

# **MEDICAL STAFF BYLAWS**

*Medical Staff  
Sycamore Medical Center  
Miamisburg, Ohio*

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## DEFINITIONS

**Affiliate Hospital** means Sycamore Hospital (including the Behavioral Medicine Center).

**Allied Health Professional** or "AHP" means an individual other than a licensed Physician (allopathic or osteopathic), Podiatrist, Dentist, or Psychologist who functions in a medical support role or who exercises independent judgment within the area of his or her professional competence and is qualified to render direct or indirect medical, surgical, nursing, dental, podiatric, or psychological care under the supervision of or in collaboration with a Practitioner who has been accorded privileges for such care in the Hospital. These AHPs may include, but are not limited to, physician's assistants, advanced nurse practitioners, or other individuals whose scope of practice has been recognized by the Hospital.

**Appointee** means a Practitioner who has been granted membership to the Medical Staff as defined by the assigned staff category.

**Board of Directors** or **Board** means the board of directors of Kettering Medical Center.

**Chief Executive Officer/President** or **President/CEO** means the individual appointed by the Board of Directors to act on its behalf in the overall management of the Hospital. The Medical Staff may rely upon all actions of the President/CEO as being authorized by the Board of Directors.

**Chief of Staff** means the individual elected by the Medical Staff to be the spokesperson for the Medical Staff and chair of the Medical Executive Committee.

**Clinical Privileges** or **Privileges** means the authorization granted by the Board of Directors to a **Practitioner or AHP** to provide specific patient care services at the Hospital within defined limits.

**Clinical Service** means a group of Appointees who share a specialized commonality or clinical perspective and who have been established and/or recognized by the Medical Executive Committee. Appointees are assigned to a Clinical Service as delineated in the Credentials Manual.

**Clinical Service Chief** means the individual selected by members of a Clinical Service to manage the affairs of the Clinical Service.

**Dentist** means an individual who has received a doctor of dental medicine or doctor of dental surgery degree and is currently licensed to practice Dentistry and whose practice is in the area of oral and maxillofacial surgery or the area of general Dentistry or a specialty thereof.

**Department** means a department of the Hospital. The term does not refer to a clinical division of the Medical Staff as the Medical Staff is divided into clinical services.

**Emergency Department Call** means a process whereby patients who do not have an attending Practitioner may be provided medical care services by a Practitioner scheduled to be available to

provide that service and who is capable of admitting and providing the level of medical care required during a patient's hospitalization.

*Ex Officio* means appointment to a body by virtue of an office or position held. *Ex Officio* members shall not be counted for purposes of determining a quorum nor shall they have voting rights unless a specific provision provides otherwise.

**Federal Health Program** means Medicare, Medicaid, TriCare, or any other federal or state program providing health care benefits that is funded directly or indirectly by the United States government.

**Good Standing** means absence of disciplinary actions.

**Hospital** means Sycamore Medical Center.

**Joint Conference** means an ad hoc committee of officers of the Medical Staff and officers of the Board of Directors.

**Manual** means those documents approved by the Medical Executive Committee and the Board which serve to implement and supplement the Medical Staff Bylaws including, but not limited to, the Medical Staff Credentials manual and the Medical Staff Organization Manual.

**Medical Executive Committee** or **MEC** means the executive committee of the Medical Staff.

**Medical Staff** means all allopathic Physicians, osteopathic Physicians, Dentists (including oral maxillofacial surgeons), Podiatrists, and Psychologists who have obtained appointment status at the Hospital with such responsibilities, prerogatives, and privileges as defined in the category to which each has been appointed.

**Medical Staff Bylaws** or **Bylaws** means the articles and amendments that constitute the basic governing documents of the Medical Staff.

**Medical Staff Year** means the period from January 1 to December 31 each year.

**Oral Surgeon** or **Maxillofacial Surgeon** means a practitioner who has successfully completed an accredited post-graduate/residency program in oral/maxillofacial surgery.

**Organized Medical Staff** means Active Staff.

**Patient Encounter** means (a) in the inpatient setting, an inpatient admission, consultation (resulting in not less than a progress note, or surgery/invasive procedure; (b) in the outpatient setting, treatment or consultation resulting in not less than a progress note, or surgery/invasive procedure; or (c) treatment in the Emergency Department resulting in not less than a progress note.

**Physician** means an individual who has received a doctor of allopathy degree or doctor of osteopathy degree.

**Podiatrist** means an individual who has received a doctor of podiatric medicine (D.P.M.) degree.

**Practitioner** means, unless otherwise expressly provided, a Physician, Dentist, Podiatrist, or Psychologist.

**Prerogative** means the right to participate, by virtue of Medical Staff category or otherwise, granted to an Appointee or Allied Health Professional, and subject to the ultimate authority of the Board, and the conditions and limitations imposed in these Bylaws and in other Hospital and Medical Staff policies.

**Professional Liability Insurance** means insurance coverage acceptable to the Board as the Board may determine from time to time by an insurance company licensed in the United States or having coverage by a company who has an underwriting agreement with a licensed U.S. insurance company to assure adequate reserves for payment of claims.

**Professional Review Activity** means an activity of a health care entity (as defined in the federal Health Care Quality Improvement Act of 1986 (HCQIA) and sections 2305.25 of the Ohio Revised Code) with respect to a Practitioner: to determine whether such Practitioner may have clinical privileges with respect to, or membership in, the health care entity; or to determine the scope or conditions of such privileges or membership; or to change or modify such privileges or membership; or for purposes as set forth in the Ohio Revised Code.

**Professional Review Body** means a health care entity and the governing body or any committee of a health care entity which conducts professional review activity, and includes, but is not limited to, any committee of the medical staff of such an entity when assisting the governing body in a professional review activity, and other committees as defined by section 2305.25 and as used in sections 2305.251 to 2305.253 of the Ohio Revised Code.

**Psychologist** means an individual with a doctoral degree in psychology or a doctoral degree deemed equivalent by the Ohio State Board of Psychology who is currently licensed to practice psychology.

**Rules & Regulations** means the compendium of rules and regulations promulgated by the Medical Staff as approved by the Board to govern specific administrative and patient care issues that arise at the Hospital.

**Special Notice** means written notice (a) sent by certified mail, return receipt requested; or (b) delivered personally with the affected individual either signing as proof of receipt or other written documentation from the individual delivering the notice as to why signature was not obtained.

**Telemedicine** means the use of medical information exchanged from one site to another via electronic communications for the health and education of the patient or healthcare provider, and for the purpose of improving patient care.

**Vice President Medical Affairs** means the practitioner appointed by the Board or designee, in conjunction with the medical staff, to act in this capacity.

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

Whenever an individual is authorized to perform a duty by virtue of his or her position, then the term shall also include the individual's designee.

In computing any period of time set forth in the Medical Staff governing documents, the date of the act 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 legal holiday, in which event the period runs until the end of the next day which is not a Saturday, Sunday, or legal holiday. When the period of time is less than seven (7) days, intermediate Saturdays, Sundays, and legal holidays shall be excluded.

ARTICLE 1.  
PREAMBLE & PURPOSES

These Bylaws, as adopted or amended, create a system of mutual rights and responsibilities between Practitioners and the Hospital, and are subject to the corporate authority of the Board in those matters where the Board has ultimate legal responsibility. These Bylaws are not intended to be and are not to be construed as a contract.

The purposes of this Medical Staff are to:

- (a) Provide a mechanism for accountability to the Board through defined organizational components and positions for the appropriateness of patient care services and the professional and ethical conduct of each Practitioner appointed to the Medical Staff and each Practitioner/AHP granted Privileges at the Hospital, to the end that patient care provided at the Hospital is maintained at that level of quality and efficiency which is commensurate with, or superior to, generally recognized standards of care.
- (b) To serve as the collegial body through which Practitioners and AHPs may, as applicable, obtain Prerogatives and Privileges at the Hospital, fulfill their obligations of Medical Staff appointment and/or Privileges, and practice in an environment that promotes quality and efficient patient care.
- (c) To provide on behalf of the Hospital an appropriate educational setting and to maintain high scientific and educational standards for continuing medical education programs for Practitioners.
- (d) To provide an orderly and systematic means by which Appointees can give input to the Board and President/CEO on medico-administrative problems and on the Hospital's policy-making and planning processes.
- (e) To initiate, maintain, and enforce the Medical Staff Bylaws, other related medical staff governance documents and policies for self-governing of the Medical Staff.
- (f) Assume accountability to the Board for the quality of medical care provided by an Appointee to the patients, which may include the following:
  - Acting on reports of clinical services and committees of the Medical Staff;
  - Provide reports to the Board regarding medical staff appointments, reappointments, and privilege delineations;
  - Provide reports to the Board regarding medical staff behaviors that result in suspension or other corrective action, and any fair hearing results;
  - Provide reports to the Board of organizational proposals including, Bylaws and other related manuals of the Medical Staff and Medical Staff Officers;

- Accountability to the Board for findings from ongoing professional practice evaluations of the clinical work of the Medical Staff; and
- Collaborating with administration and the Board regarding institutional planning, budgeting and appropriate utilization of available resources.

ARTICLE 2.  
MEDICAL STAFF APPOINTMENT

SECTION 2.1. NATURE OF MEDICAL STAFF APPOINTMENT

Appointment to the Medical Staff and/or granting of Privileges at the Hospital is a privilege that shall be extended only to professionally competent Practitioners who continuously meet the qualifications, standards, and requirements set forth in these Bylaws. Appointment to the Medical Staff is separate and distinct from a grant of Privileges. A Practitioner can be a Medical Staff Appointee with Privileges; a Medical Staff Appointee without Privileges; or be granted Privileges without a Medical Staff appointment. A Practitioner who is granted Medical Staff appointment is entitled to such Prerogatives and is responsible for fulfilling such obligations as set forth in these Bylaws and the Medical Staff category to which the Practitioner is appointed. Medical Staff appointment shall confer only such Privileges as are granted in accordance with these Bylaws. A Practitioner who is granted Privileges at the Hospital is entitled to exercise such Privileges and is responsible for fulfilling such obligations as set forth in these Bylaws and the applicable Privilege set.

SECTION 2.2. QUALIFICATIONS FOR APPOINTMENT

2.2.1. In General. Only Physicians, Dentists, Psychologists, or Podiatrists, holding a license to practice in the State of Ohio; who can document their background, licensure, experience, training/education, judgment, individual character, and demonstrated current competence; ability to exercise the privileges requested with or without a reasonable accommodation (health status); adherence to the ethics of their profession; and ability to work cooperatively with others with sufficient adequacy to assure the Medical Staff and the Board that any patient treated by them in the Hospital will be given a high quality of health care, shall be qualified for appointment to the Medical Staff. Any criminal records check that is performed must not evidence convictions of certain offenses that would act to disqualify an applicant from consideration for appointment or reappointment to the Medical Staff. No practitioner, including those in a medico-administrative position by virtue of a contract with the Hospital, shall treat or otherwise provide medical care to a patient in the Hospital unless the practitioner is an Appointee and has been granted privileges to do so. No practitioner shall be entitled to appointment to the Medical Staff or to exercise privileges in the Hospital merely by virtue of the fact that the practitioner is duly licensed to practice medicine, dentistry, psychology, or podiatry in this or any other state; or solely based upon certification, fellowship or membership in a specialty body or society; or that the practitioner had in the past, or now has, such privileges at another hospital.

2.2.2. Eligibility.

- (a) Proof of professional liability insurance consistent with the amount specified by the Board.
- (b) Proof of current licensure or registration and verification of not currently being excluded for cause by the secretary of Health and Human Services from

participation in any Federal Health Program as a provider, pursuant to Sec. 1128 (42 U.S.C. 1320a-7).

- (c) For appointment of a Physician or Podiatrist to the active or courtesy Medical Staff category, documentation of experience and training, including completion of a residency approved by Accreditation Council for Graduate Medical Education (ACGME”), American Board of Medical Specialties (“ABMS”), or American Osteopathic Association (“AOA”). Physicians and Podiatrists who have been on the Medical Staff prior to January 1, 1996 are not obligated to meet this requirement.
- (d) For appointment of a Physician or Podiatrist to the active or courtesy Medical Staff category, applicants must be within six (6) years of completing their residency program or possess current board certification as specified by the ABMS, AOA, American Board of Oral & Maxillofacial Surgery (“ABOMS”), American Board of Podiatric Surgery (“ABPS”), or the American Board of Podiatric Primary Medicine and Orthopedics (ABPPMO). Those applicants (excluding Dentists and Psychologists) who do not possess current board certification at initial appointment must obtain board certification within six (6) years of completing his/her residency program to maintain appointment to the Medical Staff and Privileges. Physicians and Podiatrists who have been on the Medical Staff since January 1, 1996 are not obligated to meet this requirement.
- (e) All applicants must evidence good moral character as evidenced, in part, by the absence of convictions for certain criminal offenses.

### SECTION 2.3. NONDISCRIMINATION

Neither the Hospital nor its Medical Staff will discriminate in granting Medical Staff appointment or privileges on the basis of sex, race, creed, national origin, and handicap or other considerations not impacting the applicant’s ability to discharge the privileges for which he/she has applied.

### SECTION 2.4. CONDITIONS AND DURATION OF APPOINTMENT

2.4.1. Appointment and Reappointment. Initial appointment and reappointment to the Medical Staff and the granting/regranting of Privileges shall be made by the Board of Directors and as otherwise provided in these Bylaws. The Board shall act on appointment, reappointment, and Privileges only after there has been a recommendation from the Medical Executive Committee or as otherwise provided in these Bylaws. All individuals and committees required to act on an application for Medical Staff appointment must do so in a timely manner and, except for good cause, each application should be processed within one hundred twenty (120) days from receipt of an application determined to be complete.

