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Preamble

Fayette County Memorial Hospital is a county owned critical access hospital organized under the laws of the State of Ohio for the purpose of providing health care and medical services for inpatients and outpatients and promoting the well-being of the citizens of Fayette County, Ohio and the surrounding area. The Board of the Hospital has charged the Medical Staff of the Hospital with the responsibility for providing, monitoring, and improving patient care within the Hospital. To that end, the Medical Staff of Fayette County Memorial Hospital is continually striving to achieve quality patient care for inpatients and outpatients of the Hospital and accepts and agrees to discharge its responsibilities subject to the ultimate authority of the Board.

The Physicians, Dentists, Podiatrists and Psychologists practicing in the Hospital therefore organize their activities in conformity with these Bylaws in order to carry out the functions delegated to the Medical Staff by the Board.

These Bylaws are not intended to and shall not create any contractual rights between the Hospital and any Practitioner. Any and all contracts of association or employment shall control contractual and financial relationships between the Hospital and Practitioner.
DEFINITIONS

"Adverse" means a recommendation or action of the Medical Executive Committee or Board that denies, limits, or otherwise restricts Medical Staff appointment and/or Privileges on the basis of quality of care or professional conduct or as otherwise defined in the Medical Staff Bylaws or Fair Hearing Policy.

"Allied Health Professional" or "AHP" means an individual other than a licensed Physician, Podiatrist, Dentist, or Psychologist who functions in a medical support role to or who exercises independent judgment within the area of his/her professional competence and is qualified to render direct or indirect medical, surgical, 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. AHPs may include, but are not limited to, physician assistants and advanced practice registered nurses who are granted Privileges and other Practitioner-directed AHPs who practice pursuant to a scope of service/position description recognized by the Hospital.

"Applicant" means a Practitioner who seeks appointment to the Medical Staff and/or Privileges at the Hospital.

"Appointee" means a Practitioner who has been granted appointment to the Medical Staff. An Appointee must also have applied for and been granted Privileges unless the appointment is to a Medical Staff category without Privileges or unless otherwise provided in the Bylaws.

"Board" means the Board of Trustees of the Hospital or the Board’s designee(s).

"Bylaws" or "Medical Staff Bylaws" means the articles herein, and amendments thereto, that constitute the basic governing documents of the Medical Staff. A reference to the Bylaws shall include Medical Staff Policies and Rules & Regulations to the extent applicable.

"Chief Executive Officer" or "CEO" means the individual appointed by the Board to serve as the Board's representative in the overall administration of the Hospital. The Chief Executive Officer may, consistent with the authority granted to him/her by the Hospital’s bylaws, appoint a representative to perform certain administrative duties identified in these Bylaws.

"Chief of Staff" means the Active Appointee who serves as chief administrative officer of the Medical Staff.

"Dentist" means an individual who has received a Doctor of Dental Surgery (“D.D.S.”) or Doctor of Dental Medicine (“D.M.D.”) degree and who is currently licensed to practice dentistry.

"Ex Officio" means service as an appointee to a body by virtue of an office or position held and, unless otherwise expressly provided, without voting rights.

"Federal Healthcare Program" means Medicare, Medicaid, TriCare, or any other federal or state program providing healthcare benefits that is funded directly or indirectly by the United States government.

"Good Standing" means that an Appointee, at the time the issue is raised, has met the attendance and Service/committee participation requirements during the previous Medical Staff Year; is not in arrears in dues payments; and has not received a suspension or restriction of his/her appointment and/or Privileges in the previous twelve (12) months; provided, however, that if an Appointee has been suspended in the previous twelve (12) months for failure to comply with the Hospital's policies or procedures regarding
medical records and has subsequently taken appropriate action, such suspension shall not adversely affect the Appointee's Good Standing status.

"Hospital" means Fayette County Memorial Hospital, located in Washington Court House, Ohio and shall include the Hospital’s provider based locations.

