff Member or Allied Health Professional.

7.2.3 Appointment Considerations. Each recommendation concerning the appointment of a staff member and/or for clinical privileges to be granted shall be based upon an evidence-based assessment of the applicant's experience, ability, and current competence by the Credentials Committee, MEC and Board, including assessment of the applicant's proficiency in the following areas:

(a) Patient Care with the expectation that practitioners provide patient care that is compassionate, appropriate and effective;

(b) Medical/Clinical Knowledge of established and evolving biomedical clinical and social sciences, and the application of the same to patient care and educating others;

(c) Practice-Based Learning and Improvement through demonstrated use and reliance on scientific evidence, adherence to practice guidelines, and evolving use of science, evidence and experience to improve patient care practices;

(d) Interpersonal and Communication Skills that enable establishment and maintenance of professional working relationships with patients, patient's families, members of the Medical Staff, Hospital Administration and employees, and others;

(e) Professional behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude to patients, the medical profession and society; and

(f) Systems-Based Practice reflecting an understanding of the context and systems in which health care is provided

7.2.4 Procedure. All requests for Clinical Privileges shall be evaluated and granted, modified, or denied pursuant to, and as part of, the procedures outlined in Article 6.

7.2.5 Term of Privileges. Clinical Privileges shall be granted for a term of not more than two (2) years.

7.2.6 Limitations on Privileges. All Clinical Privileges granted shall specify the limitations, if any, on a Member's or Allied Health Professional's privileges to admit and treat patients or to direct the course of treatment for the conditions upon which admission of the patient was based.

### **7.3 SPECIAL CONDITIONS FOR ALLIED HEALTH PROFESSIONAL SERVICES.**

A Member shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during treatment and shall determine the risk and effect of any proposed procedure on the total health status of the patient.

## 7.4 TEMPORARY PRIVILEGES.

### 7.4.1 Qualifications for Temporary Privileges.

Temporary privileges may be granted under the following conditions:

To meet an important patient care need. When temporary privileges are granted to meet an important care need, the organized medical staff verifies current licensure and current competence.

If the file is complete and contains at least 1) appropriate qualifications, relevant training or experience, 2) current competence, 3) ability to perform the privileges requested, 4) complete application, 5) no current or previously successful challenge to licensure or registration, 6) not subject to involuntary termination of medical staff membership of another organization, 7) not subject to involuntary limitation, reduction, or denial or loss of clinical privileges, 8) a valid and current State license, 9) a current DEA registration, and 10) professional liability insurance coverage, and 11) a query must be submitted as required by federal law to the National Practitioner Data Bank.

By applying for Temporary Privileges, all applicants agree to be bound by the Medical Staff Bylaws, Rules and Regulations, and the Facility's Policies and Procedures. Allied Health Professionals are not eligible for Temporary Privileges.

7.4.2 Authority to Grant Temporary Privileges. The CEO, with the written concurrence of the Medical Director and President of the Medical Staff, may grant Temporary Privileges under the circumstances noted below. In all cases, Temporary Privileges shall be granted for a specific period of time, not to exceed one hundred twenty (120) days. Temporary Privileges shall terminate automatically at the end of the specific period without the hearing and appeal rights set forth in these Bylaws. Special requirements of supervision and consultation may be imposed upon the granting of Temporary Privileges.

- (a) Care of a Specific Patient. Notwithstanding the items in Section 7.4.1 that must be verified before the granting of Temporary Privileges, such Temporary Privileges may be granted to an appropriate licensed applicant who is not applying for Staff membership but whose services are required for the care of a specific patient, upon the verification of the applicant's licensure status and current competence. Such Temporary Privileges are restricted to the treatment of no more than one (1) patient per calendar year, after which Staff membership must be properly obtained before being permitted to attend additional patients during the same calendar year.
- (b) Locum Tenens. Temporary Privileges may be granted to an appropriately qualified applicant serving as locum tenens for a Member of the Medical Staff. Such Clinical Privileges shall be limited based on the locum tenens Member's individual training, experience and qualifications, and may be renewed for no more than two (2) additional periods of fifteen (15) days each.
- (c) Pendency of Appointment to the Medical Staff. After service of an application for Staff appointment and in accordance with the conditions specified in Section 7.4, an appropriately licensed applicant may be granted Temporary Privileges for a period not more than one hundred twenty (120) days. In exercising such Clinical Privileges, the applicant shall act under the supervision of the Medical Director.

7.4.3 Conditions. Temporary Privileges shall be granted only when the information available reasonably supports a favorable determination regarding the applicant's qualifications, ability, and judgment to exercise the Clinical Privileges granted. During the period of Temporary

Privileges granted for the pendency of the application, such applicant shall be subject to proctoring and supervision by a Member of the Active Medical Staff to be designated by the Medical Director and CEO. Special requirements of consultation and reporting may be imposed by and in the discretion of the Medical Director or President of the Medical Staff. The monitoring and proctoring activities contemplated herein are not to be viewed as disciplinary measures, but rather as information gathering measures. Monitoring and proctoring of the exercise of Temporary Privileges do not give rise to the administrative remedies available under these Bylaws. Before Temporary Privileges are granted, the applicant must acknowledge in writing that he has read and received the Medical Staff Bylaws, the Rules and Regulations, and the Facility's Policies and Procedures, and that he agrees to be bound by the terms thereof.

- 7.4.4 Termination. The CEO may at any time upon reasonable notice under the circumstances and for any reason, after consultation with the Medical Director or director responsible for supervision, terminate any or all Temporary Privileges granted. In the event of any such termination, the Medical Director shall assign the Member's patients then in the Facility to an appropriately privileged Medical Staff Member. The desires of the patient shall be considered, where feasible, when choosing a substitute.
- 7.4.5 Rights. Denial or termination of Temporary Privileges, or consultation, reporting, monitoring, or proctoring activities shall not constitute a summary professional review action, as defined in Section 8.3.3, or an adverse action, as defined in Section 9.2 and shall not entitle the Member to pursue the administrative remedies available under these Bylaws.

## **7.5 EMERGENCY PRIVILEGES.**

- 7.5.1 Definitions. For the purposes of this section, an "emergency" is defined as a condition in which serious or permanent harm could result to an individual or in which the life of an individual is in imminent danger, or when the Facility's emergency management plan has been activated and the Facility is unable to handle immediate patient needs.
- 7.5.2 Emergency Clinical Privileges. In the case of an emergency, any professional, to the degree permitted by his license and, regardless of Staff status or Clinical Privileges, shall be permitted to do and be assisted by Facility personnel in doing, everything possible to save the life of an individual or to save the individual from serious harm.
- 7.5.3 Emergency Privileges During Activation of the Emergency Disaster Plan. When the Facility's emergency management plan is activated, and the immediate needs of patients cannot be met, the CEO, or Medical Director, or their designees may implement a modified credentialing and privileging process for eligible volunteer practitioners and grant Temporary Privileges, provided that the volunteer practitioner presents a valid government issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and, at least one of the following:
- (a) a current Facility ID with picture that clearly identifies professional designation;
  - (b) a current license, certification, or registration;
  - (c) a current Member of the Medical Staff vouches for the professional's identity and credentials;
  - (d) the professional has validated authority to treat patients in disaster circumstances by the federal, state, or local government; or



- (e) the professional is a validated member of the Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), or the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP).

The verification process for the professional granted Emergency Privileges must begin as soon as the immediate situation is under control, usually within 72 hours, unless there is a documented lack of resources or means of communication to do so. This option to grant disaster privileges to volunteer practitioners is made on a case by case basis in accordance with the needs of the organization and its patients and on the qualifications of its volunteer practitioners.

7.5.4 The Medical Director, or his designee, shall have responsibility for oversight of the care provided by the professional, and for the assignment and management of duties. Oversight of care may involve direct observation, mentoring, and/or clinical record review.

7.5.5 Once the emergency situation no longer exists, the Emergency Privileges shall terminate, and care shall be transferred to a Member or Allied Health Professional with appropriate, current Clinical Privileges. Termination of Emergency Privileges does not constitute a summary professional review action, as defined in Section 8.3.3, or an adverse action, as defined in Section 9.2, and shall not entitle the professional to pursue administrative remedies available under these Bylaws.

## **7.6 UNAVAILABLE CLINICAL PRIVILEGES.**

Notwithstanding any other provisions of these Bylaws, to the extent that any requested Clinical Privileges are not available within the Facility (whether because of exclusive contract, lack of space, equipment, staffing, or financial resources, policy decision of the Board, or otherwise), the request shall be rejected. Rejection of a request under such circumstances shall not constitute a summary professional review action, as defined in Section 8.3.3, or an adverse action, as defined in Section 9.2, and shall not entitle the applicant to pursue the administrative remedies available under these Bylaws.

## **ARTICLE 8 PROFESSIONAL PERFORMANCE IMPROVEMENT & CORRECTIVE ACTION**

### **8.1 PROFESSIONAL PERFORMANCE IMPROVEMENT.**

8.1.1 Responsibility for Routine Monitoring and Education. Under certain circumstances, routine monitoring and education of Members may be an appropriate alternative to corrective action. It shall be the responsibility of the Medical Director to design and implement effective programs to monitor and assess the quality of professional practice and to promote the quality of practice by:

- (a) providing education and counseling;
- (b) issuing letters of instruction, admonition, warning, or censure, as necessary; and
- (c) requiring routine monitoring when deemed appropriate.

### 8.1.2 Procedure.

- (a) The Medical Staff shall conduct regular patient care reviews and studies of practice and patient care outcomes within the Facility in conformity with a written Performance Improvement Plan approved by the MEC and Board. In order to assist Members to conform their conduct or professional practice to the standards of the Medical Staff and Facility, the Medical Director may make informal comments or suggestions, either orally or in writing, which shall be discussed with the Member. A summary of such statements shall be kept in the Member's credentials file. Such comments or suggestions shall be subject to the confidentiality and privilege requirements of all Medical Staff peer review information and may be issued with or without prior consultation with the Member. Such comments or suggestions shall not constitute a summary professional review action, as defined in Section 8.3.3, or an adverse action, as defined in Section 9.2, and shall not entitle the Member to pursue the administrative remedies available under these Bylaws.
- (b) Following discussions of identified concerns with a Member, the Medical Director may issue a letter of instruction, admonition, or warning to the Member or to require the Member to be subject to performance monitoring for such time as shall appear reasonable. The term "performance monitoring" as used in this Section shall mean review of a Member's practice for which the Member's only obligation is to provide reasonable notice of patient admissions, procedures, or other patient care activity. The discussions of such actions with individual Member shall be informal, but shall be treated as confidential matters pursuant to the confidentiality standards set forth herein. The above-described letters, performance monitoring, and discussions of same shall not constitute a summary professional review action, as defined in Section 8.3.3, or an adverse action, as defined in Section 9.2, and shall not entitle the Member to pursue the administrative remedies available under these Bylaws. Written letters of instruction, admonition, or warning or performance monitoring required pursuant to this Section shall be reported to the MEC promptly after such actions are taken.

8.1.3 Focused Review of Member's Performance. When a Member's performance is questioned, the MEC may initiate a focused review (Focused Professional Practice Evaluation, or FPPE) in order to attempt to resolve the matter in a professional, helpful and non-adversarial manner. Focused review is conducted with a positive "performance improvement" philosophy, and efforts will be made to motivate, educate and help a Member whose performance requires improvement. Because the purpose of a focused review is the review of professional practices in the Facility so as to reduce morbidity and mortality and improve the quality of health care, focused reviews are confidential under State law. The circumstances that may trigger focused review include: (i) Patient death; (ii) "Sentinel Events" as defined by the Joint Commission; (iii) A pattern or trend is found regarding significant deviations from the standards of practice; (iv) A pattern or trend in issues regarding patient safety and/or negative patient outcomes; (v) the practitioner is cited for quality issues from an outside peer review or quality improvement organization requiring a plan for improvement; or (vi) All level III and IV incidents as defined by Risk Management Severity Index.