- 2.4.2. Term. Appointments to the Medical Staff and grants of privileges will be for no more than twenty-four (24) calendar months. Appointments and/or grants of privileges for a period of less than twenty-four (24) calendar months shall not be deemed adverse.
- 2.4.3. Prerogatives. Appointment to the Medical Staff shall confer on the Appointee only prerogatives as have been granted in accordance with these Bylaws.

#### SECTION 2.5. MEDICAL STAFF DUES

- 2.5.1. Dues. Annual Medical Staff dues shall be governed by the most recent action recommended by the Medical Executive Committee and adopted at a regular or special Medical Staff meeting. The Chief of Staff shall notify each Appointee, in writing, of any contemplated change in Medical Staff dues at least twenty-one (21) days before the meeting at which voting on such proposed change is to take place.
- 2.5.2. Exceptions. Consulting Peer Review, Retired, and Honorary Medical Staff Appointees are not required to pay dues.
- 2.5.3. Payment. Dues, if required, shall be due and payable within thirty (30) days of written request. A failure to pay Medical Staff dues within the required time frame shall be construed as a voluntary resignation from the Medical Staff.

#### SECTION 2.6. ETHICAL REQUIREMENTS

A practitioner who accepts appointment to the Medical Staff and/or privileges agrees to act in an ethical, professional, and courteous manner consistent with the Hospital's code of ethics as well as any applicable ethics of the practitioner's professional association and related Hospital and Medical Staff Bylaw provisions and policies.

No Appointee shall either receive from or pay to another physician, either directly or indirectly, any part of a fee received for professional services that are in violation of applicable state and federal laws and regulations.

#### SECTION 2.7. RESPONSIBILITIES OF APPOINTMENT & EXERCISE OF PRIVILEGES

Each Appointee may independently direct the care of his/her patients within the scope of the Appointee's privileges subject to the Medical Staff Bylaws, Organization Manual, Credentials Manual, and any other applicable policies. Each Appointee is subject to review as a part of the Hospital's performance improvement activities. No Appointee is responsible for the actions of other Appointees or AHPs unless the individual is practicing in collaboration with or under the supervision of such Appointee. No Appointee is responsible for the actions of Hospital employees unless the Appointee contracts, in writing, to undertake such responsibility.

SECTION 2.8. QUALIFICATIONS/RESPONSIBILITIES FOR APPOINTMENT  
WITHOUT PRIVILEGES

Practitioners appointed to non-privileged Medical Staff categories shall meet such qualifications and fulfill such obligations as set forth in the applicable Medical Staff category, and/or as otherwise recommended by the MEC and approved by the Board.

ARTICLE 3.  
CATEGORIES OF THE MEDICAL STAFF

SECTION 3.1. ACTIVE MEDICAL STAFF

Appointment to the active Medical Staff will be provisional for at least one (1) year pending satisfactory clinical performance and fulfillment of other Medical Staff requirements as determined by the Credentials Committee and Medical Executive Committee, and as approved by the Board. Active Appointees consist of those Physicians, Dentists, Podiatrists, and Psychologists who engage in significant clinical practice at the Hospital. Hospital-based Practitioners (including but not limited to anesthesiologists, emergency medicine physicians, nuclear medicine physicians, pathologists, radiologists, and radiation oncologists) who are either employed by the Hospital or have exclusive contracts for the provision of patient care at the Hospital must meet the qualifications for active Medical Staff.

3.1.1. Qualifications. Appointees to this category must:

- (a) Meet all qualifications for Medical Staff appointment as set forth in Section 2.2.
- (b) Actively participate in Medical Staff activities and responsibilities, such as committee and Clinical Service assignments.
- (c) Provide evidence of clinical performance at all other hospitals in which they practice in such form as the Hospital may reasonably request. In addition, they shall provide other information as the Hospital may reasonably require in order to be able to appropriately evaluate the Appointee's qualifications.

3.1.2. Prerogatives. Appointees to this category may:

- (a) Admit, treat and consult on patients without limitation, in accordance with the Privileges granted, except as otherwise provided in the Medical Staff Rules & Regulations or by specific privilege restriction.
- (b) Attend meetings of the Medical Staff and of the Clinical Service of which the Practitioner is member as well as Medical Staff or Hospital education programs.
- (c) Vote on all matters presented at general and special meetings of the Medical Staff, and of the Clinical Service and committee(s) of which the practitioner is a member.
- (d) Hold Medical Staff office, serve as a Clinical Service Chief, and sit on or be the chair of any committee, unless otherwise specified in these Bylaws.
- (e) Participate in Hospital and Medical Staff education programs as appropriate.

3.1.3. Responsibilities. Appointees to this category must:

- (a) Contribute to the organization and administrative affairs of the Medical Staff.
- (b) Actively participate in recognized functions of Medical Staff appointment, including performance improvement, peer review, and other monitoring activities; proctor Appointees during their provisional period or when new privileges are granted; and discharge other Medical Staff functions as may be required from time to time.
- (c) Participate in the care of unassigned patients, Emergency Department Call, consultation and other specialty coverage programs, as requested by the Medical Staff, Administration or Board. Appointees with unique or scarce expertise are expected to collegially assist other Appointees when urgent patient care needs arise. This assistance is not intended to be unreasonably burdensome. Active Appointees who receive “refer and follow” privileges only shall not be required to comply with this requirement.
- (d) Attend applicable meetings.
- (e) Serve on Medical Staff committees, as assigned.
- (f) Faithfully perform the duties of any office or position to which elected or appointed.
- (g) Must pay all application fees, dues, and assessments that may be enacted by the Medical Executive Committee.

SECTION 3.2. COURTESY MEDICAL STAFF

Appointment to the Courtesy Medical Staff will be provisional for at least one (1) year pending satisfactory clinical performance and fulfillment of other Medical Staff requirements as determined by the Credentials Committee and Medical Executive Committee, and approved by the Board.

3.2.1. Qualifications. Appointees to this category must:

- (a) Meet all qualifications for Medical Staff appointment as set forth Article II, Section 2.
- (b) Have not more than fifty (50) Patient Encounters in a consecutive twenty-four (24) month period (not including referrals to the Hospital's diagnostic facilities, access to which is unlimited). Appointees that have more than fifty (50) Patient Encounters will automatically be transferred to the Active Medical Staff.
- (c) Provide evidence of clinical performance at all other hospitals in which they practice, in such form as the Hospital may reasonably request. In addition, they

shall provide other information as the Hospital may reasonably require in order to be able to appropriately evaluate the Appointee's qualifications.

3.2.2. Prerogatives. Appointees to this category:

- (a) May admit, treat, and consult on patients without limitation, based on applicable Privileges, except as otherwise provided in the Medical Staff Rules & Regulations, or by specific Privilege restriction.
- (b) May attend Medical Staff meetings (without vote).
- (c) May attend applicable Clinical Service meetings (without vote).
- (d) May be invited to serve on committees (with vote).
- (e) May not hold office or serve as a Clinical Service Chief or committee chair.
- (f) Is excused from the care of unassigned patients and from Emergency Department Call (unless there is a determination by the applicable Clinical Service Chief, Medical Executive Committee, Administration and/or the Board that courtesy Medical Staff Appointees of a particular Clinical Service must participate in these responsibilities).
- (g) Must participate in performance improvement, monitoring, and peer review activities, including responding fully and timely to any inquiries regarding the care of patients.
- (h) Must pay all application fees, dues and assessments, which may be enacted upon by the Medical Executive Committee.

3.2.3. Responsibilities. Appointees to this category have the same responsibilities as active Medical Staff, if requested.

## SECTION 3.3. ASSOCIATE MEDICAL STAFF

### 3.3.1. Membership Only

3.3.1.1. Qualifications. Appointees to this category shall consist of those practitioners who desire to be affiliated with the Hospital, but who do not intend to provide patient care at the Hospital. The primary purpose of the Associate Medical Staff - Membership is to promote professional and educational opportunities, including continuing medical education endeavors, and to allow such practitioners to refer patients to other Appointees for admission, evaluation, and/or care and treatment. Appointees to this category must meet the general qualifications for appointment but shall not be required to maintain professional

liability insurance or to otherwise provide documentation establishing current clinical competence.

3.3.1.2. Prerogatives. Appointees to this category:

- (a) May attend meetings of the Medical Staff and appropriate Clinical Service (without vote).
- (b) Have no Medical Staff committee responsibilities, but may be assigned to special committees (with vote).
- (c) May attend educational programs of the Medical Staff.
- (d) May refer patients to Appointees of the active and courtesy Medical Staff for admission and/or treatment.
- (e) May visit their patients when hospitalized and review their medical records (provided the patient consents), but may not write orders, make medical record entries, or otherwise actively participate in the provision or management of care to patients.
- (f) May refer patients to the Hospital's diagnostic and treatment facilities.
- (g) May not be granted privileges and may not admit or treat patients at the Hospital.

3.3.1.3. Responsibilities. Appointees to this category:

- (a) Must pay all application fees, dues and assessments that are enacted by the Medical Executive Committee.

3.3.2. Clinical Privileges Only

3.3.2.1. Qualifications. Appointees to this category shall consist of those practitioners who desire to have clinical privileges with the Hospital, but who do not desire medical staff membership. The purpose of the Associate Medical Staff – Clinical Privileges is limited to those practitioners who desire to provide health care services to patients in either a locum tenens and/or proctoring capacity or residents who desire an opportunity to obtain privileges to moonlight in the Emergency Services Department.

- (a) Appointees to this category must meet all qualifications for Medical Staff appointment as set forth in Article II, Section 2. with the exception of residents who will not have yet fulfilled the criteria in Article II, Section 2.2.2 (c) and (d).
- (b) Provide evidence of clinical performance at all other hospitals and healthcare organizations in which they practice, in such form as the

Hospital may reasonable request. In addition, they shall provide other information as the Hospital may reasonably require in order to be able to appropriately evaluate the Appointee's qualifications.

3.3.2.2. Prerogatives. Appointees to this category:

- (a) Admit and consult on patients without limitation, except as otherwise provided in the Medical Staff Rules & Regulations or by specific privilege restriction.
- (b) Participate in Hospital and Medical Staff education programs as appropriate.
- (c) Have no Medical Staff committee responsibilities, but may be assigned to special committees (with vote).
- (d) May refer patients to Appointees of the active and courtesy Medical Staff for admission and/or treatment.

3.3.2.3. Responsibilities. Appointees to this category:

- (a) Participate in the care of unassigned patients, Emergency Department Call, consultation and other specialty coverage programs, as requested by the Medical Staff, Administration or Board. Medical Staff members with unique or scarce expertise are expected to collegially assist other medical staff members when urgent patient care needs arise. This assistance is not intended to be unreasonably burdensome.
- (b) Attend applicable meetings.
- (c) Must pay all application fees, dues and assessments, which may be enacted upon by the Medical Executive Committee.

## SECTION 3.4. AFFILIATE MEDICAL STAFF

Appointment to the Affiliate Medical Staff is for Practitioners who are appointed to the active staff at an Affiliate Hospital. Appointments to this category will be automatic upon appointment to the active staff at an Affiliate Hospital and shall be without Privileges. The primary purpose of this category is to provide for broad collaboration between affiliate medical staffs to promote and further effective peer review and quality of care to patients. Practitioners automatically appointed to this category may apply for Medical Staff appointment in a different category if they qualify and desire to be so appointed or seek Clinical Privileges.

3.4.1. Qualifications. An Affiliate Medical Staff Appointee must meet the following criteria:

- (a) Have an active appointment with Privileges at an Affiliate Hospital.

### 3.4.2. Prerogatives.

- (a) May attend meetings of the Medical Staff and appropriate Clinical Service (without vote).
- (b) Have no Medical Staff committee responsibilities, but may be assigned to special committees (with vote).
- (c) May attend educational programs of the Medical Staff.
- (d) May refer patients to Appointees of the active and courtesy Medical Staff for admission and/or treatment.
- (e) May visit their patients when hospitalized and review their medical records (provided the patient consents), but may not write orders, make medical record entries, or otherwise actively participate in the provision or management of care to patients.
- (f) May refer patients to the Hospital's diagnostic and treatment facilities.
- (g) May not be granted privileges and may not admit or treat patients at the Hospital.
- (h) May not hold Medical Staff office or serve as a Clinical Service Chief, except that they may serve as Vice Chief at Large.

### 3.4.3. Responsibilities.

- (a) If requested, serve on committees (including acting as committee chair) with vote.

## SECTION 3.5. CONSULTING PEER REVIEW MEDICAL STAFF

3.5.1. Qualifications. A consulting peer review Medical Staff Appointee must meet the following criteria:

- (a) Practice either locally or in another city and state in which he or she has a valid license to practice.
- (b) Possess specialized skills needed at the Hospital for a specific project or on an occasional basis when requested by Hospital administration, Chief of Staff/designee, Medical Staff committee or the Board.
- (c) Demonstrate active participation on the active medical staff at another Hospital requiring performance improvement/quality assessment activities similar to those of this Hospital unless the nature of the services being requested do not require that the individual have such experience.

3.5.2. Prerogatives. Appointees to this category:

- (a) May review selected medical record components, organization information, and peer review materials retained by the Hospital for the purpose of rendering an opinion on the quality of health care rendered to patients at the Hospital or otherwise perform related peer review services as specifically requested.
- (b) May be requested to attend Medical Staff meetings or attend certain committee or Clinical Service meetings.
- (c) May not be granted Privileges and may not admit or treat patients to the Hospital.
- (d) May not be permitted to hold office or to vote.

3.5.3. Responsibilities. A consulting peer review Medical Staff Appointee shall perform such duties as are requested and which he or she agrees to perform.

### SECTION 3.6. PROBATIONARY MEDICAL STAFF STATUS

The Medical Executive Committee may impose a probationary Medical Staff status (different than the provisional period required for the first year of active and courtesy Medical Staff categories) for corrective action issues related to privileges and/or for non-clinical reasons. The Medical Executive Committee shall define the time period (not longer than one (1) year) and the expected requirements of a successful probationary period. If the Appointee does not successfully fulfill the requirements of the probationary period as determined by the Medical Executive Committee, the Medical Executive Committee may initiate corrective action in accordance with these Bylaws.