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

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

“Medical Staff Policy” or “Policy” means those Medical Staff policies, approved by the Medical Executive Committee and the Board, that serve to implement the Medical Staff Bylaws. Medical Staff Policies shall include, but not be limited to, the Fair Hearing Policy and Allied Health Professional Policy.

"Medical Staff Year" means the period from January 1 to December 31 of each calendar year.

"Patient Encounter" means: a professional contact between a Practitioner and patient, whether an admission, consultation, or diagnostic, operative, or invasive procedure at the Hospital.

"Physician" means an individual who has received a Doctor of Medicine (“M.D.”) or Doctor of Osteopathic Medicine (“D.O.”) degree and who is currently licensed to practice medicine.

"Podiatrist" means an individual who has received a Doctor of Podiatric Medicine (“D.P.M”) degree and who is currently licensed to practice podiatry.

"Practitioner" means an appropriately licensed Physician, Dentist, Podiatrist, or Psychologist.

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

"Privileges" mean the permission granted to a Practitioner or Allied Health Professional to render specific diagnostic, therapeutic, medical, dental, pediatric, surgical, or psychological services within the Hospital based upon the individual's professional license, experience, competence, ability and judgment.

“Professional Liability Insurance” means professional liability insurance coverage of such kind, in such amount and underwritten by such insurers as required and approved by the Board.

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

“Rules and Regulations” means the Medical Staff rules and regulations, approved by the MEC and the Board, that govern the provision of care, treatment and services to Hospital patients.

“Service” means a Medical Staff grouping or division of clinical services as provided for in these Bylaws.

“Service Chief” means the Active Appointee with Privileges who serves as the leader of a Service.
"Special Notice" means written notice (a) sent by certified mail, return receipt requested; or (b) delivered personally as evidenced by written receipt therefore.
OTHER

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

Time Computation: 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.

Designee: Whenever an individual is authorized to perform a duty by virtue of his/her position, then the term shall also include the individual’s authorized designee.
ARTICLE I
NAME

These Bylaws address the Medical Staff of Fayette County Memorial Hospital.
ARTICLE II
PURPOSES

2.1 Purposes: The purposes of the Medical Staff are:

2.1.1 To be accountable to the Board for the appropriateness of patient care services and the professional and ethical conduct of each Practitioner appointed to the Medical Staff; to oversee the quality of patient care, treatment, and services provided by Practitioners and AHPs privileged through the Medical Staff process; and, to promote patient care within the Hospital that is consistent with generally recognized standards of care.

2.1.2 To be the formal organizational structure through which the benefits of Medical Staff appointment and/or Privileges may be obtained and the obligations of Medical Staff appointment and/or Privileges may be fulfilled.

2.1.3 To provide an appropriate and efficient forum for Practitioner input to the Board and Chief Executive Officer on applicable administrative and medical issues.

2.2 Responsibilities: The Medical Staff’s responsibilities shall be:

2.2.1 To participate in the Hospital’s performance improvement/quality assessment, quality review, and utilization management programs, and to conduct activities required by the Hospital to assess, maintain, and improve the quality and efficiency of medical care in the Hospital by, without limitation:

(a) Evaluating Practitioner/AHP and Hospital performance through use of a valid measurement system as developed by the Hospital based upon clinically sound criteria.

(b) Monitoring patient care practices on an ongoing basis.

(c) Establishing criteria and evaluating Practitioners’ credentials for appointment and reappointment to the Medical Staff, including category and Service assignments, and for identifying the Privileges that are granted to Practitioners and AHPs who provide patient care.

(d) Initiating and pursuing corrective action with respect to Medical Staff Appointees when warranted.

(e) Identifying and advancing, in accordance with sound resource utilization practices, the appropriate use of the Hospital’s resources available for meeting patients’ medical, social, and emotional needs.

2.2.2 To assist in the development, delivery, and evaluation of continuing medical education and training programs.

2.2.3 To develop, maintain, and enforce compliance with Medical Staff Bylaws, Policies, and Rules & Regulations that promote sound professional practices, organizational principles, and compliance with applicable law.
2.2.4 To participate in the Hospital’s strategic planning activities, to assist in identifying community health needs, and to participate in developing and implementing appropriate Hospital policies and programs to meet those needs.