- (a) Focused review will be used in circumstances where questions have been raised about a Member's performance, in the judgment of the MEC, a less formal focused review may be productive.
- (b) Once it decides to implement a focused review, the MEC shall appoint an ad hoc committee of one or more persons to conduct the focused review, or may delegate the appointment to the Medical Director.

- (c) The MEC may direct that the focused review be conducted, in whole or in part, by an external reviewer in circumstances where there are few specialists on staff with sufficient knowledge of the area being reviewed or other circumstances dictate, in the judgment of the MEC, that the assistance of an external reviewer would be advantageous to the focused review process.
- (d) The chief of staff shall notify the Member that a focused review will be conducted of his or her performance. The Member shall have the right to participate in the review process. The ad hoc committee shall determine whether that participation will be written, through personal meetings, or any other form appropriate to the circumstance.
- (e) The focused review shall be completed within 45 days of the appointment of the ad hoc committee. That time may be extended for good cause by the chief of staff upon the request of the committee.
- (f) Focused review necessarily requires the cooperation of the Member. Whenever the ad hoc committee finds the Member uncooperative, the ad hoc committee may report back to the MEC and request termination of the focused review. In such an instance, the MEC will determine whether to initiate an investigation, which may lead to corrective action.
- (g) Upon concluding its focused review, the ad hoc committee shall make a written report to the MEC and the Member with recommendations which may include, but are not limited to, a recommendation for continued performance monitoring, periodic meetings with the Medical Director, or that the MEC proceed with a formal investigation and consider corrective action. The Member may, within 5 days of receiving a copy of the recommendations, provide his or her input to the MEC for its consideration.
- (h) The MEC shall consider the report of the ad hoc committee and any material submitted by the Member and shall make its determination based upon the facts found and in the furtherance of quality health care.

## **8.2 CORRECTIVE ACTION.**

### **8.2.1 Initiation of Investigation.**

An investigation shall be initiated against a Member whenever there is reason to believe the conduct of any Member:

- (a) fails to meet and satisfy the qualifications, criteria, and responsibilities for Staff status or, where applicable, membership;
- (b) is disruptive to the operations of the Facility;
- (c) constitutes fraud or abuse;
- (d) is detrimental to the delivery of quality of care in the Facility;
- (e) is detrimental to the Facility's licensure or accreditation;

- (f) is detrimental to the efforts to comply with any professional review organization, third party payer whether private or governmental, or utilization review requirements;
- (g) is in violation of the Medical Staff Bylaws, Rules and Regulations, or Facility Policies or Procedures;
- (h) is in violation of the ethics of his profession;
- (i) is believed to have engaged in criminal conduct; or
- (j) constitutes a danger to patients or others in the Facility. If the danger poses an imminent threat to the life or health of any person, the procedures for Summary Suspension should be followed in accordance with Section 8.3.

8.2.2 Request for Investigation. A request for investigation may be made by any Member, by any committee of the Medical Staff, by any Board member, or by the CEO. The request must be in writing and must describe with specificity the alleged conduct or activities which constitute the grounds for the request. Unless otherwise provided by law, the identity of the requesting individual shall be kept confidential if he so wishes. The request must be submitted to the MEC, which shall promptly determine whether, assuming the allegations to be true, the request states a sufficient criterion for investigation as set forth above. All requests found not to state an adequate basis shall be reviewed by the Board, which may overrule the MEC's determination and direct that the matter be investigated.

8.2.3 Investigation. The MEC shall promptly investigate the matter or appoint an ad hoc committee of MEC members to investigate it. As soon as practicable, any such ad hoc committee shall forward a written report of the investigation to the MEC.

8.2.4 MEC Action. Within thirty (30) days, or such reasonable additional time as the MEC deems necessary, following receipt of the ad hoc committee report or following its investigation, the MEC shall take action upon the request. Such action may include, without limitation, any of the following or a combination thereof:

- (a) take no corrective action;
- (b) issue a letter of warning, admonition, or reprimand;
- (c) impose terms of probation or require proctoring, co-admitting, or consultation;
- (d) recommend termination of an already imposed summary suspension;
- (e) recommend reduction, suspension, proctoring, co-admitting, consultation, or revocation of Clinical Privileges;
- (f) recommend that an already imposed summary suspension of Staff membership, status or Clinical Privileges be modified or sustained;
- (g) recommend that Staff membership, status or Clinical Privileges be suspended, revoked, or modified; or
- (h) take or recommend other actions deemed appropriate by the MEC.

- 8.2.5 Procedural Rights. The issuance of a letter of warning, admonition or reprimand shall not constitute a summary professional review action, as defined in Section 8.3.3, or an adverse action, as defined in Section 9.2, and shall not entitle the Member to pursue the administrative remedies available under these Bylaws.
- 8.2.6 Board Action. If the MEC's recommended action is to take no corrective action or to issue a letter of warning, admonition, or reprimand, such recommendation, together with all supporting documentation, shall be transmitted to the Board. Thereafter, the procedure to be followed shall be as provided in Section 6.4.5.(a).

### **8.3 SUMMARY SUSPENSION OR RESTRICTION.**

#### **8.3.1 Grounds for Summary Suspension and Persons Authorized to Act.**

The Chairman of the MEC, the Medical Director, the Medical Staff President, the CEO, the MEC, and Board or its designee shall have the authority to take summary professional review action under the following circumstances:

- (a) whenever a Member disregards or violates these Bylaws, the Rules and Regulations, and the Facility's Policies and Procedures;
- (b) whenever a Member's conduct requires that prompt action be taken to protect the life of any patient to reduce the substantial likelihood of injury or damage to the health or safety of any patient, employee, or any other person in the Facility;
- (c) where the failure to take such action may result in an imminent danger to the health of any individual; or
- (d) whenever there are reasonable grounds to believe that prompt action is required.

#### **8.3.2 Possible Actions.**

Summary professional review action may consist of the following:

- (a) suspension of Clinical Privileges;
- (b) suspension of Staff membership or status;
- (c) imposition of conditions or limitations on the exercise of Clinical Privileges; or
- (d) combination of actions.

#### **8.3.3 Effective Date and Notice.**

A summary professional review action shall become effective immediately, and the person or body imposing the summary professional review action shall promptly give written notice to the Member, the CEO, the MEC, and the Board. The notice shall inform the Member:

- (a) of the summary professional review action taken. This shall in no way be construed as a limitation on the grounds which may be asserted in support of such action;

- (b) of the identity of the person or body taking such action;
- (c) of the reasons supporting such action;
- (d) of his right, under Section 8.3.4, to an informal review upon his written request;
- (e) that if a summary professional review action remains in effect longer than thirty (30) days, the action shall be reported pursuant to the National Practitioner Data Bank and state law; and
- (f) that unless the summary professional review action is terminated when the MEC takes further action pursuant to Section 8.3.5, the Member shall be entitled to pursue the administrative remedies available under Article 9.

#### 8.3.4 Expedited Investigation.

- (a) The MEC or its designee, before taking further action, shall conduct an expedited investigation, which shall include at least one (1) meeting of the MEC and may include a formal interview with the party, if other than the MEC, taking the summary professional review action. An informal interview with the Member, outside the presence of the party, if other than the MEC, taking the summary professional review action shall be held if the Member delivers to the CEO a written request for an informal interview within seven (7) days after delivery of the Section 8.3.4 notice. Neither the investigation nor any other activities of the MEC in taking its further action shall constitute a hearing, and none of the procedural rules under these Bylaws shall apply.
- (b) The primary purpose of the expedited investigation is to determine whether continued summary professional review action is warranted. If the MEC determines that failure to continue the summary professional review action may result in imminent danger to the life or health of any individual, the MEC shall continue the summary professional review action while the investigation is continued. If the MEC determines that such danger is unlikely but that further corrective action may be necessary, the MEC shall discontinue the summary professional review action while the investigation continues.

8.3.5 Further MEC Action. As promptly as possible, but no later than fourteen (14) days after the date of the imposition of the summary professional review action, the MEC shall modify, continue for a definite or indefinite period, or terminate the summary professional review action. Such further action shall remain in effect unless and until altered or terminated pursuant to other provisions of these Bylaws. Within five (5) days of deciding upon the further action, the MEC shall give written notice consistent with Section 9.2.3 of its further action to the affected Member, the CEO, and the party, if other than the MEC, which imposed the summary professional review action.

8.3.6 Alternate Patient Coverage. Immediately upon the imposition of a summary suspension or restriction, the Medical Staff President or Medical Director shall provide for alternate medical coverage for the patients of the Member remaining in the Facility at the time of such suspension, if the Clinical Privileges to provide such coverage were suspended. The wishes of the patients shall be considered in the selection of such alternate coverage.

8.3.7 Board Action. Whenever a Summary Suspension is taken by the Chairperson of the Board, or the Board as a whole, the duties of the MEC in Sections 8.3.4 and 8.3.5 shall be assumed and

performed by the Board or its designee.

## **8.4 AUTOMATIC SUSPENSION AND EXPULSION.**

- 8.4.1 License. A Member whose license authorizing him to practice his profession in this State is revoked, not renewed, restricted, made subject to probationary condition, or suspended shall immediately and automatically be suspended from membership and from exercise of privileges. If such license is partially limited or restricted, his membership shall not be suspended and only those Clinical Privileges within the scope of such limitation or restriction shall be automatically suspended.
- 8.4.2 Drug Enforcement Administration (DEA) Certificate. A Member whose DEA number or other right to prescribe controlled substances is revoked or suspended shall immediately and automatically be suspended from membership and from exercise of Privileges. If such number or other right to prescribe controlled substances is partially limited or restricted, his membership shall not be suspended and only those Clinical Privileges within the scope of such limitation or restriction shall be automatically suspended.
- 8.4.3 Failure to Satisfy Special Appearance Requirement. A Member who fails to satisfy the requirements of Section 12.8.3 shall immediately and automatically be suspended from exercising all or a portion of his Clinical Privileges in accordance with the provisions of Section 12.8.3.
- 8.4.4 Medical Records. A Member who has failed to complete medical records within fifteen(15) days after receiving warning, shall be suspended from admitting patients, upon the concurrence of the President of the Medical Staff and the CEO.
- 8.4.5 Professional Liability Insurance. A Member who fails to satisfy the requirements of Section 14.2 shall immediately and automatically be suspended from his Staff membership and the exercise of Privileges until the Member provides to the CEO evidence that he has secured professional liability coverage in the required amount. Failure to provide such evidence within six (6) months after the date that the automatic suspension was imposed shall be deemed a voluntary resignation of Staff membership and voluntary relinquishment of Clinical Privileges. Such voluntary resignation and relinquishment shall not constitute a summary professional review action, as defined in Section 8.3.3, or an adverse action, as defined in Section 9.2, and the Member shall not be entitled to pursue administrative remedies available under these Bylaws.
- 8.4.6 Felony Indictment or Conviction. A Member who has been indicted, convicted of, or pled “guilty,” “no contest,” or their equivalents to a misdemeanor involving a charge of moral turpitude or to a felony in any jurisdiction shall be automatically suspended from his Staff membership and from the exercise of Privileges. Such suspension shall become effective immediately upon such indictment, conviction or plea, regardless of whether an appeal is filed. Such suspension shall remain in effect until the matter is resolved by subsequent action of the Board or through corrective action, if necessary.
- 8.4.7 Procedural Rights. Automatic suspension by operation of Section 8.4 shall not constitute a professional summary review action, as defined in Section 8.3.3, or an adverse action, as defined in Section 9.2, and shall not, except as otherwise provided in these Bylaws, entitle the Member to pursue the administrative remedies available under Article 9.
- 8.4.8 Reinstatement; New Application. Any Member automatically suspended under Section 8.4.1, 8.4.2, or 8.4.6 shall not, by the passage of time or the curing of the event which gave rise to automatic

suspension, be automatically reinstated to his membership and/or Clinical Privileges. Instead, in order to regain Staff membership and/or Clinical Privileges, such persons shall be required to file an initial application for Staff membership and Clinical Privileges, which application shall be processed as provided in Article 6. Any Member automatically suspended pursuant to Section 8.4.3, 8.4.4, or 8.4.5 shall be reinstated, at the discretion of the MEC, upon curing, in whatever manner the MEC deems appropriate. In the event a Member who has been automatically suspended pursuant to Section 8.4.3, 8.4.4, or 8.4.5 cures the failure which gave rise to automatic suspension and the MEC does not reinstate such Member within thirty (30) days after such curing, then such Member shall be entitled to pursue the administrative remedies available under Article 9.