### SECTION 3.7. RETIRED MEDICAL STAFF

3.7.1. Qualifications. The retired Medical Staff shall consist of practitioners who have retired from active practice and who, at the time of their retirement, were Appointees in good standing to the Medical Staff, and who continue to adhere to appropriate professional and ethical standards. They shall have no privileges and shall be exempt from all Medical Staff qualifications and requirements. Requests for appointment to the Retired Staff will be directed to the MEC and shall be a lifetime appointment.

3.7.2. Prerogatives. Appointees to this category:

- (a) Shall not be eligible to have Privileges, to vote, to hold office, or to serve on standing Medical Staff Committees.
- (b) May attend educational programs at the Hospital.
- (c) May be requested to sit on an ad hoc committee of the Medical Staff. If so appointed, they may participate on such committee with vote.

3.7.3. Responsibilities. Appointees to this category shall have no responsibilities other than, if appointed to a committee, to act consistent with that committee's responsibilities.

#### SECTION 3.8. THE HONORARY MEDICAL STAFF

3.8.1. Qualifications. The honorary Medical Staff shall consist of those previous Appointees who have retired from active practice, have served on the active Medical Staff for a minimum of ten (10) years, and have either contributed in an outstanding manner through leadership positions at the Hospital or through significant service to the community. They may be granted honorary Medical Staff status upon the recommendation of the Chief of Staff, supported by the Medical Executive Committee, with the approval of the Board. They shall have no privileges and shall be exempt from all Medical Staff qualifications and requirements. Requests for appointment to the honorary Medical Staff should be directed to the MEC for recommendation to the Board.

3.8.2. Prerogatives. Appointees to this category:

- (a) Shall not be eligible to have Privileges, to vote, to hold office, or to serve on standing Medical Staff Committees.
- (b) May attend educational programs at the Hospital.
- (c) May be requested to sit on an ad hoc committee of the Medical Staff. If so appointed, they may participate on such committee with vote.

3.8.3. Responsibilities. Appointees to this category shall have no responsibilities other than, if appointed to a committee, to act consistent with that committee's responsibilities.

## ARTICLE 4. OFFICERS

### SECTION 4.1. OFFICERS OF THE MEDICAL STAFF

4.1.1. The officers of the Medical Staff shall be:

- Chief of Staff
- Chief of Staff Elect
- Vice Chief Medical Staff Credentials Program
- Vice Chief at Large

### SECTION 4.2. QUALIFICATION OF OFFICERS

4.2.1. Officers must:

- (a) Be current Appointees to the active Medical Staff.
- (b) Have been on the active Medical Staff for at least the previous five (5) consecutive years.
- (c) Be in Good Standing at the time of nomination and election.
- (d) Remain active Appointees in Good Standing during their terms of office.
- (e) Be board certified as specified by the ABMS, AOA, ABOMS, ABPS or ABPPMO.

Officers may not simultaneously hold leadership positions at another hospital other than a leadership position at an Affiliate Hospital.

### SECTION 4.3. ELECTION OF OFFICERS

- 4.3.1. General. Officers shall be elected bi-annually at a meeting of the Medical Staff. Only active Appointees shall be eligible to vote. Upon completion of the Chief of Staff term, the Chief of Staff Elect automatically becomes Chief of staff.
- 4.3.2. Nominating Committee. The nominating committee shall be appointed by the MEC and shall consist of the Chief of Staff, the Chief of Staff Elect, three (2) other members of the Medical Executive Committee, two(3) other active Appointees who are not then members of the MEC. The nominating committee will present a panel of candidates to the MEC for approval no later than two (2) months prior to the meeting at which the election shall be held. When approved, the names of the nominees will be distributed to all active Appointees.
- 4.3.3. Additional Nominations. Within thirty (30) days of distribution, additional nominations may also be made by petition signed by either ten percent (10%) of active Appointees or

fifty (50) active Appointees, whichever is less. Such petition must be submitted to the Chief of Staff who shall then include these nominations on the distributed ballot.

4.3.4. Ballots. Ballots will be mailed to active Appointees no later than thirty (30) days prior to the annual meeting. Ballots must be received by the Medical Staff Office no later than seven (7) days prior to the meeting at which the election is to be held.

4.3.5. Disclosure of Conflicts. All nominees for election or appointment to Medical Staff offices at the time of nomination shall disclose in writing to the MEC those personal, professional, or financial affiliations or relationships of which they are reasonably aware that could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff. Such disclosures will be provided with the ballot.

#### SECTION 4.4. TERM OF OFFICE

All elected officers will serve a term of two (2) years. Officers shall take office on the first day of the calendar year. The number of consecutive terms a person may serve as an officer shall be limited to three (3) at the discretion of the nominating committee.

#### SECTION 4.5. VACANCIES IN OFFICE

Vacancies in office during the Medical Staff year, except the office of the Chief of Staff, shall be filled by the MEC. If there is a vacancy in the office of the Chief of Staff, the Chief of Staff Elect shall serve the remainder of the term, and then may serve his or her own term as Chief of Staff.

#### SECTION 4.6. DUTIES OF OFFICERS

4.6.1. Chief of Staff. The purpose of this position is to provide overall leadership and guidance to the Medical Staff. Additionally, it is essential that the Chief of Staff will promote effective communications among the Medical Staff, Medical Executive Committee, Administration, and the Board. The individual occupying this position will be responsible for bylaws implementation, Medical Staff involvement in securing and maintaining Hospital accreditation, providing information to the Board concerning matters that pertain to the care and treatment of patients and generally facilitating positive relationships among administration, the Medical Staff and other support services of the institution.

4.6.2. Chief of Staff-Elect. The purpose of this position is to provide continuity in leadership during times when the Chief of Staff is absent or otherwise unable to perform his/her assigned functions. The Chief of Staff-Elect will be expected to remain knowledgeable about all Medical Staff issues of current Medical Staff interest. At the conclusion of the term of the Chief of Staff, the Chief of Staff-Elect will succeed as Chief of Staff.

4.6.3. Vice Chief, Medical Staff Credentials Program. To provide oversight for the Credentials Program of KMC and direction to the hospital Board of Directors in credentialing members of the Medical Staff. To maintain compliance with the credentialing policies of the hospital, applicable accrediting body and applicable law.

4.6.4. Vice Chief at Large. The purpose of this office is to serve as Secretary/Treasurer for the Medical Staff as well as other duties that may be assigned by the Chief of Staff.

*Please refer to the Organization Manual for details as to the position requirements, accountabilities and functions.*

#### SECTION 4.7. REMOVAL FROM OFFICE

Any officer of the Medical Staff may resign at any time by giving written notice to the Medical Executive Committee. Such resignation shall take effect on the date of receipt or at any later time specified therein.

Any officer of the Medical Staff may be removed from office for conduct detrimental to the interests of the Medical Staff (malfeasance in office) or for failure to fulfill the duties of the office. A request for the removal of any officer must be made in writing by the Hospital Board, the Medical Executive Committee or twenty-five percent (25%) of the active Appointees to the Medical Staff Services Department. The request for removal shall state the basis for the request and shall be signed by an appropriate member of the Hospital Board, the Medical Executive Committee or a petition signed by each of the Medical Staff members requesting the removal. The Medical Staff Services Department shall deliver a copy of the written request to the officer. Within thirty (30) days of receiving said request, the Medical Staff shall vote by a written ballot. No officer shall be removed from office without a majority vote in favor of removal by active Appointees. Any officer removed under this provision shall have access to the hearing and appeal process set forth in Article 9.

ARTICLE 5.  
MEDICAL STAFF STRUCTURE

SECTION 5.1. ORGANIZATION OF THE MEDICAL STAFF

5.1.1. Medical Executive Committee. The Medical Staff shall be non-departmentalized. The MEC shall be responsible for the promotion of quality of care at the Hospital and reviewing the professional performance of Practitioners and AHPs rendering care at the Hospital. The MEC shall constitute the governing body of the Medical Staff as described in these Bylaws.

5.1.2. Clinical Services. The following groups of Practitioners have been organized into Clinical Services:

- Anesthesiology
- Cardiology
- Emergency Medicine
- Family Medicine
- Diagnostic Radiology
- Internal Medicine
- Obstetrics/Gynecology
- Orthopedics
- Pathology
- Pediatrics
- Surgery

Other groups may elect to organize in the future with the approval of the Medical Executive Committee.

5.1.3. Organization. Organized Clinical Services must select a Clinical Service Chief and an assistant Clinical Service Chief, each to serve for a two (2) year term (which may be repeated for an unlimited number of terms). Should the Clinical Service be unable to elect a Chief or Assistant Chief, then the MEC will appoint an appointee to fulfill these positions.

5.1.4. Election Process

- (a) Clinical Service Chief will be elected by majority vote of the active members of the clinical service participating in the vote.
- (b) Six months prior to completion of the term of the Clinical Service Chief, the current clinical service chief will put forth a communication (i.e. memo, email, agenda item, etc.) calling for nominations.
- (c) 30 days prior to the next scheduled clinical service meeting, a ballot will be distributed to all active appointees within the clinical service for vote.
- (d) The results of the election will be announced at the next clinical service meeting.

## SECTION 5.2. MEDICAL STAFF CLINICAL SERVICE CHIEFS

### 5.2.1. Qualifications. Individuals occupying this position must:

- Be an active Appointee.
- Have been an active Appointee for at least the prior three (3) consecutive years.
- Board Certified within respective specialty.

### 5.2.2. Responsibilities. A Clinical Service Chief has the following responsibilities:

- (a) Overseeing all clinically related activities of the Clinical Service, including the development of applicable sections within the clinical service.

The Clinical Service Chief may, on his/her own initiative, organize a clinical sub-specialty service. The purpose of this sub-specialty service is to assist the clinical service chief in meeting his/her responsibilities as they relate to that particular sub-specialty. If so organized, the Clinical Service Chief shall appoint a chairperson. Such individual shall be an active Appointee and board certified within the sub-specialty. The clinical sub-specialty chairperson shall have the authority, upon consultation with Clinical Service Chief, to convene and chair meetings of such subspecialty providers to discuss specialty-specific matters as they relate to the responsibilities of the Clinical Service Chief.

- (b) Making recommendations to the Chief of Staff, as requested, on appointments of Clinical Service members to committees.
- (c) Recommending to the Medical Staff professional criteria for privileges that are relevant to the quality care provided in the Clinical Service.
- (d) Reviewing applications for initial appointment and reappointment as well as requested privileges for each practitioner and AHP assigned to the Clinical Service and for providing opinions to the Credentials Committee as to what action should be taken on the application.
- (e) Integrating the Clinical Service into the primary function of the Hospital.
- (f) Providing orientation and monitoring of the continuing education of all Practitioners and AHPs in the Clinical Service.

- (g) Coordinating and integrating services within the Clinical Service with other Clinical Services.
- (h) Overseeing all administratively related activities of the Clinical Service, unless otherwise provided for by the Hospital or the Medical Staff.
- (i) In conjunction with the Chief of Staff, accessing and recommending to the relevant Hospital authority off-site sources for needed patient care services not provided by the Clinical Service or the Hospital.
- (j) In conjunction with the Chief of Staff, developing and implementing policies and procedures that guide and support the provision of care, treatment and services.
- (k) In conjunction with the Chief of Staff, making recommendations for a sufficient number of qualified and competent persons to provide care, treatment or services.
- (l) In conjunction with the Chief of Staff, determining qualifications and competence of Hospital Department and Clinical Service personnel who are not licensed independent practitioners and who provide patient care, treatment and services.
- (m) In conjunction with the Chief of Staff, making recommendations for space, capital equipment, personnel, and other resources needed by the Clinical Service.
- (n) In conjunction with the Chief of Staff, providing continuing surveillance of the professional performance of all practitioners and AHPs in the Clinical Service.
- (o) In conjunction with the Chief of Staff, providing continuous assessment and improvement of the quality of care, treatment and services.
- (p) In conjunction with the Chief of Staff, assuring the maintenance of quality control programs, as appropriate.

### SECTION 5.3. ASSISTANT CLINICAL SERVICE CHIEF

#### 5.3.1. Qualifications. Individuals occupying this position must:

- Be an active Appointee.
- Have been an active Appointee for at least the past three (3) consecutive years.
- Board Certification within respective specialty.

5.3.2. Responsibilities. The Assistant Clinical Service Chief is responsible for (a) working with the Clinical Service Chief, for all clinically related activities of the Clinical Service; and (b) fulfilling the duties and responsibilities of the Clinical Service Chief in his/her absence.

#### SECTION 5.4. REMOVAL OF CLINICAL SERVICE CHIEF/ASSISTANT CHIEF

Clinical Service Chiefs/Assistant Chiefs may resign at any time by giving written notice to MEC. Such resignation shall take effect on the date of receipt, or at such later time as specified in the written notice. Clinical Service Chief/Assistant Chiefs may also be removed from their position by the MEC upon receipt of a recommendation of the majority of the active Appointees of the clinical service, or, in the absence of such recommendation, the MEC may remove a Clinical Service Chief on its own by a majority vote, of members present, if any of the following occurs:

- The Chief/Assistant Chief ceases to be an active member in good standing of the medical staff or to otherwise meet the qualifications for the position (i.e. failure to maintain board certification).
- The Chief/Assistant Chief suffers an involuntary loss or significant limitation of practice privileges.
- The Chief/Assistant Chief fails, in the opinion of the MEC, to demonstrate to the satisfaction of the MEC or Board that he or she is effectively carrying out the responsibilities of the position.

If removal and/or vacancy of the Clinical Service Chief is required, then the assistant chief automatically assumes the responsibilities of the Chief until a new election can be held or an appointment made by the MEC. If removal and/or vacancy of the Assistant Clinical Service Chief occurs, then a new election can be held or an appointment made by the MEC.