2.2.5 To fulfill the obligations and appropriately use the authority granted in these Medical Staff Bylaws in a timely manner through the use of Medical Staff officers, committees, and Practitioners and to account therefore to the Board.

2.2.6 Reviewing and recommending action on all applications for Medical Staff Appointment/Reappointment and changes in Medical Staff Category.

2.2.7 Reviewing and recommending action on all requests for Clinical Privileges/Re-grant of Privileges.
ARTICLE III
APPOINTMENT AND PRIVILEGING

3.1 Nature of Appointment and/or Privileges. Appointment to the Medical Staff is separate and distinct from a grant of Privileges. A Practitioner who is granted appointment to the Medical Staff is entitled to such Prerogatives and is responsible for fulfilling such obligations as are set forth in these Bylaws and the Medical Staff category to which the Practitioner is appointed. A Practitioner who is granted Privileges is entitled to exercise such Privileges as are granted by the Board, or as otherwise provided in these Bylaws, and is responsible for fulfilling such obligations as set forth in these Bylaws and the applicable Privilege set. Medical Staff appointment shall confer only such Privileges and Prerogatives as granted by the Board in accordance with these Bylaws. No Practitioner, including those with a contract or employment with the Hospital, may admit or provide any health care services to patients in the Hospital unless he/she has been granted Privileges to do so in accordance with the procedures set forth in these Medical Staff Bylaws.

3.2 Non-Discrimination. No Applicant shall be denied appointment and/or Privileges on the basis of gender/sex, race, age, religion, creed, color, national origin, sexual preference, disability or a handicap unrelated to his/her ability to fulfill patient care and required Medical Staff obligations; or, to any other criteria unrelated to the delivery of quality patient care in an efficient manner at the Hospital’s facilities, to professional qualifications, to the Hospital’s purposes, needs and capabilities, or to community need.

3.3 No Entitlement to Appointment and/or Privileges. No Applicant shall be entitled to Medical Staff appointment and/or Privileges at the Hospital merely by virtue of the fact that he/she:

3.3.1 Holds a certain degree, or a valid license to practice medicine, dentistry, podiatry, or psychology in Ohio or any other state.

3.3.2 Is certified by any clinical board.

3.3.3 Is a member of any professional organization.

3.3.4 Has previously had a Medical Staff appointment or Privileges in this Hospital; or, is a current or former medical staff appointee or holds or has held privileges in any other hospital or other health care facility.

3.3.5 Contracts with, or is employed by, the Hospital.

3.4 Qualifications for Appointment and/or Privileges

3.4.1 With the exception of Applicants for Medical Staff appointment without Privileges, every Applicant who applies for appointment and/or Privileges shall, at the time of application and initial appointment/privileging and continuously thereafter, demonstrate to the satisfaction of the Medical Staff and the Board that he/she meets all of the following qualifications for appointment and/or Privileges and any other qualifications and requirements as set forth in these Medical Staff Bylaws, the Hospital’s bylaws, or as otherwise hereinafter recommended by the MEC and approved by the Board. Each Applicant must:
(a) Hold a current, valid certificate/license issued by the State of Ohio to practice medicine, dentistry, podiatry, or psychology and meet the continuing medical education requirements for licensure as determined by the applicable state licensure board.

(b) Hold, if appropriate, a current, valid Drug Enforcement Administration (DEA) registration.

(c) Have educational documentation in accordance with the requirements that follow:

(i) **Physicians.** A Physician Applicant must (a) hold a MD or DO degree issued by an allopathic or osteopathic school of medicine approved at the time of the issuance of such degree by the Ohio State Medical Board; or, (b) have a diploma or license from a foreign country that has been approved by the Ohio State Medical Board and confers a full right to practice all branches of medicine or surgery in the State of Ohio.