## **8.5 IMPAIRED PRACTITIONER PROGRAM.**

In lieu of formal corrective action as described in Sections 4.3 and 4.4 hereof, affected practitioners recognized as being physically or mentally impaired may be referred to the Medical Executive Committee.

- 8.5.1 Grounds and Procedure for Referral. Any person who has reason to believe that a practitioner on the Medical Staff is suffering from physical or mental impairment, including impairment due to substance abuse, should communicate such belief to the President of the Medical Staff. The facts supporting such belief shall be reduced to writing by the person reporting the same, or by the President of the Medical Staff. Following confidential consultation with others as may be deemed appropriate, the President may refer the affected practitioner to the MEC for referral to an Impaired Practitioner Program.
- 8.5.2 Referral After Request for Corrective Action. If the facts of a request for corrective action made pursuant to Subsection 4.3.1 suggest practitioner impairment and it is determined to exist by the President of the Medical Staff following confidential consultation with the Medical Director, the affected practitioner may be referred to an Impaired Practitioner Program. Any affected practitioner who refuses or neglects to respond to a referral to an Impaired Practitioner Program as provided herein, or who accepts such referral but later is uncooperative with the committee, shall be immediately subject to corrective action as otherwise provided in Section 4.3 or Section 4.4, as circumstances may require.
- 8.5.3 Notice to Practitioner. The referral made pursuant to this Section shall be communicated immediately when made by the person making such referral. Notice may be given orally, followed immediately with written notice sent to the affected practitioner no later than the following business day. The written notice shall contain a statement of the affected practitioner's right to choose to participate or not, and a summary of the consequences of not participating.
- 8.5.4 Emergency Corrective Action Not Prohibited. Nothing in this Section shall be construed as prohibiting the imposition of emergency corrective action pursuant to Section 4.4. The Impaired Practitioner Program shall report to the MEC any instances in which an impaired practitioner is providing unsafe treatment.
- 8.5.5 Referral Not Mandatory. Nothing in this Section shall be construed as mandating referral to an Impaired Practitioner Program when in the best judgment of the President of the Medical Staff such referral is not appropriate.
- 8.5.6 Referral Not a Waiver of Fair Hearing Right. Acceptance of a referral to an Impaired Practitioner Program shall not be a waiver of the affected practitioner's rights under Section 4.6, if the affected practitioner shall later elect to withdraw against medical advice from the program or treatment



prescribed by the MEC.

8.5.7 Voluntary Self-Referral. This Section shall not apply to a voluntary self-referral of a practitioner occurring prior to the making of a request for corrective action, the imposition of emergency corrective action, or the communication of a belief that an impairment exists to the President of the Medical Staff.

## **8.6 PRACTITIONER CODE OF CONDUCT & DISRUPTIVE PRACTITIONER POLICY.**

8.6.1 Purpose. It is the policy of the Hospital that all individuals within its facilities be treated courteously, respectfully, and with dignity. To that end, the Board of Directors requires all physicians and other independent practitioners to conduct themselves in a professional and cooperative manner in the Hospital and when performing services on behalf of the Hospital. All practitioners are expected to refrain from disruptive, abusive, or otherwise inappropriate conduct toward patients, employees, visitors, and other practitioners. This policy has been adopted and will be enforced in recognition of the position that disruptive practitioner conduct adversely affects the quality of patient care within the Hospital.

8.6.2 Definition of Disruptive Conduct. Disruptive conduct can take many forms. Raised voice, profanity, name-calling, throwing things, abusive treatment of patients or employees, sexual harassment, disruption of meetings, repeated violations of policies or rules, or behavior that disparages or undermines confidence in the Hospital or its staff may be disruptive behavior, although this is not an exhaustive list. Unacceptable disruptive conduct can also include such behavior as:

- (a) Sexual harassment and/or misconduct, assault, fraud, throwing equipment/records, or other inappropriate physician behavior.
- (b) Attacks (verbal or physical) leveled at others which are personal, irrelevant, or go beyond the bounds of fair professional comment.
- (c) Knowingly falsifying patient records, or knowingly making untrue statements (whether or not related to the operations of the Hospital).
- (d) Impertinent and inappropriate comments written or illustrations drawn in patient medical records, or other official documents, impugning the quality of care in the Hospital, or attacking particular practitioners, employees, or Hospital policy.
- (e) Non-constructive criticism, addressed to its recipient in such a way as to intimidate, undermine confidence, belittle, or to impute stupidity or incompetence.
- (f) Refusal to accept medical staff assignments, or to participate in committee or departmental affairs on anything but his or her own terms or to do so in a disruptive manner.
- (g) Imposing idiosyncratic requirements on the Hospital staff which have little impact on improved patient care but serve only to burden employees with “special” techniques and procedures.

When a practitioner’s conduct disrupts the operation of the Hospital, it affects the ability of others to get their jobs done, creates a “hostile work environment” for Hospital employees or

other practitioners, or begins to interfere with the practitioner's own ability to practice competently, action must be taken.

### 8.6.3 Reporting & Documenting Disruptive Behavior.

(a) Any employee, practitioner, patient, or visitor who observes behavior by a practitioner that disrupts the smooth operation of the Hospital or jeopardizes patient care shall immediately report the incident verbally to the immediate supervisor, with a follow up written report within the shift of the incident, if possible. If the immediate supervisor is unavailable, report to the nursing supervisor.

(b) Documentation of disruptive conduct is critical since it is ordinarily not one incident that justifies disciplinary action, but rather a pattern of conduct. The documentation shall include:

1. the date and time of the questionable behavior;
2. whether the behavior was in the presence of a patient or affected or involved a patient in any way, and if so, the name of the patient;
3. the circumstances which precipitated the situation;
4. a description of the questionable behavior, limited to factual, objective language as much as possible;
5. the consequences, if any, of the disruptive behavior as it relates to patient care or personnel or hospital operations;
6. the names of witnesses, if any; and
7. any action taken including date, time, place, action, and name(s) of those intervening.

8.6.4 The report shall be submitted to the CEO who shall present a copy to the Medical Director, or in the case where the Medical Director is alleged to have exhibited the disruptive behavior, to the President of the Medical Staff. In the absence of the CEO, submit the report to the Director of Nursing.

8.6.5 Reports of disruptive behavior will be investigated by the CEO and the Medical Director, or President of the Medical Staff, as the case may be, or their designees (the "Investigators"). Reports, which are not founded, may be dismissed, and the person initiating the report so apprised. Reports that are confirmed will be addressed as follows.

8.6.6 Reports of disruptive behavior shall be confidential, and unless of such severity or continuation after intervention as to cause the Medical Executive Committee to recommend adverse action against a practitioner that would entitle the practitioner to the right to a hearing, the identity of the person(s) reporting disruptive behavior shall not be disclosed to the practitioner.

## 8.7 CORRECTIVE ACTION OF DISRUPTIVE BEHAVIOR.

8.7.1 Isolated Disruptive Behavior. A single confirmed incident of a non-aggressive nature warrants a discussion with the practitioner. The Investigators or other appropriate

persons shall meet with the practitioner and emphasize that such conduct is inappropriate. The practitioner shall be given a copy of this policy and advised to take immediate steps to end the behavior.

- 8.7.2 Pattern of Disruptive Behavior. If it appears to the Investigators that a pattern of disruptive behavior is developing, one or both of the Investigators shall discuss the matter with the practitioner, emphasizing that if the behavior continues, formal action will be taken to stop it. It is neither necessary nor appropriate to await several incidents before making this determination. Smooth operation of the Hospital and protection of patients, employees or others within the Hospital from mistreatment and abuse is a paramount concern. A letter to the practitioner shall follow up the meeting, identifying the disruptive behavior and stating that the practitioner is required to behave professionally and cooperatively, a copy of which shall be maintained in the practitioner's credentialing file.
- 8.7.3 Documentation. All meetings with the practitioner shall be documented and copies of the same shall be maintained in the practitioner's credentialing file. Informal meetings with the practitioner do not constitute a "hearing" subject to the procedural requirements of the Medical Staff Bylaws; however, the practitioner may submit a written rebuttal to the complaint which shall be maintained in the practitioner's credentialing file. After each meeting with the practitioner, with the exception of Section 8.6.4(a), a letter shall be sent to the practitioner confirming that the practitioner is required to behave professionally and cooperatively, or that formal action will be taken.
- 8.7.4 Repeated/Continued Disruptive Behavior. If the practitioner's disruptive behavior continues, or if the Investigators determine it to be necessary, the CEO, Medical Director, President of the Medical Staff, and Board chairperson, or an individual acting on the chairperson's behalf shall meet with and advise the practitioner that such conduct must stop. This meeting constitutes the practitioner's final warning. It shall be followed with a letter identifying the disruptive behavior and reiterating the warning; a copy of which shall be maintained in the practitioner's credentialing file. This letter shall articulate in detail, as specific as possible, what behavior is unacceptable and shall state that the consequences of unacceptable behavior will include suspension or termination of privileges in accordance with Article 9.
- 8.7.5 While this policy outlines several warnings and meetings with a practitioner, the conduct at issue may be so egregious as to make these multiple opportunities inappropriate. Based on the misconduct at issue, corrective action, including immediate precautionary summary suspension under Section 8.3 may be warranted.

## **ARTICLE 9 INTERVIEWS, HEARINGS, AND APPELLATE REVIEW**

### **9.1 DUTY TO EXHAUST REMEDIES.**

Each Member shall follow and complete the procedures set forth in this Article, including administrative appellate procedures, before attempting to obtain judicial relief related to any issue or decision which may be subject to a hearing or appeal under this Article. An affected Member who fails to exhaust the remedies set forth in this Article 9 shall indemnify and hold harmless the Hospital, MEC, Board, and every Member named as a defendant against all costs they may incur in defending such an action.