ARTICLE 6.  
MEDICAL EXECUTIVE COMMITTEE

6.1.1. Composition. The majority of voting members of the Medical Executive Committee must be doctors of medicine or osteopathy and will include the Chief of Staff, Chief of Staff Elect, immediate past Chief of Staff, Vice Chief Medical Staff Credentials Program, Vice Chief at Large, and representatives from each Clinical Service (selected by the members of each Clinical Service for a two year term). The President/CEO, Vice President Medical Affairs, Vice President Patient Care Services (CNO), Medical Staff representative to the Organized Medical Staff Section of the American Medical Association, Director of Medical Education and a member representing the Board of Directors will be members *Ex Officio*. The Chief of Staff of the Medical Staff serves as chair of the committee. All active Medical Staff Appointees, of any discipline or specialty, are eligible for membership on the MEC; provided, however, that, at all times, Physician Appointees of the active Medical Staff shall comprise at least a majority of the voting members of the MEC.

6.1.2. Duties. The duties of the Medical Executive Committee shall be to:

- (a) Represent and to act on behalf of the Medical Staff, in the intervals between general Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws.
- (b) Receive and act upon reports and recommendations from Medical Staff committees, joint Hospital/Medical Staff committees, Clinical Services, and assigned activities groups, and to make recommendation to the Board regarding the same, including the following Quality Assurance Performance Improvement (QAPI) functions:
  - Medication therapy, including antibiotic and non-antibiotics for all service types (inpatient, outpatient, ambulatory, and emergency care) of patients;
  - Infection control, including community acquired and healthcare acquired infections in patients and health care workers;
  - Surgical/invasive and manipulative procedures, including tissues and non-tissue producing cases, with and without anesthesia and/or moderate sedation;
  - Blood (including component) product usage;
  - Data management (accuracy, currency, transferability) with emphasis on medical record pertinence and timeliness;
  - Discharge planning and utilization review;

- Complaints regarding medical staff related issues;
  - Restraint/seclusion usage; and
  - Mortality review.
- (c) Coordinate, provide leadership, and implement the professional, clinical, performance improvement (including customer satisfaction and patient safety), and organization activities and policies of the Medical Staff including peer review, which helps to create and maintain a culture of safety and quality throughout the hospital.
  - (d) Act as liaison between the Medical Staff and the Chief of Staff.
  - (e) Recommend action to the Chief of Staff on matters of a medico-administrative nature and to recommend the Medical Staff organization structure to the Board of Directors.
  - (f) Make recommendations on Hospital management matters to the Board of Directors through its Professional Practice Committee.
  - (g) Ensure that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation and licensure status of the Hospital.
  - (h) Fulfill the Medical Staff's accountability to the Board of Directors for the medical care rendered to patients in the Hospital.
  - (i) Design a mechanism to ensure that the same level of appropriate quality of patient care is provided by all individuals with privileges, within the Clinical Services, across Clinical Services, and between Appointees and non-Appointees who have privileges during the patient's entire stay at the Hospital.
  - (j) Oversee the quality of patient care, treatment, and services provided by Practitioners and AHPs.
  - (k) Review the qualifications, credentials, performance, professional competence, and character of applicants, Appointees, practitioners, and privileged AHPs, and to make recommendations to the Board of Directors regarding, appointment, reappointment, termination, assignments to Clinical Services, privileges, and corrective action.
  - (l) Request evaluations of a practitioner's or AHP's privileges through the Medical Staff process in instances where there is doubt as to an applicant's, Appointee's, or AHP's ability to perform the privileges requested.

- (m) Take all reasonable steps to ensure ethical professional conduct and competent clinical performance on the part of practitioners and AHPs with privileges.
- (n) Conduct such other functions as are necessary for the effective operation of the Medical Staff.
- (o) Direct mechanisms for corrective action, including indications and procedures for automatic and summary suspension of an individual's appointment and/or privileges.
- (p) Establish mechanisms to provide effective communications among the Medical Staff, Hospital administration, Board, and all levels of governance involved in policy decisions affecting patient care services in the Hospital.
- (q) Establish mechanisms by which house staff are supervised by Appointees in carrying out their patient care responsibilities.
- (r) Report at each general Medical Staff meeting.
- (s) Access and recommend to the relevant Hospital authority off-site sources for needed patient care services not provided by the Hospital.
- (t) Make recommendations for the position of Vice President Medical Affairs to the Board of Directors from among those nominees.

6.1.3. Meetings. The Medical Executive Committee shall meet at least ten (10) times per year and maintain a permanent record of its proceedings and actions.

6.1.4. Any active Appointee has the right to an audience with the Medical Executive Committee. In the event a practitioner is unable to resolve an issue by working with his/her Clinical Service Chief, the Appointee may, upon presentation of at least two (2) week written notice, meet with the Medical Executive Committee at its next regularly scheduled meeting to discuss any unresolved issues.

ARTICLE 7.  
MEDICAL STAFF FUNCTIONS

Provisions shall be made in these Bylaws, or by resolution of the Medical Executive Committee approved by the Board, either through assignment to Medical Staff committees, to Medical Staff officers, or to interdisciplinary Hospital committees, for the effective performance of the Medical Staff functions specified in this Section and described in other related medical staff governance documents, and of such other Medical Staff functions as the Medical Executive Committee or the Board shall reasonably require.

SECTION 7.1. FUNCTIONS

- (a) Monitoring and evaluating the care provided in and developing clinical policy for special care areas, such as intensive or coronary care units and all Hospital-based services.
- (b) Conducting or coordinating quality and appropriateness and improvement activities, including invasive and non-invasive procedures, blood usage, drug usage reviews, medical record and other reviews.
- (c) Conducting or coordinating utilization review activities.
- (d) Conducting or coordinating credentials investigations regarding Medical Staff appointment and grants of Privileges and specified scopes of services.
- (e) Providing continuing education opportunities responsive to quality assessment/improvement activities, new state-of-the-art developments, and other perceived needs and supervise the Hospital's professional library services.
- (f) Developing and maintaining surveillance over drug utilization policies and practices.
- (g) Investigating and controlling nosocomial infections and monitoring the Hospital's infection control program.
- (h) Directing Medical Staff organization activities, including review and revision of Medical Staff Bylaws, Medical Staff officer and committee nominations, acting as liaison with the Board and Hospital administration, and review and maintenance of Hospital accreditation and licensure.
- (i) Coordinating the care, including patient and family education, provided by Appointees with the care provided by the nursing service and with the activities of other Hospital patient care and administrative services.
- (j) Engaging in other functions reasonably requested by the Medical Executive Committee and Board.

## SECTION 7.2. HISTORY AND PHYSICAL

A medical history and physical must 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, oral maxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

An updated examination of the patient, including any changes in the patient's condition, must be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination are completed within 30 days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physicians, an oral maxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

If other qualified practitioners perform any part of the physical examination and medical history, the physician shall sign for and assume full responsibility for this activity.

*See Organization Manual, Rules and Regulations for additional information.*

## SECTION 7.3. CREDENTIALING, PRIVILEGING, AND APPOINTMENT

Applications for appointment, reappointment and privileges shall be submitted to the KHN Central Credentialing Office. The Central Credentialing Office shall review the application for completeness, collect the required information and perform primary source verification. Upon completion of the collection and verification process, the completed application and all supporting documentation shall be submitted to the respective Medical Staff Services Department for review and action upon by the applicable Clinical Service Chief, the Credentials Committee, and the Medical Executive Committee. Initial appointments and reappointments to the Medical Staff and/or the granting of privileges shall be made by the Board, or as otherwise specified in the Bylaws or Credentials Manual. The Board shall act on appointments, reappointments and/or privileges only after there has been a recommendation from the MEC. Time frame to complete this process is 120 days. Temporary privileges for a new applicant, new procedure, locum tenens, or to fulfill an important patient care need may be requested and granted under circumstances as outlined in the Credentials Manual.

In the event of a disaster, volunteer licensed independent practitioners, may be granted "disaster" privileges as outlined in the Credentials Manual and in accordance with applicable hospital policies and procedures.

Full details regarding the credentialing/re-credentialing, appointment/reappointment and privileging/re-privileging processes are set forth in the Credentials Manual.

Each applicant must attest as part of the application for appointment, reappointment, or privileges, that he or she has read the Bylaws, Manuals, applicable policies, and Code of Ethics, and will abide by the same.

## SECTION 7.4. MEETINGS

### 7.4.1. Medical Staff Meetings

The Medical Staff shall meet quarterly throughout the medical staff year. One of these meetings will be designated by the MEC as an annual meeting. Written notice of these meetings shall be sent at least seven (7) days in advance to all appointees and shall also be conspicuously posted.

The primary objective of the meetings shall be to report on the activities of the Medical Staff and to conduct other business as may be on the agenda. Written minutes of all meetings shall be prepared and recorded.

### 7.4.2. Special Meetings

The Chief of Staff may call a special meeting of the Medical Staff at any time. The Chief of Staff shall call a special meeting within twenty (20) days after receipt of a written request signed by not less than ten percent (10%) or fifty (50) members, whichever is less, of the active medical staff, or upon resolution by the Medical Executive Committee. Such request or resolution shall state the purpose of the meeting. The Chief of Staff shall designate the time and place of any special meeting.

Written or printed notice stating the time, place, and purpose of any special meeting of the Medical Staff shall be conspicuously posted and shall be sent to each member of the Medical Staff at least ten (10) days before the date of such meeting. The attendance of a member of the Medical Staff at a meeting shall constitute a waiver of notice of such meeting. No business shall be transacted at any special meeting, except that stated in the notice of such meeting.

A special meeting of any committee or clinical service may be called by the chair, clinical service chief, medical director, or a medical staff officer.

### 7.4.3. Regular Meetings of Clinical Services and Committee

Regular meetings shall be those clinical service meetings as well as medical staff and/or hospital committees that are identified in the Bylaws and related manuals. Committees may, by resolution, provide the time for holding regular meeting without notice other than such resolution. Meetings may be held jointly for the hospital system as deemed appropriate.

Each clinical service is required to have an adequate number of meetings to process business at a minimum of two meetings a year.

Each committee of the Medical Staff shall hold its first meeting of the calendar year at a time and place designated by the Chief of Staff subject to review by the Medical Executive Committee. The Chief of Staff or each committee chair shall establish a time for regular meetings, shall select a recorder to record minutes of meetings, and shall

adopt such rules of procedure necessary to accomplish the purposes for which the committee was established.

#### 7.4.4. Quorum

*Medical Staff Meetings.* Those Active staff members present.

*Medical Executive Committee.* Fifty percent (50%) of the voting members of the committee. Those members not meeting this requirement will receive a letter of reprimand from the Chief of Staff, which will outline the requirements of said position, up to and including removal from the position.

*Credentials Committee.* Minimum of five (5) medical staff members.

*Performance Improvement Committee.* A minimum of three (3) medical staff members.

*Committee/Clinical Service Meetings.* Those active members present.

#### 7.4.5. Attendance Requirements

Medical Staff Meeting Attendance. All members of the Medical Staff are encouraged to attend meetings of the Medical Staff. Meeting attendance is required for active Medical Staff members. At a minimum, each active medical staff member is required to attend at least fifty percent (50%) of clinical service meetings and fifty percent (50%) of the quarterly medical staff meetings each year. Meeting attendance will be used by the Credentials Committee as one parameter in evaluating physicians, podiatrists, psychologists, and dentists at the time of reappointment. Active Medical Staff members who do not meet attendance requirements will be subject to assignment to provisional status and other corrective or administrative disciplinary measures as determined by the Medical Executive Committee. Meeting attendance will be considered by the Credentials Committee in evaluating practitioner at the time of reappointment.

Attendance by members of the Medical Executive, Credentials, and Performance Improvements Committees. Members of the Medical Executive Committee, Credentials Committee, and Performance Improvement Council, are expected to attend at least fifty percent (50%) of the meetings held. The Medical Executive Committee may require Medical Staff meeting attendance on any Medical Staff, joint Medical Staff/hospital committee or clinical service meetings. Those members not meeting this requirement will receive a letter of from the Committee Chair, which will outline the requirements of said position, up to and including removal from the position.

#### 7.4.6. Participation by Chief of Staff

The Chief of Staff and/or any representative assigned by the Chief of Staff may attend any committee or clinical service meetings of the medical staff.

ARTICLE 8.  
CORRECTIVE ACTION

**SECTION 8.1      INFORMAL INVESTIGATIONS FOR CORRECTIVE ACTION**

Prior to initiating a formal corrective action against an Appointee for professional conduct or competency concerns, the Medical Staff leadership (officers of the Medical Staff or Clinical Service Chiefs) or the Board (through the Chief Executive Officer or the Vice President of Medical Affairs) may elect to attempt to resolve the concern(s) informally.

An informal investigation may be initiated by such individuals as stated in Subsection 8.1.1 whenever an Appointee engages in, makes, or exhibits acts, statements, demeanor, or professional conduct (either within or outside the Hospital), and the same is, or is reasonably likely to be, detrimental to the quality of patient care or safety, disruptive to the Hospital's operations, or an impairment to the community's confidence in the Hospital.

When initiating an informal investigation, the involved Appointee shall be invited to be interviewed by the Medical Staff leadership (or its designee), and by either/or both of the Chief Executive Officer, and/or the Vice President of Medical Affairs. At such interview, circumstances prompting the informal investigation should be discussed, and the Appointee asked to present relevant information on his/her own behalf.

8.1.1. Effect of Informal Investigation. If the involved Appointee's action(s) is not subject to Section 8.2 (Automatic Suspension) or Section 8.3 (Summary Suspension), the individual conducting the informal investigation will recommend to the Chief of Staff that the matter in question be considered resolved or be referred to the MEC for further review or formal investigation.