(ii) **Dentists and Oral Surgeons.** A Dentist or oral surgeon Applicant must hold a DDS, DMD or equivalent degree issued by a dental school approved at the time of the issuance of such degree by the Ohio State Dental Board.

(iii) **Podiatrists.** A Podiatrist Applicant must hold a DPM degree conferred by a college of podiatric medicine approved at the time of issuance of such degree by the Ohio State Medical Board.

(iv) **Psychologists.** A Psychologist Applicant must hold a degree in psychology, school psychology, or a doctoral degree deemed equivalent by the Ohio State Board of Psychology issued by an educational institution accredited at the time of issuance of such degree by the Ohio State Board of Psychology.

(d) Provide documentation of successful completion of an approved internship, residency or training program, in the specialty in which the Applicant seeks Privileges. Fellowship in an institution approved for residency training shall be regarded as residency training or internship.

(e) **Board Certification:** Current board certification by the American Board of Medical Specialties, the American Osteopathic Association Board, the American Board of Physician Specialties, or additional alternative boards recommended by the Medical Executive Committee and approved by the Board at initial appointment; or be actively pursuing board certification with the intent to be board certified within four (4) years.
(i) If the Practitioner is not board certified within four (4) years of the initial appointment date, an extension may be requested, in writing, from the Medical Executive Committee for a period not to exceed two (2) years. The request must set forth the reason why board certification has not been obtained and the reasons why the Practitioner believes an extension should be granted. Upon receipt of such request, the MEC shall forward its recommendation to the Board for final decision. The request for an extension will be evaluated on a case by case basis. If the extension is approved it will only be granted on a one (1) time basis. A denial of the request will not constitute an Adverse event for purposes of the Bylaws or Fair Hearing Policy.

(ii) If a Practitioner is board certified on or after October 26, 2011, then the Practitioner shall be obligated to maintain board certification based upon the Privileges requested, even if the Practitioner was exempt from obtaining board certification pursuant to (a)(iv).

(iii) If a Practitioner loses or fails to maintain board certification after his or her initial appointment, the Practitioner may request an exemption from the board certification requirement. Such request shall be made in writing to the Medical Executive Committee within 10 days of Practitioner becoming aware of the loss of board certification. Absent any extenuating circumstances, the Medical Executive Committee will grant the exemption, providing the Practitioner provides proof that he or she is eligible to take the appropriate board exam and is actively pursuing such board certification. The Medical Executive Committee may revoke the exemption at any time it determines that the Practitioner is not eligible to take the appropriate board certification exam or is not actively pursuing such board certification.

(iv) Practitioners who are currently appointed to the Medical Staff with Privileges, who are not board certified in their specialty/subspecialty, and who completed their residency more than five (5) years before October 26, 2011, are exempt from the requirement of obtaining board certification.

(v) Termination of Medical Staff appointment/Privileges for failure to provide documentation of board certification within the time period required or for failure to maintain board certification will not be considered Adverse, and the procedural rights set forth in the Fair Hearing Policy shall not apply.

(f) Provide documentation evidencing current competence and an ongoing ability to provide continuous patient care, treatment, and services consistent with acceptable standards of practice and available resources including, but not limited to, information regarding current experience, clinical results, and utilization practice patterns.

(g) Have demonstrated an ability to work with and relate to others in a cooperative, professional manner that maintains and promotes an environment of quality and efficient patient care.
(h) Designate, as a precondition to the exercise of Privileges, another Practitioner with comparable Privileges who has agreed to provide back up coverage for the Practitioner's patients in the event the Practitioner is not available.

(i) Agree to fulfill, and fulfill, the obligations of Medical Staff appointment and/or Privileges as set forth in these Bylaws including, but not limited to, successful completion of their Focused Professional Practice Evaluation (“FPPE”) period.

(j) Demonstrate an ability to exercise the Privileges requested safely and competently with or without reasonable accommodation.

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

(l) Have and maintain current, valid Professional Liability Insurance in the amount of at least One Million Dollars ($1,000,000) each occurrence and Three Million Dollars ($3,000,000) general aggregate coverage.