### **9.2 HEARING PROCESS.**

9.2.1 Grounds for Hearing. Unless taken in compliance with a business decision of the Facility and except as otherwise provided in these Bylaws, the taking or recommending of any one or more of the following actions shall constitute grounds for a hearing pursuant to this Article:

- (a) denial of Staff membership, reappointment, advancement from Provisional Status, or Clinical Privileges, except for Temporary Privileges unless otherwise required by state law;
- (b) summary suspension of Staff membership or Clinical Privileges for more than twenty-nine (29) days;
- (c) non-reinstatement of Staff status or Clinical Privileges within thirty (30) days after curing an event which gave rise to an automatic suspension under Section 8.4;
- (d) revocation, restriction, or involuntary reduction of Staff Membership or Clinical Privileges;
- (e) involuntary imposition of significant consultation or proctoring requirements that restrict or limit the affected Member's ability to exercise Clinical Privileges, but excluding proctoring incidental to the granting of new Clinical Privileges or insufficient activity by the affected Member to determine quality of care; and
- (f) any other disciplinary action or recommendation that must be reported to the state licensing authority, unless unrelated to the quality of care or the professional conduct or competency;

9.2.2 Informal Interviews. Nothing in these Bylaws shall be deemed to prevent any person or committee contemplating any action or recommendation set forth in these Bylaws from, in its sole discretion, inviting the affected Member to participate in an informal discussion of the contemplated action or recommendation. Such discussion shall not be deemed to constitute a hearing and need not be conducted in accordance with the procedural rules governing hearings.

9.2.3 Notice of Adverse Action or Recommended Action; Request for Hearing.

- (a) Whenever any of the actions constituting grounds for a hearing has been taken or recommended, the CEO shall serve upon the affected Member written notice within five (5) days of the recommendation or decision to take the adverse action.
- (b) The notice of adverse action shall:
  - (i) describe what action has been taken or recommended;
  - (ii) summarize the reasons for the action. This summary shall in no way be construed as a limitation on the grounds which the MEC or Board may assert in its Statement of Grounds for the adverse action or recommendation;
  - (iii) state whether the action, if finally adopted, will be reported to the appropriate licensing entity and to the National Practitioner Data Bank (NPDB);

- (iv) advise that the affected Member has the right to request a hearing by serving upon the CEO, within thirty (30) days following the date of service of the notice of adverse action or recommendation, a written request for a hearing;
- (v) advise that the affected Member must at least ten (10) days prior to the date of the hearing serve upon the CEO written notice of his intent to be represented by legal counsel or by a physician licensed to practice in this state and, if so, the identity of same; and
- (vi) provide a copy of these Bylaws.

9.2.4 Settlements. At any time following service of notice of a recommendation or action which would entitle an affected Member to request a hearing under this Article, the parties may discuss voluntary settlement or resolution of the matter. In a matter arising from an adverse recommendation of the MEC, if the affected Member and the MEC reach a written agreement which could settle the matter, the MEC shall promptly notify the CEO and the Board of the terms of such settlement and request the Board's approval of the same. If the Board does not approve of the terms of the MEC and the affected Member's written settlement, the matter shall proceed as set forth in this Article 9 as if the settlement did not exist. In a matter arising from an adverse recommendation of the Board, if the affected Member and the Board reach a written agreement which could settle the matter, the Board shall promptly notify the MEC of the terms of such settlement.

9.2.5 Request for Hearing.

- (a) The affected Member has the right to make a written request for a hearing by serving upon the CEO within thirty (30) days after service of notice pursuant to Section 9.2.3.
- (b) The request for hearing must indicate whether the affected Member will be represented by legal counsel or a physician licensed to practice in this state and, if so, the identity of same.
- (c) Failure to make an appropriate and timely request shall be deemed an acceptance by the affected Member of the action or recommendation of the MEC and a waiver by the affected Member of all administrative remedies under this Article and the Bylaws. The matter shall thereupon be forwarded to the Board for its decision.

9.2.6 Notice of Hearing.

- (a) Upon receipt of a timely and proper request for hearing, the CEO shall deliver the request to the MEC.
- (b) The MEC shall, not less than thirty (30) days prior to the date of the hearing, give written notice to the affected Member of the time, place, and date thereof. In cases arising from the adverse action of the Board following the favorable recommendation of the MEC, the Board, or its designee, shall, not less than thirty (30) days prior to the date of the hearing, give written notice to the affected Member of the time,.

9.2.7 Statement of Grounds. Not less than thirty (30) days prior to the date of the hearing, the MEC shall serve upon the affected Member a Statement of the Grounds for the adverse action or

recommendation. Amendments to the Statement of the Grounds may be made from time to time, but not later than the close of the case by the MEC at the hearing before the Medical Review Committee (“MRC”). Such amendments may delete, modify, or add to the acts, omissions, or reasons specified in the original notice.

#### 9.2.8 Medical Review Committee Appointments.

- (a) After a hearing has been properly requested, the MEC shall appoint an MRC consisting of three (3) members, all of whom shall be physicians/practitioners who shall be licensed to practice medicine but need not be Members of the Medical Staff. One or more alternate members may also be appointed. The MRC members shall not have actively participated in conducting the investigation nor in the MEC’s decision, and they shall not be in direct economic competition with the affected Member.
- (b) At least twenty (20) days prior to the hearing the MEC shall serve upon the affected Member a list of the MRC members. The Member must then make any objections in writing at least fifteen (15) days prior to the hearing. The MEC may elect either to remove or replace the disputed MRC member(s) or to go forward with the member(s), subject to the decision of the Presiding Officer.

#### 9.2.9 Presiding Officer.

- (a) The CEO may, at his option, appoint a licensed attorney to serve as the Presiding Officer. If a Presiding Officer is not appointed, the chairman of the MRC shall act as the Presiding Officer.
- (b) The Presiding Officer shall:
  - (i) preside at the hearing;
  - (ii) rule on questions of procedure and the admissibility of evidence;
  - (iii) swear witnesses;
  - (iv) advise the MRC members as to the provisions of this Article and the Bylaws;
  - (v) determine order of procedures;
  - (vi) maintain decorum;
  - (vii) prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, abusive or causes undue delay; and
  - (viii) take any other action as may be necessary to ensure that the proceedings are carried out in accordance with this Article and the Bylaws.
- (c) In advising the MRC on procedural matters, the Presiding Officer may participate in the drafting of the MRC’s decision and report.
- (d) The Presiding Officer shall not vote on the MRC’s decision unless the Presiding Officer is the chairman of the MRC.

- (e) The Presiding Officer may be advised by legal counsel to the Facility.

#### 9.2.10 Hearing Officer.

- (a) After consulting the President of the Medical Staff, the CEO may appoint a Hearing Officer, preferably an attorney, to perform the functions of the MRC and the Presiding Officer. The Presiding Officer may not be or represent clients in direct economic competition with the affected Member requesting the hearing.
- (b) If a Hearing Officer is appointed, all references in this Article to the “Medical Review Committee,” “MRC,” or “Presiding Officer” shall be deemed to refer to the Hearing Officer.

9.2.11 Postponements, Continuances, and Extensions. Postponements, continuances or extensions beyond the times required by these Bylaws may be requested by any of the parties, and shall be granted upon agreement of the parties or by the Presiding Officer upon a showing of good cause.

#### 9.2.12 Ex-Parte Communications.

- (a) Neither the Presiding Officer nor the members of the MRC nor the Board may communicate, directly or indirectly, regarding any issue in the proceeding, while the proceeding is pending, with any party without notice and opportunity for all parties to participate in the communication.
- (b) Notwithstanding subsection (a), the Presiding Officer, MRC members, and the Board may communicate with the CEO and Facility administration regarding a pending matter if such persons do not furnish, augment, diminish, or modify the evidence in the record.

9.2.13 Representation. Not less than thirty (30) days prior to the hearing before the MRC, the MEC shall advise the affected Member in writing as to whether it will be represented by legal counsel or a Medical Staff Member, and if so, it must identify said individual(s). In all cases, representation of the MEC whether by legal counsel or a Medical Staff Member, shall be determined by the Board.

### **9.3 HEARING PROCEDURE BEFORE THE MRC.**

#### 9.3.1 Witness Lists and Production of Documents.

- (a) At least ten (10) days after receiving notice of the hearing, the parties shall exchange: (i) a list of witnesses expected to testify at the hearing and a description of the subject matter of each witness’ anticipated testimony and (ii) a list of the documents expected to be introduced at the hearing. At least ten (10) days before the hearing, each party shall make available for inspection and copying the documents expected to be introduced at the hearing.
- (b) Failure of a party to provide timely the lists or documents, or to update them at least five (5) business days before the commencement of the hearing, shall constitute good cause for the granting of a continuance, or for barring or otherwise limiting the introduction of any document or witness not properly disclosed.

9.3.2 Failure to Appear. Except as permitted by the MRC, the affected Member’s failure to be present for the duration of the hearing shall be deemed to constitute the affected Member’s voluntary acceptance of the MEC’s recommendation or action and waiver by the Member of all hearing

and appeal rights under this Article and the Bylaws.

9.3.3 Record of the Hearing. The MRC proceedings shall be recorded by a court reporter. No other record of the hearing shall be permitted.

9.3.4 Pre-Hearing Conference. Upon reasonable notice to the parties, the Presiding Officer may convene a pre-hearing conference to consider such matters as may aid in the disposition of the proceeding, including but not limited to, procedural issues and any objections to the members appointed to the MRC.

9.3.5 Rights of Both Sides.

(a) At a hearing, both sides shall have the following rights, subject to reasonable limits determined by the Presiding Officer:

(i) to call and examine witnesses, to the extent they are available and willing to testify;

(ii) to introduce exhibits;

(iii) to cross-examine any witness on any matter relevant to the issues;

(iv) to have representation by counsel who may call, examine, and cross-examine witnesses and present the case; and

(v) to submit a written statement at the close of the hearing.

(b) The individual who requested the hearing and who does not testify may be called and questioned.

(c) The MRC may question witnesses, request the presence of additional witnesses, and request documentary evidence or a written statement.

9.3.6 Burden of Proof.

(a) Recommendation or Action Upon Application for Membership or Clinical Privileges. In cases where the contested recommendation or action is to deny an application for Staff membership or to deny requested Clinical Privileges, the affected Member has the burden of persuading the MRC by a preponderance of the evidence that he is qualified for membership or Clinical Privileges. If the burden of proof is not met, the MRC shall affirm the decision or modify the decision in conformity with the evidence. Otherwise, the MRC shall reverse the decision or modify the decision in conformity with the evidence.

(b) Other Recommendations or Actions. In cases where the contested recommendation or action is other than those described in Section 9.3.6.(a), the MEC, or Board, as the case may be, has the burden of proving by a preponderance of the evidence that, regardless of the information and evidence before the MEC, or Board, at the time of its decision, the evidence presented to the MRC demonstrates that there is a reasonable basis for the action(s) or recommendation(s). If the burden of proof is met, the MRC shall affirm the decision or modify the decision in conformity with the evidence. Otherwise, the MRC shall reverse the decision or modify the decision in conformity with the evidence.



9.3.7 Admissible Evidence. Except as otherwise provided in these Bylaws, the following rules shall apply in the hearing:

- (a) The general rule of evidence shall be that any relevant matter, whether written or oral, upon which reasonable individuals would be expected to rely in the conduct of serious affairs, shall be admitted, regardless of its admissibility in a court of law.
- (b) The MRC may, in its discretion, receive and consider any written statement, brief, or memorandum presented by any party.

#### **9.4 DECISION AND REPORT OF THE MRC.**

9.4.1 Within twenty (20) days after final adjournment of the hearing (the date when the MRC receives the hearing transcript or any post-hearing statements, whichever is later), the MRC shall render and deliver to the CEO a written report. The final decision of the MRC must be sustained by a majority vote of the members appointed.

9.4.2 The MRC may, consistent with the burden of proof, recommend that the Board affirm, reverse or modify the MEC's action or recommendation. The report shall include findings of fact and conclusions articulating the connection between the evidence presented at the hearing and the recommendation.

9.4.3 An MRC decision that affirms a prior adverse action of the Board shall be transmitted to the Board for final action, and the affected Member shall, other than an appearance before the Board, have no further right of appeal to the Board.