8.1.2. Written Record. A written summary shall be maintained for each informal investigation. The summary shall identify the persons conducting the informal investigation, a summary of the physician's actions (including pertinent dates) that prompted the informal investigation, a summary of the interview with the Appointee (if so conducted), and the effect of the informal investigation. The Appointee will be provided with a copy of this written summary.

8.1.3. Informal Investigations Relating to Hospital Employee Complaint. If the circumstances prompting an informal investigation arise out of a Hospital employee's report or allegation of Appointee misconduct, the informal investigation may, at the discretion of the Vice President or Medical Affairs and/or Chief Executive Officer or his/her designee, also serve to satisfy certain Hospital administrative policies regarding an employee's report or allegation of misconduct, unless otherwise stated in such policies. In such instance, the identity of such employee shall be protected to the extent accorded by applicable Hospital policies. If the Appointee knows or has a reasonable suspicion as to the identity of such employee, and such applicable Hospital policies state otherwise, the

Appointee is prohibited from contacting the employee regarding such report or allegation, it is the responsibility of the Vice President of Medical Affairs and/or the Chief Executive Officer or his/her designee to notify the Appointee of such prohibition.

- 8.1.4. Statutory Protections. Formal and informal investigations and all proceedings, information, and records in connection with such informal investigations are considered peer review activities and are subject to the protection of Ohio's peer review privilege statutes as set forth at Ohio Rev. Code § 2305.24, § 2305.252, and § 2305.253.

Nothing in this Section 8.1 shall be construed as obligating the Medical Staff leadership or Hospital to engage in informal remediation prior to implementing a formal investigation or other corrective action. Section 1 does not confer a procedural right to the Appointee, and any interview conducted under Section 8.1 shall not be subject to the provisions of Article 9.

## SECTION 8.2. FORMAL INVESTIGATIONS FOR CORRECTIVE ACTION

- 8.2.1. Notice and Request. A voting member of the Medical Executive Committee, Board Member, Chief of Staff, Vice President of Medical Affairs, Chair of appropriate Clinical Service, or the Hospital President may request the Medical Executive Committee to initiate a Formal Investigation regarding the necessity or advisability of corrective action against an Appointee. All requests for a Formal Investigation must be in writing, which may be reflected by minutes submitted to or created by the Medical Executive Committee, and supported by reference to specific activities or conduct that constitute grounds for the request. The Chief of Staff shall promptly notify the President/CEO of all such requests.
- 8.2.2. Criteria for Initiation of Formal Investigation. Upon notice or request to the Medical Executive Committee in accordance with Section 8.2.2 that there is reliable information that an Appointee may have exhibited acts, demeanor, or conduct that is reasonably likely to be (a) detrimental to patient safety or to the delivery of quality patient care within the Hospital; (b) unethical; (c) contrary to the bylaws or policies of the Hospital or Medical Staff Bylaws, Policies, Rules or Regulations; (d) a felony conviction of any degree; or (e) below applicable professional standards of behavior or clinical management, the Medical Executive Committee by majority vote shall initiate a Formal Investigation.
- 8.2.3. Procedure for Formal Investigation. The MEC shall meet as soon after receiving the request for Formal Investigation as is practicable and if, in the opinion of the MEC, the request for a Formal Investigation contains on its face sufficient information to warrant action or investigation, the Medical Executive Committee shall immediately appoint an investigating committee (“*ad hoc* committee”) to do so. The *ad hoc* committee shall consist of at least three (3) persons of equivalent credentialing who may or may not hold appointment to the Professional Staff and must have at least one Medical Staff Officer. The *ad hoc* committee shall also include any other individuals (who may or may not be Medical Staff members) as is required by relevant Hospital policy. Non-members of the MEC may be utilized in the investigation process in accordance with relevant Hospital policy and provided appropriate steps are taken to assure that the activities of such a non-

member, as related to the investigatory process, are protected by the Ohio Peer Review Privilege Statute and other relevant law. The *ad hoc* committee shall not include as members anyone that is a partner or associate of those members sitting on the Medical Executive Committee, or who is in economic competition with the Appointee or otherwise has a conflict of interest. The *ad hoc* committee shall have available the full resources of the Medical Staff and the Hospital to aid in their work, as well as the authority to use outside consultants as required. The Appointee being investigated will be promptly notified of the investigation and the reason for such investigation and shall be given an opportunity to meet with the *ad hoc* committee before it makes its report. Prior to this meeting, the individual shall be informed of the charge and the evidence supporting the Formal Investigation requested, shall be provided access to any medical records involved in the Formal Investigation, and shall be invited to discuss, explain or refute the basis of the Formal Investigation. The investigative process, including any interviews conducted, do not constitute a "hearing" as that term is used in Article 9 and shall not entitle the Appointee to the procedural rights provided in Article 9. A record of such interview with the affected Appointee shall be made by the *ad hoc* committee and included with its report to the Medical Executive Committee. The Formal Investigation shall be completed and the report submitted to the Medical Executive Committee within thirty (30) days. The Medical Executive Committee shall then make its recommendation to the individual. At any time during the Formal Investigation the Medical Executive Committee may suspend all or any part of the clinical privileges of the person being investigated. This suspension shall be deemed to be administrative in nature, for the protection of hospital patients. It shall remain in effect during the Formal Investigation only, without appeal, but in no event for longer than fourteen (14) days, and shall not indicate the validity of the charges. If such a suspension is placed into effect, the Formal Investigation shall be completed within fourteen (14) days. Nothing in this section shall limit or preclude the imposition of a summary suspension pursuant to these Bylaws. The MEC may, at any time within its discretion, terminate the investigation process and proceed with action as provided at subsection 8.2.4 below.

The Appointee is not entitled to be represented by an attorney or other representative at any interview, meeting, review, informal investigation, Formal Investigation, or other proceeding or process that takes place prior to a formal "hearing" as that term is used in Article 9.

Unless otherwise required by law or Hospital policy, during the Formal Investigation concerning alleged Appointee misconduct based upon a report of such conduct by a Hospital employee, the identity of such employee shall not be disclosed to the Appointee or any other person on behalf of the Appointee, and such employee shall not be contacted, directly or indirectly, by the Appointee or his/her attorney or any other person on behalf of the Appointee where such employee is a current employee of the Hospital. During such Formal Investigation, the Appointee shall be informed as to the general and specific allegations of any employee's allegations; and may contact the President to request assistance in clarifying any aspect of the employee's report of alleged misconduct.

If the *ad hoc* committee has reason to believe that the Appointee's conduct giving rise to the request for corrective action was the result of a physical or mental impairment, the MEC may either refer the matter to the Medical Staff Wellness Committee or require the Appointee to undergo an impartial physical or mental evaluation within a specified time and pursuant to guidelines set forth in the Medical Staff Wellness Policy. The MEC shall provide names of qualified independent third party Practitioners who may be asked to conduct the examination at the Appointee's expense.

8.2.4. Medical Executive Committee Action. As soon as practicable after conclusion of the investigative process, but in any event at its next meeting unless deferred, the Medical Executive Committee must act upon the recommendation of such investigative action. Its action may include without limitation:

- (a) Determining that no corrective action be taken.
- (b) Deferring action for a reasonable time where circumstances warrant.
- (c) Issuing a letter of admonition, censure, reprimand, or warning, In the event such letter is issued, the affected Practitioner may make a written response that shall be placed in the Practitioner's file.
- (d) Imposition of a probationary period with retrospective review of cases and/or other review of professional behavior, but without a requirement of prior or concurrent consultation or direct supervision.
- (e) Recommending the imposition of prior or concurrent consultation, direct supervision, or other form of probation that limits the Appointee's ability to exercise Privileges for a specified time period.
- (f) Referring the matter to the Medical Staff Wellness Committee for evaluation and action as appropriate for the Practitioner's condition.
- (g) Recommending reduction, suspension, or revocation of all, or any part, of the Appointee's Privileges.
- (h) Recommending reduction of Medical Staff category or limitation of any Medical Staff Prerogatives directly related to the Appointee's delivery of patient care, or suspension or revocation of Medical Staff appointment.
- (i) Take other actions deemed appropriate under the circumstances including summary suspension.

8.2.5. Procedural Rights. A Medical Executive Committee recommendation pursuant to (e) through (i) above may be deemed Adverse and entitle an affected Appointee to the procedural rights contained in Article 9 when such restriction or revocation lasts longer than 30 days. If Adverse action is taken or recommended, the Appointee must exhaust the remedies afforded by these Bylaws before resorting to legal action.

- 8.2.6. Board Notification. A Medical Executive Committee recommendation or action that does not limit the ability of an Appointee to exercise his or her Prerogatives of appointment or Privileges is not deemed Adverse and shall be transmitted to the Board of Directors together with all supporting documentation for informational purposes.
- 8.2.7. Summary Suspension; Automatic Suspension/Termination. The commencement of corrective action procedures against an Appointee shall not preclude the summary suspension, or automatic suspension or termination of the Medical Staff appointment and/or all, or any portion of, the Appointee's Privileges in accordance with the procedures set forth in Sections 8.3, 8.4 and 8.5.

### SECTION 8.3. AUTOMATIC SUSPENSION OR LIMITATION

- 8.3.1. Imposition of Automatic Suspension or Limitation and Subsequent Process. The following events shall result in an automatic suspension or limitation of appointment and/or Privileges without recourse to the procedural rights set forth in Article 9:
- (a) Licensure. Action by any federal or state authority suspending or limiting an Appointee's professional license shall result in an automatic comparable suspension/limitation on the Appointee's Privileges. Whenever an Appointee's licensure is made subject to probation, the Appointee's right to practice shall automatically become subject to the same terms of the probation. The imposition by the Ohio State Medical Board of any restriction or condition shall give rise to a formal investigation pursuant to Section 8.2 of these Bylaws.
  - (b) Controlled Substance Authorization. Whenever an Appointee's federal or state controlled substance certificate is suspended, limited, or revoked, or not renewed, the Appointee shall automatically and correspondingly be limited of the right to prescribe medications covered by the certificate as of the time such action becomes effective and through its term. Whenever an Appointee's state or federal controlled substance certificate is made subject to probation, the Appointee's right to prescribe such medications shall automatically become subject to the same terms of the probation.
  - (c) Professional Liability Insurance Coverage. If an Appointee's Professional Liability Insurance coverage lapses, falls below the required minimum, is terminated, or otherwise ceases to be in effect, in whole or in part, the Appointee's granted admitting and clinical privileges shall be automatically suspended until valid coverage is obtained and becomes effective and the Hospital is provided with proof of required coverage and a written statement from the Appointee (i) explaining the circumstances of the previous insurance being canceled or not renewed, and any limitations on the new policy; and (ii) providing a summary of relevant activities during the period of no coverage to establish current competency. Suspension shall not apply if the Appointee has timely requested a waiver or reduction of such coverage in connection with changed

circumstances in compliance with law and these Bylaws, and is awaiting final action on such request.

- (d) Federal Health Program. Whenever an Appointee is suspended, for cause, from participating in a Federal Health Program, the Appointee's privileges shall be immediately and automatically suspended. Voluntary non-participation or exclusion for contractual non-participation would not be grounds for suspension/termination
- (e) Failure to Provide Requested Information. Failure to provide required information pursuant to a written request by the Medical Executive Committee or the President/CEO as set forth herein shall result in automatic suspension of all Privileges until the required information is provided. For purposes of this section, "required information" may include but not be limited to: (i) physical or mental examination reports if authorized by these Bylaws, or (ii) information regarding a conflict of interest.
- (f) Failure to Satisfy Continuing Education Requirements. Failure to complete mandated state licensure continuing education requirements shall result in automatic suspension of the Appointee's Privileges and Prerogatives until such time as the requirements are met.
- (g) Failure to Pay Dues/Assessments. Failure to pay Medical Staff dues or fines as required within ninety (90) days after notice that such dues or fines are due shall result in an automatic suspension of the Appointees' privileges until such time as the dues or fines are paid.
- (h) Failure to Obtain NPI. Failure to obtain a National Provider Identifier ("NPI"), which is required as part of the administrative simplification section of the Health Insurance Portability and Accountability Act shall result in the automatic suspension of the Appointee's privileges until such time as the NPI is obtained.
- (i) Failure to Complete Medical Records. Whenever an Appointee fails to complete medical records in accordance with applicable policy, rules and regulations, the Appointee shall be automatically suspended consistent with such policy.
- (j) Contractual. When the Hospital elects to enter into an exclusive contract for the provision of certain services, an affected Appointee who is not a party to the exclusive arrangement will not be able to exercise privileges granted in the certain service.

8.3.2. Impact of Automatic Suspension/Limitation. During such period of time when an Appointee's privileges are suspended or limited, he/she may not exercise any Prerogatives of appointment or exercise any Privileges at the Hospital, participate in Emergency Department call (with the exception of an automatic suspension for delinquent medical records), schedule surgery, or otherwise provide professional services within the Hospital for patients, nor can he or she render professional care except as follows:

- (a) To conclude the management of any patient under his or her care in the Hospital at the time of the effective date of the suspension of Privileges.
- (b) To attend an obstetrical patient who has been under his or her active care and management and who comes to term and is admitted to the Hospital in labor.
- (c) To attend to the management of any patient under his or her care whose admission or outpatient procedure was scheduled prior to the effective date of the suspension.
- (d) To attend to the management of any patient requiring emergency care and intervention.

8.3.3. Action Following Imposition. As soon as practical after the imposition of an automatic suspension, the MEC shall convene to determine if further corrective action is necessary in accordance with this Article 8I. The lifting of the action or inaction that gave rise to an automatic suspension or limitation of the Appointee's privileges shall result in the automatic reinstatement of such privileges; provided, however, that to the extent the suspension or limitation remained in effect for a period of more than thirty (30) days, the Appointee shall be obligated to provide such information as Medical Staff Services shall reasonably request to assure that all information in the Appointee's credentials file is current.

#### SECTION 8.4. AUTOMATIC TERMINATION

The following events shall result in an automatic termination of an Appointee's privileges without recourse to the procedural rights set forth in Article 9.