3.4.2 Practitioners applying for Medical Staff appointment without Privileges shall satisfy such qualifications as set forth in the applicable Medical Staff category and such other qualifications as recommended by the MEC and approved by the Board.

3.4.3 In the case of applications for initial Medical Staff appointment and/or Privileges and with respect to requests for new Privileges during the course of an appointment/Privilege period, the requested appointment/Privileges must be compatible with any policies, plans, or objectives formulated by the Board concerning:

(a) The Hospital's patient care needs, including current and projected needs.

(b) The Hospital's ability to provide the facilities, equipment, personnel, and financial resources that will be necessary if the application is approved.

(c) The Hospital's decision to contract exclusively for the provision of certain medical services with a Practitioner or a group of Practitioners other than the affected Practitioner.

3.5 Obligations of Appointment and/or Privileges

3.5.1 With the exception of Practitioners granted an appointment without Privileges, each Practitioner granted an appointment and/or Privileges under these Bylaws must, as applicable:

(a) Provide his/her patients with professional services consistent with the recognized standards of practice in the same or similar communities and the resources locally available.

(b) Comply with the Medical Staff Bylaws, Policies, and Rules & Regulations, the Medical Staff Code of Conduct, the Hospital’s bylaws, the corporate compliance plan, and all other applicable standards, policies, procedures and laws.
(c) Perform any Medical Staff, Service, committee, and Hospital functions for which he/she is responsible.

(d) Complete medical records and other records in such manner and within the time period required by the Hospital for all patients he/she admits, or otherwise provides care for at the Hospital.

(e) Abide by generally recognized standards of medical and professional ethics.

(f) Satisfy the ongoing continuing education requirements as applicable and as established by the Medical Staff.

(g) Abide by the terms of the Hospital’s Notice of Privacy Practices prepared and distributed to patients as required by the federal patient privacy regulations.

(h) Exercise the Prerogatives and satisfy obligations of the Medical Staff category to which he/she is assigned and the Service of which he/she is a member.

(i) Cooperate and participate, as requested by the Medical Staff, in quality assurance activities and utilization review activities, whether related to oneself or others.

(j) Work in a cooperative, professional and civil manner and refrain from any behavior or activity that is disruptive to the Hospital’s operations.

(k) Cooperate in any relevant or required review of a Practitioner’s (including his/her own) credentials, qualifications or compliance with these Bylaws; and refrain from directly or indirectly interfering, obstructing or hindering any such review, whether by threat of harm or liability, by withholding information, by refusing to perform or participate in assigned responsibilities, or otherwise.

(l) Assist with any Medical Staff approved education programs, if applicable.

(m) Comply with the Hospital’s policy related to conflicts of interest, if applicable.

(n) Promptly notify Medical Staff Services of the following:

   (i) Any change in the Practitioner’s physical or mental health status that could adversely affect his/her ability to effectively and safely discharge clinical responsibilities.

   (ii) The revocation or suspension of the Practitioner’s professional license; the imposition of terms of probation or limitation of practice by any state licensing agency; or, the revocation, suspension, limitation or relinquishment of his/her DEA registration.

   (iii) The voluntary/involuntary loss of the Practitioner’s medical staff appointment or the voluntary/involuntary loss, reduction or restriction of privileges at any hospital or other healthcare facility, or with any health plan with duration greater than fourteen (14) days.
(iv) The cancellation, lapse, or restriction of the Practitioner’s Professional Liability Insurance.

(v) The commencement of formal investigation, or the filing of charges by the Department of Health and Human Services or any law enforcement or health regulatory agency of the United States or State of Ohio, regarding the Practitioner.

(vi) The Practitioner’s suspension or exclusion from participation in a Federal Healthcare Program or payment of civil monetary penalties.

(vii) The Practitioner pleads guilty or no contest to, or is found guilty of a felony or other serious offense that involves violence or abuse upon a person; diversion, embezzlement, or misappropriation of property; fraud, bribery, evidence tampering, or perjury; or, a drug offense.

The Practitioner shall comply with such other notice requirements as are set forth in these Bylaws.