#### **9.5 APPEAL TO THE BOARD.**

9.5.1 Grounds for Appeal. The grounds for appeal are limited to:

- (a) Substantial and prejudicial failure of the MRC to comply with the Article or the Bylaws resulting in a denial of due process, i.e., denial of a fair hearing;
- (b) The MRC's action or recommendation that prompted the hearing was arbitrary or capricious; or
- (c) The MRC's decision was clearly contrary to the weight of the evidence.

9.5.2 Request for Appeal.

- (a) Either party has the right to request an appeal by service upon the CEO and the other party, within ten (10) days after service of the decision of the MRC, a written request for an appellate review by the Board.
- (b) The request for appeal must adequately articulate and describe the basis for each ground for appeal. Failure to articulate and describe the basis for each ground for appeal shall be construed as a waiver of the ground for appeal.

9.5.3 Notice of Appellate Review Meeting. At least thirty (30) days prior to the appellate review meeting, the Board shall notify the parties in writing of the date for the appellate review meeting.

#### 9.5.4 Appellate Review Proceedings.

- (a) Board Member Participation. No member of the Board who is in direct competition with the affected Member or who actively participated in conducting the initial investigation or in the MEC's or MRC's decisions shall vote in the appellate review process.
- (b) Presiding officer. The Board may, in its sole discretion, appoint a licensed attorney to serve as a Presiding Officer to conduct the appellate review meeting, rule on procedural matters, act as advisor to the Board as to procedural matters, and assist in the preparation of its decision. If a Presiding Officer is not appointed, the chairman of the Board shall act as the Presiding Officer and shall be entitled, subject to the provisions of Section 9.5.4.(a), to vote on the Board's decision.
- (c) Hearing Officer. After consulting with the chairman of the Board, the CEO may appoint a Hearing Officer, preferably an attorney, to perform the functions of the Board and Presiding Officer. The Hearing Officer may not be or represent clients in direct economic competition with the individual requesting the hearing. If a Hearing Officer is appointed, all references in this Article to the "Board," "Board," or "Presiding Officer" shall be deemed to refer to the Hearing Officer.

9.5.5 Record for Review. The Board shall limit its review to the record of the hearing before the MRC and to the MRC's decision and report. Upon request by a party at least seven (7) days prior to the appellate review meeting date, the Board, within its discretion and subject to the review of the Presiding Officer, may accept written briefs, oral arguments, or oral or written evidence subject to the rights of cross-examination and rebuttal.

9.5.6 Burden of Proof. The party appealing the decision of the MRC has the burden of establishing by a preponderance of the evidence that one or more of the grounds for appeal exist. If the burden of proof is not met, the Board shall affirm the MRC's decision or modify the decision in conformity with the evidence. Otherwise, the Board shall reverse the MRC's decision or modify the decision in conformity with the evidence.

9.5.7 Settlement, Acceptance, Waiver. In the case of settlement, acceptance by the affected Member of the MEC's or MRC's decision, or waiver of appeal or hearing rights, the Board may affirm, modify, or reverse the action, recommendation, or decision.

#### 9.5.8 Board Decision.

- (a) Within thirty (30) days after settlement, acceptance by the affected Member of the decision, waiver by the affected Member of hearing or appeal rights, or the adjournment of the appellate review meeting (the date when the Board receives the hearing transcript or any post-hearing statements, whichever is later), the Board shall submit a written decision which shall include findings of fact and conclusions articulating the connection between the evidence produced at the hearing and the decision reached.
- (b) Except where the matter is referred for further action and recommendation, the final decision of the Board following the appeal shall be effective immediately and shall not be subject to further review. If the matter is referred for further action and recommendation, such action or recommendation shall be promptly made in accordance with the instructions given by the Board.

## **9.6 RIGHT TO ONLY ONE MRC HEARING AND APPELLATE REVIEW.**

No party shall be entitled to more than one (1) evidentiary hearing and one appellate review on any matter that may be the subject of a MRC hearing or appeal. If the Board denies initial appointment to the Medical Staff or reappointment or revokes the appointment and/or Clinical Privileges, that individual may not apply for Staff appointment or for those Clinical Privileges for a period of five (5) years, unless the Board provides otherwise.

## **9.7 CONFIDENTIALITY.**

All persons involved in any peer review activity at this Facility shall keep all peer review investigations, as well as all hearing and appellate review proceedings and the contents thereof, confidential. No one shall disclose or release any information or documents furnished to or by; generated in or by; produced in, to or by; or about from or about the proceedings to any person or entity, except as required or permitted by law.

## **9.8 EXCEPTIONS TO ADMINISTRATIVE REMEDIES RIGHTS.**

9.8.1 In addition to other exceptions set forth in these Bylaws, the administrative remedies rights under these Bylaws are not applicable under the following circumstances:

- (a) Closed Staff/Contracted Services. The administrative remedies rights under these Bylaws do not apply to an affected Member: (1) whose application or reapplication for Medical Staff membership and/or Privileges was denied on the basis that the Privileges sought are granted only pursuant to a closed Staff or exclusive use policy, or (2) whose Medical Staff membership and/or Privileges were terminated on the basis that the Member ceases to be employed by an organization contracted to deliver clinical services at the Facility or on the basis that the contract with the organization through which he had the contractual right to access the Facility is terminated.

9.8.2 Board Actions. In all matters where an affected Member may request a hearing arising from an adverse decision of the Board, or its designee, following a favorable recommendation of the MEC, the duties of the MEC as set forth in Section 9.2.7 regarding the Statement of the Grounds, and in Section 9.2.8 regarding appointment of the Medical Review Committee shall be assumed by the Board.

## **ARTICLE 10 OFFICERS**

### **10.1 OFFICERS OF THE STAFF.**

10.1.1 Identification. The officers of the staff shall be:

- (a) President;
- (b) Vice President; and
- (c) Secretary-Treasurer.

In the event the Medical Staff consists of fewer than three (3) Members, the officers shall be the President and Secretary-Treasurer.

10.1.2 Qualifications. Officers must be Members of the Active or Consulting 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.

- 10.1.3 Election. Officers shall be nominated and elected at the annual meeting of the Staff each year. Only Staff Members accorded the Prerogative to vote for Staff officers under Article 4 shall be eligible to vote. Voting shall be by secret written ballot, and voting by proxy shall not be permitted. A nominee shall be elected upon receiving a majority of the votes cast, subject to the approval of the Board.
- 10.1.4 Runoff Elections. If no candidate for the office receives a majority vote on the first ballot, a runoff election shall be held at the annual meeting between the two candidates receiving the highest number of votes.
- 10.1.5 Term of Elected Office. Each officer shall serve a one year term, commencing on the first day of the Medical Staff year following his election. Each officer shall serve until the end of his term unless the officer resigns or is removed from office.
- 10.1.6 Removal of Officer. The Medical Staff may call a special meeting, as described in Section 12.1.3, to consider the removal of an officer, or may do so at a regular staff meeting. An officer may be removed from office by a vote of two thirds of all eligible to vote. Removal requires the approval of the MEC and the Board. The Board may remove an officer. Reasons for removal of an officer shall include but are not limited to the following: 1) failure to perform duties as required in the by-laws, 2) loss of license to practice medicine, 3) felony conviction or 4) loss of malpractice insurance.
- 10.1.7 Vacancies in Elected Office. If there is a vacancy in the office of President, the Vice President shall serve out the remaining term. A vacancy in the office of Vice President shall be filled by the secretary-treasurer. A vacancy in the office of the Secretary-Treasurer shall be filled by a special election conducted as soon after the vacancy occurs as practical following the procedure provided by Sections 10.1.3, and 10.1.4.
- 10.1.8 Duties of Elected Officers.
- (a) President: The President shall:
- (i) aid in coordinating the activities of the administration and of nursing and other patient care services with those of the Medical Staff;
  - (ii) communicate and represent to the Medical Director, the CEO, and the Board the opinions, policies, concerns, needs, and grievances of the Medical Staff;
  - (iii) perform the duties required of the President by these Bylaws;
  - (iv) call, preside at, and be responsible for the agenda of all meetings of the Medical Staff;
  - (v) serve as a member of the MEC and as an ex officio member of all other medical staff committees;
  - (xi) confer with the CEO, CFO, CNO and Department Directors on at least a quarterly basis as to whether there exists sufficient space, equipment, staffing, and financial resources or that the same will be available within a reasonable time to support each privilege requested by applicants to the Medical Staff and to report on the

same to the MEC and to the Board; and

- (xii) assist the Medical Director as to the types and amounts of data to be collected and compared in determining and informing the Medical Staff of the professional practice of its members.
- (b) Vice President: In the absence of the President, the Vice President shall assume all the duties and have the authority of the President. He shall serve as a member of the MEC, and he shall perform such additional duties as may be assigned to him by the President or MEC.
- (c) Secretary-Treasurer: The responsibilities, duties, and authority of the Secretary-Treasurer are as follows:
  - (i) serve as a member of the MEC;
  - (ii) maintain accurate and complete minutes of all Medical Staff meetings;
  - (iii) give proper notice of all Medical Staff meetings on order of the Medical Director, President, or other authorized person; and
  - (iv) perform other such duties as required of his office.

## **ARTICLE 11 COMMITTEES AND FUNCTIONS**

### **11.1 DESIGNATION AND SUBSTITUTION.**

There shall be an MEC and such other standing and special committees of the Staff responsible to the MEC as may from time to time be necessary and desirable to perform the Staff functions. Whenever these Bylaws require that a function be performed by or that a report or recommendation be submitted to:

11.1.1 A named Medical Staff committee, but no such committee shall exist, the MEC shall perform such function or receive such report or recommendation.

11.1.2 The MEC, but a standing or special committee shall have been formed to perform the function, the committee so formed shall act in accordance with the authority delegated to it.

### **11.2 MEDICAL EXECUTIVE COMMITTEE.**

11.2.1 Composition. MEC shall consist of Members, a majority of whom shall be fully licensed physician Members of the Active Staff. The Medical Director shall be a member and chairman of the MEC. The CEO shall be an ex officio member. The CEO shall attend every meeting of the MEC or shall send a designee in his stead. The remaining Members of the Committee shall be:

- (a) the President of the Staff;
- (b) the Vice President of the Staff (if any);
- (c) the Secretary-Treasurer of the Staff; and
- (d) up to seven (7) Members of the Active or Consulting Staff who are elected by the Staff to

serve on the MEC for one (1) year following the procedures provided by Sections 10.1.3 and 10.1.4.

11.2.2 Duties. The duties of the MEC shall be to:

- (a) receive and act upon reports and recommendations from programs, committees, officers of the Staff, and quality management activities;
- (b) coordinate the activities of and policies adopted by the Staff and its committees, the Facility, the Board, and the Medical Director;
- (c) recommend to the Board all matters relating to appointments, reappointments, Staff membership, status, Clinical Privileges, specified services, administrative remedies, quality management activities, and corrective action;
- (d) recommend to the Board matters relating to the structure of the Medical Staff and the mechanism used to review credentials and delineate individual clinical privileges;
- (e) account to the Board and to the Staff for the overall quality, uniformity, and efficiency of medical care rendered to patients;
- (f) initiate and pursue corrective action when warranted and in accordance with these Bylaws, the Rules and Regulations, and the Policies and Procedures;
- (g) participate in identifying community health needs and in setting Facility priorities and program goals and implementing programs to meet those needs;
- (h) represent and act on behalf of the Staff, subject to the limitations imposed by these Bylaws;
- (i) take all reasonable action necessary to ensure that each Medical Staff peer evaluation and quality assessment and improvement activity is performed effectively;
- (j) take all reasonable measures to assure professional ethical conduct, competence, and clinical performance on the part of all Staff Members;
- (k) make recommendations to the Board on medical administrative and Facility management matters, particularly as they relate to patient care; and
- (l) recommend to the Board policies and procedures which define the circumstances, trends, indications, deviated expectations or outcomes, or concerns that trigger a focused review of a practitioner's performance and evaluation of a practitioner's performance by peers. The information relied upon to investigate a practitioner's professional conduct and practice may include (among other items or information): internal or external chart reviews, prospective, concurrent and/or retrospective monitoring of actual practice, monitoring of clinical practice patterns, proctoring, and consultations with other physicians, assistants, nursing or Administrative personnel involved in the care of patients;
- (m) make recommendations to the Board of the kinds, types, and amounts of data to be collected and evaluated to allow the medical staff to conduct an evidence-based analysis of the quality of professional practice of its members; and

- (n) submit recommendations to the Board for changes in the Medical Staff Bylaws, Rules and Regulations, and other organization documents pertaining to the Medical Staff.