- 8.4.1. Licensure. Action by any federal or the Ohio State Medical Board terminating an Appointee's professional license or Appointee's failure to renew his/her license shall result in an automatic termination of the Appointee's privileges.
- 8.4.2. Professional Liability Insurance. If a Appointee's Professional Liability Insurance coverage lapses, falls below the required minimum, is terminated, or otherwise ceases to be in effect for a period greater than sixty (60) days, the Appointee's privileges shall automatically terminate as of the sixty -first 61<sup>st</sup> day. Termination shall not apply if the Appointee has timely requested a waiver or reduction of such coverage in connection with changed circumstances in compliance with law and these Bylaws and is awaiting final action on such request.
- 8.4.3. Federal Health Program. Whenever an Appointee is excluded, for cause, from participating in a Federal Health Program, the Appointee's privileges shall be automatically terminated. Voluntary non-participation or exclusion for contractual non-participation would not be grounds for suspension/termination
- 8.4.4. Illegal Conduct. If an Appointee pleads guilty to, or is found guilty of, a felony of any degree or other serious offense that involves (i) violence or abuse upon a person, conversion, embezzlement, or misappropriation of property; (ii) fraud, bribery, evidence

tampering, or perjury; or, (iii) a drug offense, (iv) an offense involving moral turpitude, the Appointee's privileges shall be immediately and automatically terminated; provided, however, if the behavior that triggered the conviction is based upon Practitioner impairment, then the matter shall be referred to the Medical Staff Wellness Committee for consideration and recommendation to the MEC as to what action should be taken.

- 8.4.5. Contracts. If an Appointee has a contractual arrangement with the Hospital, the terms and conditions of the contract will govern the obligations of the Hospital and Medical Staff relative to corrective action under Article 8 of these Bylaws; and will supersede the due process rights of the Appointee as set forth in Article 9 of these Bylaws to the extent that such due process rights are in conflict with the terms and conditions of the contractual arrangement.

## SECTION 8.5. SUMMARY SUSPENSION

- 8.5.1. Initiation. A summary suspension may be initiated by the MEC or the Board or any two of the following individual's acting as a Peer Review Committee, an officer of the Medical Staff, chair of the Board, President/CEO, or a Clinical Service Chief with respect to Appointees in the Clinical Service. Each has the authority to summarily suspend the Medical Staff appointment and/or suspend or restrict all, or any portion of, the Privileges of an Appointee whenever failure to take such action may result in an imminent danger to the health and/or safety of any individual. Such summary suspension/restriction shall be deemed an interim precautionary step for the purpose of investigation and not a final finding of responsibility for the situation that caused the suspension.
- 8.5.2. Effective Date. Such suspension/restriction shall become effective immediately upon imposition, shall immediately be reported in writing to the President/CEO (unless imposed by the President/CEO) who will inform the Board and the Chief of Staff. The President/CEO must give prompt written notice, by Special Notice, of the suspension to the Appointee. Such suspension/restriction shall remain in effect unless or until modified by the Chief of Staff or the Board.
- 8.5.3. Medical Executive Committee Action. As soon as convenient, but in no event later than seventy-two (72) hours after a summary suspension is imposed, the MEC, if it did not impose the summary suspension, shall convene to review and consider the need, if any, for a professional review action. Such a meeting of the MEC shall not be considered a "hearing" as contemplated in Article 9, even if the Appointee involved attends the meeting, and no procedural rights shall apply. The MEC may modify, continue, or terminate a summary suspension provided that the summary suspension was not imposed by the Board or the Chief Executive Officer. In the case of such summary suspension imposed by the Board or Chief Executive Officer, the MEC shall give its recommendation to the Board as to whether such summary suspension should be modified, continued, or terminated. The Board may accept, modify, or reject the MEC's recommendation. No later than fourteen (14) days following the original imposition of the summary suspension, the Appointee shall be advised, by Special Notice, of the MEC's determination or, in the case of a summary suspension imposed by the Board or

CEO, of the MEC's recommendation as to whether such suspension should be terminated, modified, or sustained, and of the Appointee's rights, if any, pursuant to Article 9.

- 8.5.4. Procedural Rights. Unless the summary suspension is lifted within fourteen (14) days of its imposition on the grounds that it was not necessary, the Summary Suspension is deemed an Adverse Action.
- 8.5.5. Other Action. A Medical Executive Committee recommendation to terminate or modify the suspension to a lesser sanction not triggering procedural rights must be transmitted, together with all supporting documentation, to the Board. In this instance, the Medical Executive Committee's recommendation will have the effect of immediately revoking the summary suspension completely or reinstating the Appointee with whatever corrective action was assessed by the Medical Executive Committee pending the final decision of the Board of Directors.

## SECTION 8.6. CONTINUITY OF PATIENT CARE

Upon the imposition of a summary suspension, an automatic suspension, or an automatic termination, and in the event that another member of the Practitioner's group is unable to assume care, a suspended/terminated Practitioner's patients then in the Hospital must be assigned to another Practitioner by an officer of the Medical Staff or the appropriate Clinical Service Chief. The wishes of the patient should be considered in choosing a substitute Practitioner when feasible.

ARTICLE 9.  
CORRECTIVE ACTION

SECTION 9.1. INITIATION OF HEARING

Unless waived, an applicant to or an Appointee of the Medical Staff with clinical privileges shall be entitled to a hearing whenever an Adverse recommendation or action has been made or taken by the Medical Executive Committee or the Board. The hearing shall be conducted pursuant to this Article. No applicant or Appointee shall be entitled as a matter of right to more than one (1) hearing with respect to the subject matter of any proposed Adverse recommendation or action giving rise to a hearing right.

SECTION 9.2. THE HEARING

9.2.1. Notice of Adverse Recommendation/Action.

9.2.1.1. When an Adverse recommendation is made or action taken which, according to these Bylaws, entitles an Appointee to a hearing prior to a final decision by the Board, the affected Appointee shall promptly be give notice, by Special Notice, by the Chief of Staff. This notice shall contain:

- (a) A statement of the Adverse recommendation made/action taken and the reasons for it, including the Appointee's alleged acts or omissions, a list of the specific or representative medical records in question, if applicable, and any other information forming the basis for the Adverse recommendation or action.
- (b) Notice that the Appointee has the right to request, in writing and by Special Notice to the Chief of Staff a hearing on the Adverse recommendation/action within thirty (30) days of his/her receipt of the notice
- (c) A summary of the Appointee's rights at the hearing as provided for in these Bylaws.
- (d) A statement that if the Appointee fails to request a hearing, in the manner and within the time period prescribed, such failure shall constitute a waiver of his/her right to a hearing and to an appellate review on the issue that is the subject of the notice.

9.2.1.2. The Appointee shall have thirty (30) days following the date of the receipt of such notice within which to request a hearing. The request must be made in writing, sent by Special Notice, to the Hospital President with a copy to the MEC Chair. In the event the affected Appointee does not request a hearing within the time and in the manner hereinabove set forth, he/she shall be deemed to have waived his/her right to such hearing and to any appellate review to which he/she might otherwise have been entitled. The reports of the

investigation of the *ad hoc* committee and the MEC, together with the Adverse recommendation/action and all supporting material shall thereupon be referred to the Board for final action. The Appointee shall be informed of the Board's final decision by Special Notice.

9.2.2. Grounds for Hearing. Except as otherwise specified in these Bylaws, any one or more of the following actions (when the basis for such action is related to clinical competence or professional conduct) shall be deemed Adverse and entitle an Appointee to request a hearing, provided that the action(s) has been recommended by the MEC or taken by the Board under circumstances where no prior right to request a hearing existed:

- (a) Denial or termination of Medical Staff appointment or reappointment.
- (b) Suspension of Medical Staff appointment for longer than 14 days.
- (c) Denial or termination of requested Privileges.
- (d) Involuntary reduction of existing Privileges.
- (e) Suspension of Privileges for longer than 14 days.
- (f) Imposition of individual mandatory prior or concurrent consultation requirement or direct supervision or other form of probationary status that limits the ability to exercise Privileges.
- (g) Imposition of modifications of Privileges or conditions for reinstatement, if a report to the National Practitioner Data Bank is required.

9.2.3. Actions Which Do Not Give Right to a Hearing. Notwithstanding the above provision, no Appointee shall be entitled to a hearing as a result of, but not limited to, the following actions described in this subsection:

- (a) An oral or written admonition, reprimand or warning, or corrective counseling.
- (b) The denial, termination, modification, or suspension of temporary, disaster, emergency, locum tenens, or telemedicine Privileges.
- (c) Imposition of a probationary period with retrospective or concurrent review of cases provided that such probationary period does not otherwise limit the Appointee's ability to exercise his or her Privileges.
- (d) Denial of requested Privileges because the Appointee failed to satisfy the basic qualifications or criteria of training, education, or experience established for the granting of Privileges for a specific procedure or procedures. Any action taken by the MEC or the Board against an Appointee where the action was taken solely for administrative or technical failings of the Appointee (e.g. failure of an Appointee to satisfy the basic qualifications for Medical Staff appointment and/or Privileges, or to provide requested information, etc.)

- (e) Ineligibility for Medical Staff appointment or reappointment or the Privileges requested, in whole or in part, because a Clinical Service or subspecialty has been closed or there exists an exclusive contract limiting the granting of Privileges requested by the Appointee.
- (f) Termination of or the inability to exercise Privileges either in whole or in part because the Hospital has determined to close a Department or grant an exclusive contract limiting the ability of current Appointee's to exercise such Privileges.
- (g) Termination of the Appointee's employment or other contract for services with the Hospital or through a group contract unless the contract provides otherwise.
- (h) Ineligibility for Medical Staff appointment or requested Privileges because of lack of facilities, equipment, or support services, or because the Hospital has elected not to perform, or does not provide, the service which the Appointee intends to provide or the procedure for which Privileges are sought.
- (i) An automatic suspension or automatic termination of appointment and/or Privileges as defined in the Bylaws.
- (j) Voluntary suspension or relinquishment of Privileges or Medical Staff appointment when professional competence or conduct is not at issue.
- (k) Voluntary suspension or relinquishment of Privileges or Medical Staff appointment that is not tendered during a Formal Investigation or that is not in return for the Medical Staff or Board refraining from conducting a Formal Investigation based upon professional competence or conduct.
- (l) An automatic transfer to the Associate Membership Only Medical Staff category as defined at Section 3.3.1 on the basis that the Appointee failed to exercise any of the Privileges granted to the Appointee during the prior two (2) year period.
- (m) Any other action that does not relate to the competence or professional conduct of an Appointee.
- (n) A change in Medical Staff category resulting from a failure to meet minimum objective criteria for a particular Medical Staff category.
- (o) Temporary restriction or suspension of Privileges for a period of not longer than 14 days while an investigation is pending or otherwise in accordance with corrective action that does not give rise to due process rights under the Bylaws.
- (p) The appointment of an *ad hoc* investigation committee or the conduct of an investigation into any matter, or a resulting report of, or recommendation made by such committee.
- (q) The imposition of observation, focused review, monitoring, proctoring, educational or training requirements, consultation or review requirements, any of

which do not restrict Privileges and is not reportable to the National Practitioners Data Bank.

- 9.2.4. Notice of Hearing and Statement of Reasons. The Chief of Staff is responsible for scheduling the hearing and giving notice, in writing, by Special Notice, to the affected Appointee of the time, place, and date of the hearing. The hearing shall begin as soon as practicable, considering the schedules and availability of all concerned, but in no event earlier than thirty (30) days from the date of the hearing notice (unless the affected Appointee agrees to an earlier time). The notice shall contain the original statement of the reasons for the recommendation/action as well as the list of patient record numbers (if applicable) and information supporting the recommendation/action; a list of witnesses, if any, expected to testify on behalf of the MEC; and a summary of the Appointee's rights in connection with the hearing.
- 9.2.5. List of Witnesses. A written list of the names and addresses of the individuals so far as is then reasonably known, who will give testimony or evidence in support of the Medical Executive Committee or the Board shall be given with the notice of hearing. The Practitioner requesting the hearing shall provide a written list of the names and addresses of the individuals expected to offer testimony or evidence on his/her behalf within ten (10) days after receiving notice of the hearing. The witness list of either party may, at the discretion of the presiding officer, be supplemented or amended at any time during the course of the hearing, provided that notice of the change is given to the other party.
- 9.2.6. Exhibits. The parties shall cooperate in the exchange of exhibits reasonably in advance of the hearing date. Prior to any exchange of exhibits, the parties must agree that all such documents will be maintained as confidential peer review documents and not be disclosed or used for any purpose other than the hearing and appeals related thereto.
- 9.2.7. Objections. All objections to witnesses or exhibits to the extent then reasonably known, shall be submitted to the presiding officer in writing in advance of the hearing.
- 9.2.8. Continuing Obligation. Each party remains under a continuing obligation to provide to the other party any exhibits or witnesses identified after the initial exchange which a party intends to introduce at the hearing. The introduction of any exhibits not provided prior to the hearing, or the admissibility of testimony to be presented by a witness not so listed, shall be at the discretion of the presiding officer.

### SECTION 9.3. HEARING PANEL AND PRESIDING OFFICER

- 9.3.1. Determination. The hearing shall be conducted by a hearing panel.

9.3.1.1. Presiding Officer. The President and the Chief of Staff or Board Chair shall appoint a presiding officer who is experienced in conducting administrative hearings and in particular peer review hearings and is knowledgeable regarding HCQIA and Ohio law. The presiding officer may be an Appointee, or an individual from outside the Hospital qualified to conduct the hearing. The affected Appointee shall be notified of the

name of the prospective presiding officer and if the affected Appointee has an objection he/she shall, within 5 calendar days after notification, state the objection and reason therefor in writing. The President and Chief of Staff, after considering such objection, shall decide, in their sole discretion, whether to uphold the objection and replace the presiding officer.