3.5.2 Failure to satisfy any of the aforementioned obligations may be grounds for denial of Medical Staff reappointment and/or Privileges, change in Medical Staff category, or corrective action pursuant to these Bylaws.

3.5.3 Practitioners granted a Medical Staff appointment without Privileges shall fulfill the obligations set forth in the Medical Staff category to which the Practitioner is appointed and such other obligations as recommended by the MEC and approved by the Board.

3.6 Duration of Appointment/Privileges.

Subject to Section 3.7 of this Article, initial appointments and/or Privileges, modifications of Medical Staff appointment and/or Privileges, and reappointments/regrant of Privileges shall be for a period of not more than two (2) years; provided, however, that the duration of any such initial appointment, reappointment and/or grant/regrant of Privileges shall be subject to the provisions of the Fair Hearing Policy and may be less than two (2) years if approved by the Board. An appointment or grant of Privileges of less than two (2) years shall not be deemed Adverse for purposes of these Bylaws or the Fair Hearing Policy.

3.7 Contract Practitioners.

3.7.1 A Practitioner who is or will be providing professional services pursuant to a contract with the Hospital must meet the same qualifications, must be processed in the same manner, and must fulfill all of the obligations of Medical Staff appointment and/or Privileges as any other Applicant or Practitioner. The contract may require the Practitioner to meet additional criteria or qualifications beyond those required under the Medical Staff Bylaws.

3.7.2 The effect of the expiration or termination of a contract upon a Practitioner’s appointment and/or Privileges will be governed solely by the terms of the Practitioner’s contract with the Hospital. If the contract is silent on the matter, then:
In the absence of language in the contract to the contrary, if an exclusive contract under which such Practitioner is engaged is terminated, or if the relationship of the Practitioner with the entity that has the exclusive contractual relationship with the Hospital is terminated or expires, then the Practitioner’s Medical Staff appointment and those Privileges covered by the exclusive contract shall also be terminated, and the procedural rights afforded by the Fair Hearing Policy shall not apply; provided, however, that the Board in its sole discretion may waive this automatic termination result.

3.7.3 Whenever certain professional services are provided on an exclusive basis in accordance with contracts between the Hospital and qualified Practitioner(s)/groups, then other Practitioners must, except in an emergency or a life-threatening situation, adhere to the exclusivity policy in arranging for or providing care. Applications for initial appointment/reappointment or for Privileges/regrant of Privileges related to professional services covered by exclusive agreements will not be processed unless the Applicant/Practitioner is employed by or under contract with the relevant exclusive provider(s).

3.7.4 If the Hospital adopts a policy involving a closed service or an exclusive arrangement for a particular service(s), any Practitioner with Privileges to provide such service(s), but who is not a party to the exclusive contract/arrangement, may not provide such service(s) as of the effective date of the closure of the service or exclusive arrangement, irrespective of any remaining time on his/her appointment, reappointment and/or Privilege period.

3.8 Leave of Absence.

3.8.1 At the discretion of the MEC and subject to approval by the Board, an Appointee may, for good cause shown such as for medical reasons, educational reasons, or military service, be granted a voluntary leave of absence from the Medical Staff by submitting a written request to the MEC and the Chief Executive Officer stating the approximate period of time of the leave, which may not exceed one (1) year or the last date of the current appointment/Privilege period, whichever occurs first.

3.8.2 During a leave of absence, the Appointee is not entitled to exercise Privileges at the Hospital, and has no appointment Prerogatives and responsibilities, with the exception that he/she must continue to pay Medical Staff dues, unless otherwise waived by the MEC. Prior to a leave of absence being granted, the Appointee shall have made arrangements, acceptable to the MEC and Board, for the care of his/her patients during the leave.

3.8.3 In order to qualify for reinstatement following a leave of absence, the Appointee must maintain Professional Liability Insurance coverage during the leave or purchase tail coverage for all periods during which the Appointee held Privileges. The Appointee shall provide documentation to demonstrate satisfaction of continuing Professional Liability Insurance coverage or tail coverage as required by this provision upon request for reinstatement.