11.2.3 Meetings. MEC shall meet at least four (4) times during the year and maintain minutes as is appropriate for each meeting.

### **11.3 FUNCTIONS.**

Provision shall be made by the MEC, either through assignment to Staff committees, to specific individuals, or to the MEC itself, for the performance of: (a) the Staff functions described in Section 11.4; (b) all other staff functions required by these Bylaws and the Facility's quality management program; and (c) other staff functions as the MEC or the Board may require.

### **11.4 DESCRIPTION OF FUNCTIONS.**

#### 11.4.1 Quality Management/Performance Improvement.

- (a) The duties involved in the overseeing quality assessment and improvement are to:
  - (1) coordinate and integrate all quality assessment and improvement components of the quality management program to reduce or eliminate duplications, omissions, inconsistencies, and failure to effect change;
  - (2) monitor the quality management program to the extent that it is comprehensive and that it conducts appropriate evaluations;
  - (3) monitor corrective action to determine that it has been taken, is effective, and is maintained. The Board shall assess the Medical Staff and administration effectiveness in assuring corrective action needed;
  - (4) receive, analyze, and recommend action regarding any significant clinical findings from the Facility's risk management and patient safety program;
  - (5) monitor the development of policies and procedures with respect to special treatment procedures, including restraints, seclusion, electroconvulsive therapy and other forms of anesthesia, and other special treatment procedures for children and adolescents;
  - (6) maintain a liaison with risk management and patient safety, utilization review, pharmacy and therapeutics, patient safety program, infection control, and in-service education;
  - (7) perform at least an annual evaluation of the quality management program to assure its comprehensiveness and effectiveness, and document improvement in patient care and patient outcome studies; and
  - (8) document performance of this function in a report on at least a quarterly basis.
- (b) The Performance Improvement Steering Committee will be actively involved in the following processes:

- (1) medical assessment and treatment of patients;
- (2) use of information about adverse privileging desirous for any practitioner privileged through the Medical Staff process;
- (3) use of medications;
- (4) appropriateness of clinical practice patterns;
- (5) significant departures from established patterns of clinical practice; and
- (6) use of developed criteria for autopsies.

Information used as part of the foregoing includes sentinel event data and patient safety data.

#### 11.4.2 Credentials Review.

The duties involved in performing credentials review are to:

- (a) review and evaluate the qualifications of each applicant for initial appointment, reappointment, or modification of appointment, and for Clinical Privileges;
- (b) review and evaluate the qualifications of designated personnel, regardless of their source of employment, to provide specific patient care services in the Facility;
- (c) submit a report, in accordance with these Bylaws, on the qualifications of each applicant for Staff membership or Clinical Privileges. Such report shall include recommendations as to appointment, Staff category assignment, and Clinical Privileges;
- (d) submit reports, in accordance with these Bylaws, on the status of pending applications, including the specific reasons for any unusual delay in processing an application or request;
- (e) monitor activities implemented for evaluation of the performance of patient care, such as for Members in Provisional status or who have been granted Temporary Privileges;
- (f) initiate, investigate, review, and report on corrective action matters and on any other matters involving the clinical, ethical, or professional conduct of any Members and Allied Health Professionals assigned or referred by the appropriate individuals; and
- (g) assure that a separate credentials file, including reports from quality assessment and improvement activities and of corrective actions of any degree, is maintained for each Staff Member and Allied Health Professional with Clinical Privileges.

#### 11.4.3 Continuing Education.

The duties involved in overseeing and conducting continuing education are to:

- (a) develop, plan, and participate in programs of continuing education regarding significant new developments and new skills in medicine and that are responsive to evaluation findings;



- (b) evaluate through the Facility's quality management program and specifically the patient care evaluation function, the effectiveness of the educational programs developed and implemented;
- (c) act upon continuing education recommendations from the MEC, the Medical Director, or other committees responsible for patient care evaluation, quality maintenance, and monitoring functions;
- (d) maintain a permanent record of educational activities specifically including their relationship to the findings of patient care evaluation and patient care monitoring functions; and

#### 11.4.4 Bylaws, Rules and Regulations.

The duties involved in this function are to:

- (a) conduct, every two (2) years, a thorough review of the Bylaws, the Rules and Regulations, and the procedures and forms promulgated in connection therewith to ensure that they reflect current practice, national standards of patient care, and an efficient organization of the Medical Staff to perform its functions;
- (b) recommend any changes deemed necessary or desirable in the Bylaws, the Rules and Regulations, and the procedures and forms; and
- (c) develop and implement the Rules and Regulations to establish standards of patient care and ensure that these Rules and Regulations are consistent with the Medical Staff Bylaws and with Facility Policies and Procedures.

#### 11.4.5 Treatment Plans and Medical Record Review.

The duties involved in this function are to:

- (a) review patient treatment plans to ensure that each is developed promptly, reappraised as appropriate, and reviewed, considered, and followed by members of the appropriate treatment team;
- (b) review and evaluate medical records objectively using prescribed worksheets, to ensure that they: (i) adequately describe the diagnosis, condition, and progress of the patient, the therapy provided, the results thereof, results of diagnostic tests, the discharge condition, and the identification of responsibility for all actions taken; (ii) are sufficiently complete so as to facilitate continuity of care and communications between all those providing patient care services; (iii) are adequate in content and form to permit appropriate quality assessment and improvement activities; and (iv) comply with applicable standards to protect the legal interests of the interested parties;
- (c) establish, in collaboration with the Health Information Management Department, the format of the medical record;
- (d) review and make recommendations upon all policies, procedures, rules and regulations relating to medical records, including all forms to be used therein;

- (e) recommend and participate in decisions for computerizing medical record data; and
- (f) develop and implement a uniform record review system that, over a reasonable period of time, causes a representative sampling of the records to be evaluated.

#### 11.4.6 Utilization Review.

The duties involved in this function are to:

- (a) develop and ensure compliance with all requirements of the utilization review plan approved by the Medical Staff and the Board;
- (b) require documentation confirming the application, regardless of payment source, of admission and continued stay criteria;
- (c) monitor and evaluate objective clinical data regarding practice patterns and prepare such reports as may be required;
- (d) determine whether underutilization or overutilization impacts adversely the quality of patient care and recommend corrective action; and
- (e) oversee physician/**practitioner** reviews with managed care companies and professional review organizations.

#### 11.4.7 Pharmacy and Therapeutics.

The duties involved in this function are to:

- (a) perform an objective evaluation of the clinical use of all drugs in the Facility to reduce practice variation, errors, and misuse;
- (b) establish and implement a well controlled formulary to help control drug use in the Facility, and make recommendations as to which drugs should be added to and deleted from the formulary;
- (c) monitor and evaluate the prophylactic, therapeutic, and empiric use of drugs, and evaluate all significant untoward reactions to drugs in an effort to ensure that drugs are provided appropriately, safely, and effectively;
- (d) ensure the appropriate reporting of actual or suspected untoward drug reactions, including the recommendation of periodic in-service training for nursing personnel;
- (e) evaluate all significant medication errors;
- (f) assist in the formulation of and approve all professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, ordering and transcribing, preparing and dispensing, administration and monitoring, and other matters related to drugs in the Facility;
- (g) make recommendations on protocols proposed for the use of investigational or experimental drugs in the Facility; and

- (h) maintain records of any and all findings, conclusions, reports, recommendations, and actions taken.

#### 11.4.8 Infection Control.

The duties involved in this function are:

- (a) maintain surveillance of Facility infection potentials;
- (b) develop a system for identifying, reporting, and analyzing the incidence and major causes of Facility acquired infections;
- (c) develop and implement a corrective action program designed to minimize infection hazards and to include an employee health program;
- (d) actively promote the adequate application of general policies relating to infection control in all areas of the Facility, to include but not be limited to isolation procedures and techniques, universal precautions, sterilization procedures, safe disposal of contaminated and infectious waste, and prevention of cross infection through equipment use;
- (e) objectively and continuously evaluate the clinical use of all antibiotics in the Facility, whether the drugs are prescribed prophylactically, empirically, or therapeutically, and whether administered to inpatients or outpatients, including partial hospitalization and intensive outpatients;
- (f) recommend action for any required practice change and ensure that the approved change has occurred; and
- (g) institute any appropriate control measure or study when there is reasonably felt to be a danger to patients or personnel. In an emergent situation, the Medical Director or the Medical Staff President may institute the control measure immediately and shall be assisted by Facility personnel in doing so. The CEO shall be notified as soon as any emergent control measure is instituted and shall be consulted prior to the institution of any non-emergent measure.

#### 11.4.9 Risk Management and Patient Safety.

The duties involved in this function are to:

- (a) identify general areas of potential risk in the clinical aspects of patient care and safety and recommend peer review based on the findings or on high risk incidents;
- (b) develop criteria for identifying specific cases with potential risk in the clinical aspects of patient care and safety, and evaluate those cases;
- (c) correct problems in the clinical aspects of patient care and safety identified through risk management and patient safety activities;
- (d) design programs to reduce risk in the clinical aspects of patient care and safety; and
- (e) review and assess incident reports and make recommendations to prevent or reduce the

potential for future incidents.

11.4.10 Therapeutic Environment and Safety Function.

- (a) Develop and periodically review, in cooperation with the administration, procedures and facilities for maintaining an environment which enhances the self-image of patients and preserves their human dignity.
- (b) Develop and periodically review, in cooperation with the administration, procedures and facilities for maintaining functional safety and the safety and security for patients, employees, and visitors.

11.4.11 Practitioner Health. The Medical Staff, through the MEC or other designees, shall provide non-disciplinary assistance and confidential referral to other resources for diagnosis, treatment, and evaluations upon request for any practitioner concerned about health or impairment issues, and shall provide education about services available to the Staff, including impaired practitioner programs and other available resources, and conduct education for Staff and the facility as necessary regarding at-risk criteria for impaired practice.

11.4.12 Graduate Medical Education. The Medical Staff, through the MEC or other designates, shall be responsible for advising and monitoring all aspects of the Hospital's graduate medical education teaching programs, if and when such programs exist. Details of the standards can be found in the General Requirements of the Essentials of Accredited Residencies in Graduate Medical Education as established by the Accreditation Council for Graduate Medical Education, including:

- (a) establishment and implementation of policies that effect all residency programs regarding the quality of education and the work environment for the residents in each program;
- (b) establishment and maintenance of appropriate oversight of and liaison with program directors and assurance that program directors establish and maintain proper oversight of and liaison with appropriate personnel of other institutions participating in programs sponsored by the institution;
- (c) regular review of all residency programs to assess their compliance with both the Institutional Requirements and Program Requirements of the relevant ACGME RRCs;
- (d) assurance that each residency program establishes and implements formal written criteria and processes for the selection, evaluation, promotion and
- (e) dismissal of residents in compliance with both the Institutional and Relevant Program Requirements;
- (f) assurance of an educational environment in which residents may raise and resolve issues without fear of intimidation or retaliation;
- (g) collecting of intra-institutional information and making recommendations on the appropriate funding for resident positions, including benefits and support services;
- (h) monitoring of the programs in establishing an appropriate work environment and the duty hours of residents

(i) assurance that the resident's curriculum provides a regular review of ethical, socioeconomic, medical/legal, and cost-containment issues that effect GME and medical practice. The curriculum must also provide an appropriate introduction to communication skills and to research design, statistics, and critical review of the literature necessary for acquiring skills for lifelong learning. There must be appropriate resident participation in department scholarly activity, as set forth in the applicable Program Requirements.