- 9.3.1.2. Hearing Panel. When a hearing is requested, the President and Chief of Staff shall appoint a hearing panel which shall be composed of not less than three (3) impartial individuals with one alternative who did not actively participate in the consideration of the matter involved at any previous level. The individuals may be Appointees, Practitioners, or lay persons not connected with the Hospital, or any combination of such persons, except that if the matter involves an issue of clinical quality, then the panel must be composed of physicians, and where feasible, one member shall have the same healing arts licensure as the affected Appointee, and one member shall be an individual practicing the same specialty as the affected Appointee. The Chief of Staff (if the hearing is occasioned by the MEC) or Board chair (if the hearing is occasioned by a Board determination) shall designate one (1) of the panel members to act as panel chair (with the right to vote); and shall appoint a presiding officer (*e.g.* an attorney), in addition to the hearing panel members, to assist the hearing panel but who shall not have the right to vote on the hearing panel's recommendation. Subject to (c) below, knowledge of the matter involved shall not preclude any individual from serving as a member of the hearing panel.
- 9.3.1.3. Service on Hearing Panel. Any person shall be disqualified from serving on the hearing panel, or as a presiding officer if the person directly participated in initiating the Adverse recommendation or action, or in investigating the underlying matter at issue; if the person has taken an active part in the matter contested; or, if the person is a direct economic competitor or otherwise has a conflict of interest with the Appointee involved in the hearing. In the event that an attorney serves as the hearing officer, on the hearing panel, or as a presiding officer, he/she must not represent clients in direct economic competition with the Appointee who is the subject of the hearing.
- 9.3.2. Failure to Appear. The personal presence of the Appointee who requested the hearing shall be required at the hearing. An Appointee who fails, without good cause, to appear and proceed at such a hearing shall be deemed to have waived his/her right to such hearing and to any appellate review to which he/she might otherwise have been entitled. The matter shall then be referred to the Board for final decision.
- 9.3.3. Time Frame, Postponements, and Extensions. A hearing must occur no later than three (3) months after receipt of the request therefore, unless postponements or extensions are granted. Postponements and extensions of time beyond any time limit set forth in these

Bylaws may be requested but shall be permitted only by the President if a hearing date has not yet been set, or only by the presiding officer after such has been appointed. The affected Appointee must make every reasonable effort to be available for the hearing dates established by the President and/or presiding officer.

#### SECTION 9.4. HEARING PROCEDURE

- 9.4.1. Representation. The affected Appointee, at his/her sole expense, shall be entitled to be represented at the hearing by an attorney or other person of the Appointee's choice to examine/cross-examine witnesses and present his/her case. He/She shall inform the President in writing of the name of that person not less than ten (10) days prior to the date of the hearing. The President may also appoint a person, who may be an attorney, to represent the position of the Hospital or any Medical Staff Committee or Clinical Service, and who may examine and cross-examine witnesses at the hearing. Presentation by counsel shall in no way interfere with the ability of the hearing officer/panel to hear directly from the affected Appointee.
- 9.4.2. Presiding Officer. The presiding officer must not act as a prosecuting officer, or as an advocate for either side at the hearing. The presiding officer shall act to insure that all participants in the hearing have a reasonable opportunity to be heard and to present all oral and documentary evidence, that decorum is maintained throughout the hearing, and that no intimidation is permitted. He/She shall have the authority and discretion, in accordance with these Bylaws, to make rulings on all questions that pertain to matters of procedure, the admissibility of evidence, access to information, and regarding requests for postponements or extensions of time, and shall generally be responsible to regulating the proceedings. Such presiding officer shall have the authority to impose time limits for examination and cross-examination of witnesses, and to limit the number of witnesses to be called. It is understood that the presiding officer is acting at all times to see that all relevant information is made available to the hearing panel for its deliberations, report, and recommendation(s) to the Board.
- 9.4.3. Record of Hearing. A record of the hearing shall be maintained by a court reporter. The cost of such court reporter shall be borne by the Hospital. Upon request, the affected Appointee shall be entitled to obtain a copy of the record at his/her own expense. The record of any hearing is absolutely protected from disclosure to the greatest extent permitted by law.
- 9.4.4. Rights of Both Sides. At the hearing both sides shall have the following rights: to be represented by an attorney or other person of the party's choice; to be provided with a list of witnesses and copies of documents to be relied upon by the other party at the hearing; to have a record made of the proceedings, copies of which may be obtained by the affected Appointee upon payment of any reasonable charges associated with the preparation thereof; to call and examine witnesses to the extent available and relevant; to introduce exhibits; to cross-examine any witness on any matter relevant to the issues; to present and/or rebut any evidence determined relevant by the presiding officer regardless of the admissibility of the evidence in a court of law; to submit a written statement at the close of the hearing; to receive, upon completion of the hearing, a copy of the written

recommendation of the hearing panel (including a statement of the basis for the hearing panel's recommendation); and, to receive a copy of the written decision of the Board (including a statement of the basis for the Board's decision).

- 9.4.5. Admissibility of Evidence. The hearing shall not be conducted according to rules of Ohio law, or any other state or sovereign law, relating to the examination of witnesses or presentation of evidence; provided, however, that oral evidence shall only be taken on oath or affirmation administered by any person designated by the presiding officer and entitled to notarize documents in the State of Ohio. Any relevant evidence may be admitted by the presiding officer if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The hearing panel may question the witnesses, call additional witnesses, or request documentary evidence or a memorandum of points and authorities if deemed appropriate. It shall not be a defense to any action proposed by the MEC or the Board that different actions have been taken in the past with regard to any other Practitioner. No affected Appointee shall be permitted to introduce any evidence at the hearing or have access to any peer review records, medical records, minutes or other documents relating to any other Practitioner, or any action taken or not taken with regard to any other Practitioner. The affected Appointee shall be entitled to any documents relied on by the MEC or Board in making any recommendation or decision (unless otherwise stated herein), and to any documents to be introduced at the hearing, and to any medical records relied on or to be introduced at the hearing, so long as the affected Appointee and his/her attorney/representative agree in writing to keep all such documents confidential and not use them for any purpose other than in the hearing and appellate review proceedings. The production of such documents shall not constitute a waiver of any peer review protection for those documents or any other documents.
- 9.4.6. Official Notice. The presiding officer shall have the discretion to take official notice of any matters, either technical or scientific, relating to the issues under consideration that may be judicially noticed by the courts of the State of Ohio. Participants in the hearing shall be informed of the matters to be officially noticed and such matters shall be noted in the record of the hearing. Either party shall have the opportunity to request that a matter be officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority. Reasonable additional time shall be granted, if requested, to present written rebuttal of any evidence admitted on official notice.
- 9.4.7. Observers. The hearing shall be restricted to those individuals involved in the proceeding. Appropriate administrative personnel may be present as requested by the Chief of Staff and the President and agreed upon by the Appointee.
- 9.4.8. Basis of Report and Recommendation. The decision of the hearing panel shall be based on the evidence produced at the hearing. This evidence may consist of the following:
- (a) Oral testimony of witnesses.
  - (b) Memorandum of points and authorities presented in connection with the hearing.

- (c) Any information regarding the affected Appointee so long as that information has been admitted into evidence at the hearing and the affected Appointee had the opportunity to comment on and, by other evidence, refute it.
- (d) All officially noticed matters.
- (e) Any other evidence that has been admitted.

9.4.9. Order of Presentation. At the hearing, the MEC or Board, as applicable, and the affected Appointee may make opening statements. Following the opening statements, the evidence will be presented in the following order:

- (a) The body triggering the hearing shall first come forward with evidence in support of its recommendation/action.
- (b) The affected Appointee shall then come forward with evidence in his/her support.
- (c) The triggering body may then submit evidence in rebuttal to that presented by the affected Appointee.
- (d) The triggering body may then make a closing statement.
- (e) The affected Appointee may then make a closing statement. The affected Appointee's right to make a closing statement is not foreclosed if the triggering body did not make elect to make a closing statement.
- (f) The triggering party and the affected Appointee may submit written statements within 14 days of the close of the hearing.

9.4.10. Burden of Proof. In order to prevail, the affected Appointee must establish by clear and convincing evidence (substantially more likely than not) that the recommendation/action that prompted the hearing was unreasonable, not sustained by the evidence, or otherwise unfounded

9.4.11. Attendance By Hearing Panel Members. Recognizing that it may not be possible for all members of the hearing panel to be present continually at all sessions of the panel, the hearing may continue provided at least two (2) members of the hearing panel are present at all times. The fact that certain panel members were not physically present at all times during the hearings will not disqualify them or invalidate the hearing. The vote shall be by majority of those appointed to the hearing panel. An alternate shall be disqualified if not present at all times.

9.4.12. Recesses and Adjournment. The presiding officer may recess the hearing and reconvene the same for the convenience of the participants, to obtain new or additional evidence, or if consultation is required for resolution of the matter. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The hearing shall be adjourned at such time as the transcript of the proceedings is received, or upon the submission of written closing statements by the parties (if applicable), whichever is later.

- 9.4.13. Deliberations and Recommendations of the Hearing Officer. Within twenty (20) days after adjournment of the hearing, the hearing panel shall deliberate outside the presence of any other person except the presiding officer and shall render a written report and recommendation that shall contain a concise statement of the reasons justifying the recommendation made. The hearing recommendation shall be based exclusively upon the evidence presented at the hearing as set forth in Subsection 11.4.8.
- 9.4.14. Disposition of Hearing Officer Report & Recommendation. Upon its receipt, the President shall forward the hearing panel's report and recommendations, along with all supporting documentation, to the body that issued the Adverse recommendation/action. Within fifteen (15) days of receiving the hearing panel's report and recommendation, the initiating body shall make its final recommendation and deliver it to the President, who shall deliver such to the Board (if the Board is not the initiating body) for final determination.
- (a) Favorable Recommendation or Action. When the MEC's recommendation is favorable to the affected Appointee, the Board may adopt or reject all, or any portion, of the MEC's recommendation, or refer the matter back to the MEC for additional consideration. Any such referral shall state the reason(s) for the requested reconsideration, set a time limit within which a subsequent recommendation must be made, and may include a directive that an additional hearing be conducted to clarify issues in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, the Board shall take action. A favorable determination by the Board shall be effective as its final decision and the matter shall be considered closed.
- (b) Adverse Recommendation or Action. If the recommendation of the MEC and/or decision of the Board is or continues to be Adverse to the affected Appointee after exhaustion of his/her hearing rights, the Appointee shall be entitled, upon timely and proper request, to an appellate review before a final decision is rendered on the matter by the Board.
- (c) Notice of Result. The President shall provide a copy of the final recommendation of the body whose Adverse recommendation or action triggered the hearing, together with a copy of the hearing panel's report and recommendation to the affected Appointee, by Special Notice, and to the Board. The Board shall also be provided with a copy of the transcript of the proceedings and exhibits. In the event of an Adverse result, the notice shall inform the affected Appointee of the right to request an appellate review by the Board before a final decision regarding the matter is rendered.

## SECTION 9.5. APPEAL

- 9.5.1. Time for Appeal. Within ten (10) days after the affected practitioner is notified of the triggering body's final recommendation/action, and provided such recommendation/action continues to be adverse, he/she may request an appellate review. The request shall be in writing, be delivered to the President by Special Notice, and

include a brief statement of the reasons for appeal. If such appellate review is not requested within ten (10) days as provided herein, the affected individual shall be deemed to have accepted the final recommendation/action, and it shall thereupon be referred to the Board for final action.

9.5.2. Grounds for Appeal. The grounds for appeal from an adverse recommendation /action are limited to:

- (a) There was substantial failure on the part of the Medical Executive Committee or hearing officer to comply with the Medical Staff Bylaws in the conduct of hearings and/or recommendations/actions based upon hearing so as to deny procedural due process.
- (b) The recommendation/action was made arbitrarily, capriciously or with prejudice.
- (c) The recommendation/action was not supported by the evidence.

9.5.3. Time, Place, and Notice. Whenever an appeal is requested and is consistent with the grounds for appeal as set forth in the preceding sections, the President/CEO (after consultation with the Board chair) shall promptly schedule and arrange for an appellate review. The President shall give the affected practitioner notice of the time, place, and date of the appellate review.

9.5.4. Nature of Appellate Review

9.5.4.1. Review Panel. The Board may hear the appeal as a whole or the chair may appoint a subcommittee composed of not less than three (3) Board members.

9.5.4.2. Additional Evidence. In the event a party seeks to submit additional evidence at the appeal, it will be considered only if the Review Panel determines, at its discretion, that (1) the party seeking to admit it has demonstrated that he/she was unfairly deprived of the opportunity to admit it at the hearing; or (2) the information was not known, and on the basis of reasonable efforts could not have been known, at the time of the hearing. The Review Panel, at its discretion, shall decide whether to (1) hear the evidence, subject to the same rights of cross-examination or confrontation provided at the hearing; or (2) remand the matter back to the presiding officer and direct that the hearing be re-opened. In the latter case, the presiding officer shall be required to submit an amended report and recommendation to the triggering body and the provisions of §§10.3.5 and 10.3.6 shall thereafter apply.

9.5.4.3. Written Statements and Oral Arguments. Each party shall have the right to present a written statement in support of his/her position on appeal, and at its sole discretion, the Review Panel may allow each party or its representative to appear personally and present oral arguments. The Review Panel, if consisting of less than the full Board, shall recommend

final action to the Board. Its recommendation shall be in writing and supported by the reasons for such recommendation.

#### 9.5.5. Final Decision of the Board

- 9.5.5.1. Board Decision. If the appellate review is conducted by the Board as a whole, the Board may render its final decision upon conclusion of the appellate review or may defer rendering its final decision until its next regularly scheduled Board meeting. If the appellate review is conducted by a subcommittee of the Board, the Board shall render its final decision at its next regularly scheduled Board meeting following receipt of the subcommittee's written recommendation. In such event, the Board may affirm, modify, or reverse the recommendation of the subcommittee or, at its discretion, refer the matter back to the subcommittee or the hearing officer for further action. The President shall then be responsible for notifying the MEC and the affected practitioner (by Special Notice), in writing, of the Board's final decision.
- 9.5.5.2. Reporting Obligations. If the recommendation of the Board is an Adverse Review Action, the final decision of the Board shall include the actual coding and a description of the underlying action which will be reported to the National Practitioner Data Bank.
- 9.5.5.3. Further Review. Except where the matter is referred for further action and recommendation in accordance with this Article, 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 recommendations shall be promptly made to the Board in accordance with the instructions given by the Board. This further review process and the report back to the Board should not, except for good cause shown as determined by the Board, exceed thirty (30) days in duration.
- 9.5.5.4. Right to One Appeal Only. No practitioner shall be entitled as a matter of right to more than one (1) appellate review on any single matter that may be the subject of an appeal, without regard to whether such subject is the result of action by the Medical Executive Committee or hearing officer, or a combination of acts of such bodies. In the event that the Board ultimately determines to deny initial appointment or reappointment to the Medical Staff or privileges to an applicant, or to revoke or terminate the Medical Staff appointment and/or privileges of an Appointee, that individual may not again apply for Medical Staff appointment or privileges at the Hospital for a period of two years from the final Board decision, unless the Board's decision provides otherwise.

## SECTION 9.6. REPRESENTATION BY COUNSEL

At such time as the practitioner, Medical Executive Committee, or Board is represented by legal counsel, then all notices required to be sent herein may be served upon the practitioner or MEC/Board's legal counsel, and the requirement that such notices be sent by Special Notice is hereby waived; rather, such notices may be sent by regular first class U.S. mail.

ARTICLE 10.  
REVIEW, REVISION, ADOPTION AND AMENDMENT

SECTION 10.1. MEDICAL STAFF RESPONSIBILITY

The Medical Staff shall have the responsibility to formulate, review, adopt, and recommend to the Board Medical Staff Bylaws and amendments thereto, which shall be effective when approved by the Board. Such responsibility shall be exercised in good faith and in a reasonable, responsible, and timely manner. Neither the Board nor the Medical Staff may unilaterally amend or nullify the Medical Staff Bylaws, or other related medical staff governance documents. Rather, the provisions set forth in this Article X shall be the sole means for creating or adopting such documents. The Medical Staff shall review the Bylaws and Manuals at least once every two (2) years. Policies of the Medical Staff shall be supportive of and congruent with the Medical Staff Bylaws, Rules & Regulations, and other related manuals.

SECTION 10.2. METHODS OF ADOPTION AND AMENDMENT

Medical Staff Bylaws may be adopted, amended or repealed by the following actions:

10.2.1. Medical Executive Committee Action: The Medical Executive Committee may make corrections and minor, non-substantive, technical changes when such correction or change is necessary due to a change in law, or due to clerical error such as spelling, punctuation, or grammar. Any correction or technical change shall be approved by the affirmative vote of two-thirds (2/3rds) of the voting Medical Executive Committee members. No prior notice to the Medical Staff of such change is required. All corrections or changes thus made will be reported at the next scheduled general meeting of the Medical Staff.

10.2.2. Medical Staff Action. The Bylaws may be adopted, amended, or repealed by the affirmative vote of two-thirds (2/3) of the active Appointees in good standing present at a regular or special meeting of the Medical Staff provided that a copy of the proposed documents or amendments was provided to each active Appointee not less than twenty-one (21) days in advance of the meeting and provided that each active Appointee was notified that such matter would come to vote at the meeting. Absentee ballots are permitted.

10.2.3. Board Action. Adoption, amendment, or repeal of the Medical Staff Bylaws shall require the affirmative vote of the Board of Directors.

SECTION 10.3. RELATED MEDICAL STAFF GOVERNANCE DOCUMENTS

MEC may develop and amend Manuals and Medical Staff policies provided that such documents are approved by a two-third (2/3) vote of the voting members of the Medical Executive Committee. The development and amendment of such Manuals and Medical Staff policies will not require the approval of the active Medical Staff. Such Manuals and Medical Staff policies must be consistent with the Bylaws. Any such Manual or Medical Staff policy, or amendments thereto, shall not become effective until approved by the Board. The Medical Staff will be

notified of any such documents or amendments, and such documents will be available in the Medical Staff Services Department for review. A current copy of the Bylaws, Organization Manual, and, Credentials Manual will be made available to allow the practitioner to attest to reading and abiding by them at the time of appointment, reappointment, and/or granting Privileges.

#### SECTION 10.4. BOARD ACTION

10.4.1. Conflict with MEC/Medical Staff Recommendation. If the Board has determined not to accept a recommendation submitted to it by the Medical Executive Committee or the Medical Staff, the Medical Executive Committee may request a conference between the officers of the Board and the officers of the Medical Staff. Such conference shall be for the purpose of further communicating the Board's rationale for its contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the recommendation. The President/CEO will schedule such conference within fourteen (14) days after receipt of a request for a conference from the Chief of Staff. The Board may then take final action.

#### 10.4.2. Board-Initiated Action.

In the event the Medical Staff of MEC, as applicable, fails to exercise its responsibility in good faith and in a reasonable and timely manner, and after written notice from the Board to such effect including a reasonable time for responses, the Board may take action pursuant to these Bylaws. Should the Medical Staff/MEC fail to respond under such circumstances or should the Board disagree with any responses or recommendations from the Medical Staff/MEC for adoption, amendment or repeal of, as applicable, the Medical Staff Bylaws, Manuals, or Medical Staff policies, the Board's recommendation shall be referred to a Joint Conference Committee for consideration of the recommendations of the Board and the Medical Staff/MEC regarding the proposed adoption, amendment or repeal of, as applicable, the Bylaws, Manuals or Medical Staff policies prior to final action by the Board.

The Joint Conference Committee shall make a recommendation to the Board within thirty (30) days of receipt of the proposed adoption, amendment or repeal of, as applicable, the Bylaws, Manuals, or Medical Staff policies. At its next regularly scheduled meeting after receipt of a recommendation from the Joint Conference Committee, the Board shall take final action with respect to the adoption, amendment or repeal under consideration. Such action by the Board may include ratifying or modifying, in whole or in a part, the recommendation of the Joint Conference Committee to remain in compliance with law and accreditation requirements. Should there be a tie among the Joint Conference Committee members with respect to the issues being considered, the chair of the Board shall be called upon to cast a vote on the issue under consideration.

10.4.3. Conflict within Documents. In the event of a conflict between the Hospital's code of regulations or a Hospital policy and the Medical Staff Bylaws, the Hospital's code of regulations or policy, as applicable shall control. If there is a conflict between the Medical Staff Bylaws and a Manual or Medical Staff policy, the Bylaws shall control.

Such conflict shall then be reviewed by the MEC to determine how such conflict can be resolved.

#### SECTION 10.5. APPOINTEE ACTION

To the extent that a Manual provision or Medical Staff policy is not required by federal or state law or regulations, accrediting or certification standards, Medicare Conditions of Participation, or third party payors, any active Appointee in Good Standing may raise a reasonable challenge made in good faith to any Manual provision(s) or Medical Staff policy established by the MEC and approved by the Board. In order to raise such challenge, the active Appointee must submit to the MEC a petition signed by not less than ten percent (10%) of the active Appointees in Good Standing. Upon receipt of the petition, the MEC shall either (a) provide the petitioner(s) with information clarifying the intent of such Manual provision(s) or Medical Staff policy; and/or (b) schedule a meeting with the petitioner(s) to discuss the issue. In the event that the issue cannot be resolved to the satisfaction of the petitioner(s), the matter shall be brought before the Medical Staff for vote and forwarded to the Board for final action.

**NOTE:** The Appointee is responsible for researching relevant federal and state law and regulations, accrediting and certification standards, Medicare Conditions of Participation, and third party payors' requirements, and believes that the provision or policy being challenged is not required under any of such law, regulations, standards, or conditions.

#### SECTION 10.6. Miscellaneous.

If significant changes are made to any of the Medical Staff governing documents, Appointees of the Medical Staff and other individuals who have Privileges shall be provided with a text of the revised materials.

ARTICLE 11.  
CONFIDENTIALITY, IMMUNITY AND RELEASE

SECTION 11.1. SPECIAL DEFINITIONS

For purposes of the Article, the following definitions shall apply:

- INFORMATION means record of proceedings, minutes, interviews, records, reports, forms, memoranda, statements, investigations, examinations, hearing, meetings, recommendations, findings, evaluations, opinions, conclusions, actions, data and other disclosures or communications whether in written or oral form relating to any of the subject matter specified in §11.5.
- REPRESENTATIVE means the Board of Directors of the Hospital and any director or committee thereof; the President/CEO or the President/CEO's designee; registered nurses and other employees of the Hospital; the Medical Staff organization and any Appointee, officer, Clinical Service, or committee thereof; any individual authorized by any of the foregoing to perform specific information gathering, analysis, use or disseminating functions.
- THIRD PARTIES means any individual or organization providing information to any Representative.

SECTION 11.2. AUTHORIZATIONS AND RELEASES

Each practitioner shall, upon request of the Hospital, execute general and specific releases and authorizations in accordance with the tenor and import of this Article, subject to such requirements as may be applicable under the state of Ohio and federal law. Execution of such releases and authorizations is not a prerequisite to the effectiveness of this Article. Such releases and authorizations will operate in addition to the provisions of this Article.

By submitting an application for Medical Staff appointment or reappointment or by applying for or exercising privileges or scope of services at the Hospital, a practitioner:

- (a) Authorizes Representatives to solicit, provide and act upon information bearing on his or her professional ability and other qualifications.
- (b) Agrees to be bound by the provisions of the Article and to waive all legal claims against any Representative who acts in accordance with the provisions of the Article.
- (c) Acknowledges that the provisions of this Article are express conditions to his or her application for, or acceptance of, Medical Staff appointment and the continuation of such appointment and to his/her exercise of Privileges or provisions or specified patient care services at the Hospital.

### SECTION 11.3. CONFIDENTIALITY OF INFORMATION

Information with respect to any practitioner submitted, collected or prepared by any representative of this or any other health care facility or organization or medical staff for the purpose of evaluating, monitoring or improving the quality, appropriateness and efficiency of patient care, reducing morbidity and mortality, contributing to teaching or clinical research, or determining that health care services are professionally indicated or were performed in compliance with the applicable standards of care or establishing and enforcing guidelines to help keep health care costs within reasonable bounds shall, to the fullest extent permitted by law, be confidential. Said information shall not be disseminated to anyone other than a representative or other health care facility or organization of health professionals engaged in an official, authorized activity for which the information is needed, nor be used in any way except as provided herein or except as otherwise required by law. Such confidentiality shall also extend to information of like kind that may be provided to third parties. This information shall not become part of any particular patient's record. It is expressly acknowledged by each practitioner that violation of the confidentiality provided herein is grounds for immediate and permanent revocation of Medical Staff appointment and privileges or specified services.

### SECTION 11.4. IMMUNITY FROM LIABILITY

11.4.1. For Action Taken. No representative of the Hospital or Medical Staff shall be liable to a practitioner for damages or other relief for any decision, opinion, action, statement or recommendation made within the scope of his or her duties as a representative, unless such representative acts on the basis of false information knowing it to be false, after reasonable effort under the circumstances to ascertain the truthfulness of the facts and in the reasonable belief that the decision, opinion, action, statement, or recommendation is warranted by such facts.

11.4.2. For Providing Such Information. No representative of the Hospital or Medical Staff and no Third Party shall be liable to a practitioner for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative of this Hospital or Medical Staff or to any other health care facility or organization of health professionals concerning a practitioner who is or has been an Applicant to or Appointee of the Medical Staff or who did or does exercise Clinical Privileges or provide specified services at this Hospital, provided that such representative or Third Party does not act on the basis of false information knowing it to be false, and provided further that such information is related to the performance of the duties and functions of the recipient and is reported in a factual manner.

### SECTION 11.5. ACTIVITIES AND INFORMATION COVERED

11.5.1. Activities. The confidentiality and immunity provided by this Article applies to all acts, communications, proceedings, interviews, reports, records, minutes, forms, memoranda, statements, recommendations, findings, evaluations, opinions, conclusions or disclosures performed or made in connection with this or any other health care facility's or organization's activities concerning, but not limited to:

- (a) Applications for appointment, privileges, or specific services.
- (b) Periodic reappraisals for reappointment, privileges or specific services.
- (c) Corrective actions, recommended or taken.
- (d) Hearings and appellate reviews.
- (e) Performance improvement/quality assessment activities.
- (f) Utilization review activities.
- (g) Claims reviews.
- (h) Profiles and profile analysis.
- (i) Risk management activities.
- (j) Other Hospital, committee, Clinical Service, or Medical Staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

11.5.2. Information. The information referred to in this Article may relate to a practitioner's professional licensure or certification, education, training, clinical competency, judgment, utilization practices, character, ability to fully and competently carry out the privileges requested, professional ethics, or any other matter that might directly or indirectly affect the quality, efficiency, or appropriateness of patient care provided in the Hospital.

#### SECTION 11.6. CUMULATIVE EFFECT

Provisions in these Medical Staff Bylaws and in application forms relating to authorization, confidentiality of information, and immunities from liability are in addition to other protections provided by state and federal law and not in limitation thereof.

## **CERTIFICATION OF ADOPTION AND APPROVAL**

These Bylaws are adopted and made effective upon approval of the Board, superseding and replacing any and all other Medical Staff Bylaws, Rules & Regulations, policies, or Manuals pertaining to the subject matter thereof.

Adopted by the Medical Executive Committee on  
February 15, 2011

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Martha Johnston, MD  
Chief of Staff

Adopted by the Medical Staff on  
March 24, 2011

Approved and adopted by the Board of Directors on  
April 18, 2011

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Roy Chew, Secretary  
Board of Directors