(j) Confidentiality of peer review activities will be maintained. All members of the committee shall keep in confidence all papers, reports and information obtained by virtue of membership on the committee.

## **11.5. COMMITTEES OF THE STAFF.**

11.5.1 Composition and Appointment. Unless otherwise specifically provided, a staff committee established to perform one or more of the staff functions required by these Bylaws shall be composed of Members of the Active and Provisional Staffs and may include, at the discretion of the chairman of the MEC and the CEO, other Staff categories, Residents, Interns, Allied Health Professionals and representation from administration, nursing service, medical records service, pharmaceutical service, social service, and such other services as are appropriate to the function to be discharged. The Medical Staff and Allied Health Professional Members shall be appointed by the chairman of the MEC, and the administrative staff members shall be appointed by the CEO. Where not otherwise provided for in these Bylaws, each committee shall, with the approval of the MEC, select its chairman. The chairman of the MEC and the CEO, or their representative designees, shall serve as ex officio members on all committees, unless otherwise expressly provided.

11.5.2 Term and Removal. Unless otherwise specifically provided, a committee member shall continue to serve on the committee as such until the end of his normal period of appointment and a successor is elected or appointed. A Medical Staff committee member, other than one serving ex officio, may be removed by a majority vote of the MEC. An administrative staff committee member may be removed by action of the CEO. Any committee member may be removed by the Board.

11.5.3 Vacancies. Unless otherwise specifically provided, vacancies on any staff committee shall be filled in the same manner in which original appointment to such committee is made.

11.5.4 Meetings. A staff committee established to perform one or more of the staff functions required by these Bylaws shall meet as often as is necessary to discharge its assigned duties, but no less than quarterly.

## **ARTICLE 12 MEETINGS**

### **12.1 STAFF MEETINGS.**

12.1.1 Regular Meetings. Regular meetings of the MEC shall be held at least four (4) times per year, with an annual meeting to include elections.

12.1.2 Order of Business and Agenda. The order of business at a regular meeting shall be determined by the President. The agenda shall include:

(a) reading and acceptance of the minutes of the last regular and of all special meetings held since the last regular meeting;

- (b) reading of communications to and from the staff since the last regular meeting;
- (c) administrative reports from the CEO, the chairman of the MEC and other committees;
- (d) the election of officers and of representatives to staff and organization committees, when required by these Bylaws;
- (e) reports by responsible officers, committees, and directors on the overall results of quality management activities of the staff, and on the fulfillment of the other required staff functions;
- (f) discussion and recommendations for improvement of the clinical performance of each level of care. Such recommendations, conclusions, and actions taken pursuant thereto shall be maintained in the minutes;
- (g) unfinished business; and
- (h) new business.

12.1.3 Special Meetings. Special meetings of the Medical Staff may be called at any time by the Board, the President of the Medical Staff, the MEC or not less than sixty percent (60%) of the Members of the Active Staff, and shall be held at the time and place designated in the meeting notice. No business shall be transacted at any special meeting except that stated in the meeting notice.

## **12.2 COMMITTEE AND UNIT MEETINGS.**

12.2.1 Regular Meetings. Committees may provide the time for holding regular meetings, and no notice shall then be required. The frequency of regular meetings shall comply with these Bylaws, the Rules and Regulations, and the Facility's Policies and Procedures.

12.2.2 Special Meetings. A special meeting of any committee or unit may be called by or at the request of the director or chairperson thereof, the Board, the Chairman of the MEC, the President of the Medical Staff, or by one third of the committee's current Members. No business shall be transacted at any special meeting except that stated in the meeting notice, unless all Members of the committee waive this restriction.

## **12.3 NOTICE OF MEETINGS.**

12.3.1 Notice of regular meetings may be given orally.

12.3.2 For any special meeting or any regular meeting not held pursuant to resolution, written or oral notice stating the place, day, and hour of the meeting shall be served not less than two (2) days before the time of such meeting.

12.3.3 The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

## **12.4 QUORUM.**

12.4.1 Staff Meetings. The presence of sixty-seven percent (67%) of the Members of the Medical Staff eligible to vote at any meeting shall constitute a quorum for the purpose of amendment to these Bylaws. The presence of fifty percent (50%) of such Members shall constitute a quorum for the

transaction of all other business. In the event that a quorum is not present at any regular or special meeting, those Members present may meet as a subcommittee of the whole. Any action taken by those present, acting as a subcommittee of the whole, shall be referred for ratification purposes to the next regular or special meeting called for that purpose at which a quorum is present.

12.4.2 Committee Meetings. Fifty percent (50%) of the voting Members of a committee shall constitute a quorum at any meeting of such committee.

## 12.5. MANNER OF ACTION.

Except as otherwise provided in these Bylaws, the action of a majority of the Members present and voting at a meeting at which a quorum is present shall be the action of the group. Action may be taken without a meeting by a committee by a writing setting forth the action so taken and signed by a majority of Members entitled to vote thereupon.

## 12.6. MINUTES.

Minutes of all meetings shall be prepared by the secretary of the meeting and shall include a record of attendance. Copies of such minutes, approved by the meeting attendees, shall be signed by the presiding officer, forwarded to the MEC, and made available to the staff. A file of the minutes of each meeting shall be maintained.

## 12.7. ATTENDANCE REQUIREMENTS.

12.7.1 Regular Attendance. Except as otherwise provided in these Bylaws, each Member of the Staff shall be required to attend the following meetings:

- (a) the annual Medical Staff meeting;
- (b) at least seventy-five percent (75%) of all other Medical Staff meetings convened pursuant to these Bylaws; and
- (c) at least fifty percent (50%) of all meetings of any committee of which he is a Member.

12.7.2 Absence from Meetings. Any Member who is compelled to be absent from any Medical Staff, or committee meeting shall promptly provide, to the CEO or the regular presiding officer thereof, the reason for such absence. Unless excused from good cause shown, failure to meet the attendance requirements of Section 12.7.1 may be grounds for any of the corrective actions specified in Section 8.2.4, as well as removal from such committee. Reinstatement of a Staff Member whose Membership has been revoked due to absence from meetings shall be made only on application, and any such application shall be processed in the same manner as an application for initial appointment.

12.7.3 Special Appearance. A Member or Allied Health Professional whose patient's clinical course of treatment is scheduled for discussion at a regular committee meeting shall be so notified. The chairman of the meeting shall give the Member or Allied Health Professional at least three days' advance notice of the time and place of the meeting. Whenever apparent or suspected deviation from sound clinical practice is involved, notice shall be given and shall include a statement of the issue involved and that the Member's or Allied Health Professional's appearance is mandatory. Failure of Member or Allied Health Professional to appear at any meeting shall, unless excused by the MEC upon a showing of good cause, result in an automatic suspension, as provided in Section 8.4.3, of all or such portion of his Clinical Privileges, as the MEC may direct. Such automatic

suspension shall remain in effect until the matter is resolved pursuant to these Bylaws.

12.7.4 Meeting as a Committee of the Whole. Notwithstanding any other provision of these Bylaws, whenever the Medical Staff meets, it shall be considered to be meeting as a committee of the whole Medical Staff.

12.7.5 Conduct of Meetings. All meetings shall follow an acceptable form of parliamentary procedure in the conduct of meeting business.

## **ARTICLE 13 CONFIDENTIALITY, IMMUNITY AND RELEASES**

### **13.1 AUTHORIZATIONS, CONFLICT OF INTEREST, AND CONDITIONS.**

By applying or reapplying for, or requesting or exercising Staff membership, status, or Clinical Privileges within this Facility, an applicant, Member, Resident, Intern, or Allied Health Professional:

13.1.1 authorizes the Medical Staff and its committees, the Board, the Facility, and their agents and representatives to consult with others who may have information that may be relevant to credentialing, privileging, or peer review activities; performing functions under these Bylaws; achieving and maintaining quality patient care; reducing morbidity and mortality; reviewing or evaluating professional performance; or contributing to medical research; and authorizes persons to provide such information;

13.1.2 authorizes the disclosure and the inspection of all information, records, and documents that may be relevant to material to credentialing, privileging, or peer review activities; performing functions under these Bylaws; achieving and maintaining quality patient care; reducing morbidity and mortality; reviewing or evaluating professional performance; or contributing to medical research. Such records may include information obtained from data banks maintained on a statewide or national basis;

13.1.3 releases from any liability the Medical Staff and its committees, the Board, the Facility, and their agents and representatives, and third parties for their acts performed without malice in connection with credentialing, privileging, or peer review activities; performing functions under these Bylaws; achieving and maintaining quality patient care; reducing morbidity and mortality; reviewing or evaluating professional performance; or contributing to medical research; and

13.1.4 acknowledges that the provisions of this Article are express conditions to his application or reapplication for or acceptance of Staff membership, status, Prerogatives, and/or Clinical Privileges, or his exercise of Prerogatives and/or Clinical Privileges.

### **13.2 CONFIDENTIALITY OF INFORMATION.**

Information, documents and materials with respect to any applicant, Member, Resident, Intern, or Allied Health Professional submitted, collected, disclosed, or prepared for the purpose of: credentialing, privileging, or peer review activities; performing functions under these Bylaws; achieving and maintaining quality patient care; reducing morbidity and mortality; reviewing or evaluating professional performance; or contributing to medical research shall, to the fullest extent permitted by law, be confidential. This information shall not become part of any particular patient's files or of the general facility records.



Response to legal process apparently valid on its face or exercise of legal rights by, on behalf of, or in respect of a patient shall not nullify or void any other provision of this Article. Privileged peer review, credentialing and quality assurance information shall be maintained separately in the Medical Staff office and shall be available only to the appropriate persons. Dissemination of such information and records shall only be made where expressly permitted by law, pursuant to officially adopted policies of the Medical Staff, including these Bylaws, the Rules and Regulations, and the Facility's Policies and Procedures. Where no officially adopted policy exists, dissemination shall be made only with the express approval of the MEC or its designee and the CEO.

### **13.3 IMMUNITY FROM LIABILITY.**

Each applicant, Member, Resident, Intern, and Allied Health Professional agrees that the Medical Staff and its committees, the Board, the Facility, and their agents and representatives, and third parties shall be exempt from liability for damages or other relief by reason of providing, submitting, collecting, disclosing, or preparing, in good faith and without malice, information, materials, or documents for the purpose of: credentialing, privileging, or peer review activities; performing functions under these Bylaws; achieving and maintaining quality patient care; reducing morbidity and mortality; reviewing or evaluating professional performance; or contributing to medical research.

### **13.4 ACTIVITIES AND INFORMATION COVERED.**

13.4.1 Activities. The confidentiality and immunity provided by this Article shall apply to all acts, investigations, communications, reports, recommendations, decisions, letters, or disclosures performed, prepared, provided, disclosed, or made and all meetings held in connection therewith concerning, but not limited to:

- (a) applications for appointment, Staff membership, status, Prerogatives, or Clinical Privileges;
- (b) periodic reappraisal for reappointment, renewal of Staff membership, status, Prerogatives, or Clinical Privileges;
- (c) investigations, summary professional review action, and corrective action;
- (d) hearings, appellate reviews, and administrative remedies;
- (e) quality management activities;
- (f) utilization/case management reviews; and
- (g) other Facility, Staff, or committee activities relating to credentialing, privileging, or peer review activities; performing functions under these Bylaws; achieving and maintaining quality patient care; reducing morbidity and mortality; reviewing or evaluating professional performance; or contributing to medical research.

13.4.2 Information. The information, materials, and documents referred to in this Article may relate to an applicant's, Member's, Resident's, Intern's, or Allied Health Professional's professional qualification; education; competence; licensure, accreditation, or other legal credentials; clinical ability; judgment; training; background; experience; character; physical, mental, and emotional capability as related to the performance of the Privileges requested; professional ethics; utilization history; ability to provide, with reasonable, necessary accommodation, safe and competent care; or any other matter that might directly or indirectly affect patient care or Facility operations.

## 13.5 RELEASES.

Each applicant, Member, Resident, Intern, and Allied Health Professional shall, at any time and from time to time, upon request, execute general and specific releases in accordance with the tenor and import of this Article, subject to the requirements and conditions of this Article. Execution of such releases is not a prerequisite to the effectiveness of the releases provided under these Bylaws.

## 13.6 CONFLICT OF INTEREST OF MEDICAL STAFF LEADERS

13.6.1 Conflict of Interest Policy. The best interest of the community, Medical Staff and the Hospital are served by members of the Medical Executive Committee, Chair or Vice-Chair of any department, officers of the Medical Staff, the Medical Director, and/or members of the Medical Staff who are also members of the Board (each a “Medical Staff Leader”) who are objective in the pursuit of their duties, and who exhibit that objectivity at all times. The decision making process of the Medical Staff may be altered by interests or relationships which might in any instance, either intentionally or coincidentally bear on that member’s opinions or decision. Therefore, it is considered to be in the best interest of the Hospital and the Medical Staff for relationships of any Medical Staff Leader which may influence the decisions related to the Hospital to be disclosed on a regular and contemporaneous basis.

13.6.2 Self-Dealing Prohibited. No Medical Staff Leader shall use his/her position to obtain or accrue any benefit. All Medical Staff Leaders shall at all times avoid even the appearance of influencing the actions of any other staff member or employee of the Hospital or Corporation, except through his/her vote, and the acknowledgment of that vote, for or against opinions or actions to be stated or taken by or for the Medical Staff as a whole or as a member of any committee of the Medical Staff.

13.6.3 Disclosure.

- (a) Annually, on or before January 1, each Medical Staff Leader shall file with the CEO a written statement describing each actual or proposed relationship of that member, whether economic or otherwise, other than the member's status as a Medical Staff Leader, and/or a member of the community, which in any way and to any degree may impact on the finances or operations of the Hospital or its staff, or the Hospital's relationship to the community, including but not limited to each of the following:
1. Any leadership position on another medical staff, educational institution or other healthcare facility that competes directly or indirectly with the Hospital, including, but not limited to member of the governing body, executive committee, or service or department chairmanship;
  2. Direct or indirect financial interest, actual or proposed, in an entity or facility that competes directly or indirectly with the Hospital;
  3. Direct or indirect financial interest, actual or proposed, in an entity that pursuant to agreement provides services or supplies to the Hospital; or
  4. Business practices that may adversely affect the hospital or community.
- (b) A new Medical Staff Leader shall file the written statement immediately upon being elected or appointed to his/her leadership position. This disclosure requirement is to be

construed broadly, and a Medical Staff Leader should finally determine the need for all possible disclosures of which he/she is uncertain on the side of disclosure, including ownership and control of any health care delivery organization that is related to or competes with the Hospital. This disclosure procedure will not require any action which would be deemed a breach of any state or federal confidentiality law, but in such circumstances minimum allowable disclosures should be made.

- (c) Between annual disclosure dates, any new relationship of the type described in this Section 13.6.3, whether actual or proposed, shall be immediately disclosed in writing to the CEO. The CEO will provide each MEC and Board member with a copy of each Medical Staff Leader's written disclosure at the next MEC and Board meetings following filing by the Member for review and discussion by the MEC and Board.

13.6.4 Recusal. Medical Staff Leaders shall abstain from voting on any issue in which the Medical Staff Leader has an interest other than as a Member of the Medical Staff. A breach of these provisions is deemed sufficient grounds for removal of a breaching member by the remaining members of the MEC on majority vote, or by the Board.

### **13.7 CUMULATIVE EFFECT.**

Provisions in these Bylaws and in application forms relating to consents, authorizations, confidentiality, releases, and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof.

## **ARTICLE 14 GENERAL PROVISIONS**

### **14.1 STAFF RULES AND REGULATIONS.**

Subject to approval by the Board, the Medical Staff shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles found within these Bylaws. The Rules and Regulations shall relate to the proper conduct of Medical Staff organizational activities and embody the level of practice that is to be required of each Staff member or Allied Health Professional exercising Privileges. Such Rules and Regulations shall be a part of these Bylaws, except that they may be amended or repealed at any regular meeting at which a quorum is present and without previous notice or at any special meeting on notice by a two thirds vote of those present and eligible to vote. Such changes shall become effective when approved by the Board. In the event there is a discrepancy with the Bylaws and the Rules & Regulations, the Bylaws shall supersede the Rules & Regulations.

### **14.2 PROFESSIONAL LIABILITY INSURANCE.**

Each Member and Allied Health Professional granted clinical Privileges or Prerogatives shall maintain in force professional liability insurance in not less than \$1,000,000/\$3,000,000] per occurrence and annual aggregate, or such other amount as may be deemed appropriate by the Board, or participate in the applicable professional liability fund insurance plan of the state, and provide the Facility with a current certificate of insurance. In the event that the applicant is insured under a claims made policy, he shall continue the policy in full force and effect the same level of liability insurance coverage on a claims made basis until the longest statute of limitations for professional liability for acts committed at the Hospital has expired (recognizing that the statute of limitations for minors is tolled until they reach the age of majority). The insurance must cover the types of procedures he has the clinical privileges or Prerogatives to perform. He also agrees to immediately notify the CEO of any insurance policy changes

or cancellation and authorize his insurance carrier to provide to the CEO immediate notice of any change. Subject to the approval of the Board, the MEC may, for good cause shown, waive this requirement with regard to such Member or Allied Health Professional, provided that any such waiver is not granted or withheld on an arbitrary, discriminatory or capricious basis. In considering any request for a waiver, the MEC shall, among other things, consider the following: (a) whether the Member or Allied Health Professional has applied for professional liability insurance; (b) whether such application was rejected and, if so, why; (c) whether such insurance is available to such Member or Allied Health Professional and, if not, why; (d) whether the Member or Allied Health Professional is financially responsible in the absence of insurance coverage; and (e) whether the Member or Allied Health Professional is eligible to purchase such insurance at a coverage level less than that established from time to time hereunder. Denial of a waiver or of consideration of a waiver shall not constitute an adverse action and shall not entitle the Member or Allied Health Professional to pursue the administrative remedies available under these Bylaws. The minimum amount of required coverage established pursuant to this provision shall not exceed the amount of professional liability insurance carried by the Facility.

#### **14.3 STAFF DUES.**

Subject to the approval of the Board, the MEC shall have the power to set the amount of annual dues for each category of staff membership and the amount of the processing fee for initial applications and to determine the manner of expenditure of funds received.

#### **14.4 FORMS.**

Application forms and any other forms required by these Bylaws for use in connection with Staff appointments, reappointments, delineation of clinical or specified service Privileges, corrective action, notices, recommendations, reports and other matters shall be adopted by the MEC.

#### **14.5 CONSTRUCTION OF TERMS AND HEADINGS.**

Words used in these Bylaws shall be read as the masculine or feminine gender and as the singular or plural, as the context requires. The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope or effect of any provision of these Bylaws.

#### **14.6 TRANSMITTAL OF REPORTS.**

Reports and other information which these Bylaws require the Medical Staff to transmit to the Board shall be deemed so transmitted when delivered to the CEO.

#### **14.7 EXCLUSIVE MEANS.**

Except for employees of the Facility, these Bylaws provide the sole and exclusive means for the delivery of patient services by professionals at the Facility. No professionals shall deliver any such services at the Facility unless such professionals has been granted Privileges hereunder to deliver such services.

#### **14.8 COMPUTATION OF TIME.**

In computing any period of time prescribed or allowed by these Bylaws, the day of the act, event, or default from which the designated period of time begins to run shall not be included. The last day of the period shall be included unless it is a Saturday, Sunday, or day recognized by the State in which the Facility is located as a legal holiday, in which case the period runs until the end of the next day which is not one of the aforementioned days. When the period of time prescribed or allowed is less than four (4) days, Saturdays, Sundays, and holidays shall be excluded in the computation.

## **14.9 SERVICE.**

Service may be accomplished by personal delivery or by (a) United States Postal Service, first-class postage prepaid, certified or registered mail, return receipt requested, or (b) commercial overnight carrier or local courier service requiring signature on delivery. Service upon the MEC, the MRC, and the Board shall be directed to the attention of the CEO at the Facility's street address.

## **ARTICLE 15 ADOPTION AND AMENDMENT OF BYLAWS**

### **15.1 MEDICAL STAFF RESPONSIBILITY AND AUTHORITY.**

The Medical Staff shall have the initial responsibility and authority to formulate, adopt and recommend to the Board Bylaws and amendments thereto which shall be effective when approved by the Board. Such responsibility and authority shall be exercised in good faith and in a reasonable, timely, and responsible manner, reflecting the interests of providing patient care of the generally professionally recognized level of quality, uniformity, and efficiency, and of maintaining a harmony of purpose and effort with the Board and with the community and of establishing a framework for governance of the Medical Staff and its accountability to the Board. These Bylaws may not conflict with the Governing Board Bylaws.

### **15.2 METHODOLOGY.**

Bylaws shall be adopted, amended or repealed only by the following combined action:

15.2.1 Medical Staff. The affirmative vote of a majority of Staff Members eligible to vote on this matter who are present and voting at a meeting at which a quorum of sixty-seven percent (67%) is present, provided that at least ten days' written notice, accompanied by the proposed Bylaws and/or alterations, has been given of the intention to take such action; and

15.2.2 Board. The Medical Staff Bylaws may be adopted, amended or repealed by the affirmative vote of a majority of the Board after receiving the recommendations of the Medical Staff. If the Medical Staff fails to act within a reasonable time after notice from the Board to such effect, the Board may resort to its own initiative in formulating or amending Medical Staff Bylaws when necessary to provide for protection of patient welfare or when necessary to comply with accreditation standards or applicable law. However, should the Board act upon its own initiative as provided in this paragraph, it shall consult with the Medical Staff at the next regular staff meeting (or at a special called meeting as provided in these bylaws), and shall advise the staff of the basis for its action in this regard.

## **ARTICLE 16 NO CONTRACTUAL RIGHTS CREATED**

Notwithstanding anything to the contrary herein, it is understood and agreed that nothing contained in these Bylaws shall create in fact, by implication or otherwise, a contract of any nature between the Medical Staff, any Member of the Medical Staff, anyone exercising Temporary Privileges, any Resident, any Intern, or any Allied Health Professional and the Facility or the Board.

## **ARTICLE 17**

**HISTORY & PHYSICALS**

**A medical history and physical examination to be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician (as defined in section 1861(r) of the Act) or other qualified medically licensed individual in accordance with State law and hospital policy.**

Approved by the Medical Staff

By: \_\_\_\_\_ Date: \_\_\_\_\_

Adopted by the Governing Board

By: \_\_\_\_\_ Date: \_\_\_\_\_