3.8.4 The Appointee must submit to the MEC, at least thirty (30) days prior to termination of the leave of absence, or at any earlier time, a written request for reinstatement as well as such additional information as is reasonably necessary to reflect that the Appointee is
qualified for reinstatement, or as may otherwise be requested by the MEC, including but not limited to:

(a) A Physician's report on the Appointee's ability to resume practice if the Appointee is returning from a medical leave of absence.

(b) A statement summarizing the educational activities undertaken by the Appointee if the leave of absence was for educational reasons.

(c) Proof of military discharge or status if the leave of absence was for military reasons.

(d) Proof of current Ohio State Medical Board or other appropriate professional license.

3.8.5 For good cause, and upon notice received not less than thirty (30) days prior to expiration of a leave, an Appointee's leave may be extended by the MEC, with approval of the Board, for an additional period not to exceed the final date of the Appointee's current appointment/Privilege period.

3.8.6 Once the Appointee's request for reinstatement is deemed complete, the MEC shall, at its next regular meeting, take action on the request in accordance with the procedure set forth in Article IV. The Appointee shall be subject to FPPE upon reinstatement.

3.8.7 If an Appointee fails to request reinstatement upon the termination of a leave of absence, the MEC shall make a recommendation to the Board as to how the failure to request reinstatement should be construed. If such failure is determined to be a voluntary resignation, it shall not give rise to any rights pursuant to the Fair Hearing Policy.
ARTICLE IV
APPLICATION, APPOINTMENT, REAPPOINTMENT, AND PRIVILEGING PROCESS

4.1 Pre-Application. The Hospital may use a pre-application process; provided, however, that such process, if used, shall be applied to all Applicants in a uniform and consistent manner. If pre-application is required, an Applicant desiring Medical Staff appointment and/or Privileges shall obtain a pre-application form from Medical Staff Services, complete the form in full, and return it to Medical Staff Services. In the event the Hospital declines to offer the Applicant an application, he/she shall not be entitled to any procedural rights pursuant to the Fair Hearing Policy, nor shall the Hospital be subject to any reporting requirements.

4.2 Application. A written, signed application for Medical Staff appointment and/or Privileges must be submitted to Medical Staff Services on the application form approved by the Board.

4.3 Application Contents. With the exception of applications for Medical Staff appointment without Privileges, every application for Medical Staff appointment and/or Privileges must include at least the following:

4.3.1 Education and Training. Documentation of satisfaction of the education and training qualifications set forth in §3.4.1(c) and (d) including the name of the institutions and the dates attended, any degrees granted, course of study or program completed; and, for all post-graduate training, the names of persons responsible for reviewing the Applicant's performance.

4.3.2 Licensure. Documentation of satisfaction of the qualifications set forth in §3.4.1(a) and (b) including a copy of all current, valid professional licenses or certifications and DEA registration, the date of issuance, and license or provider number.

4.3.3 Board Certification. Documentation of satisfaction of the qualifications set forth in §3.4.1(e) including records verifying any specialty or subspecialty board certification, recertification, or eligibility to sit for such board's examination.

4.3.4 Ability to Perform. A statement that the Applicant is able to competently perform all the procedures for which he/she has requested Privileges, with or without reasonable accommodation, according to accepted standards of professional practice and without posing a threat to patients.

4.3.5 Professional Liability Insurance. Documentation verifying Professional Liability Insurance coverage, including the names of present and past insurance carriers, and any information related to the Applicant's malpractice claims history and experience during the past five (5) years.

4.3.6 Professional Sanctions. The nature and specifics of any prior actions involving denial, revocation, non-renewal, challenges to, or voluntary relinquishment (by resignation or expiration) of: any professional license or certificate to practice in Ohio or in any other state or country; any controlled substances registration; appointment or fellowship in local, state, or national organizations; specialty or sub-specialty board certification or eligibility; faculty appointment at any professional school; medical staff appointment, prerogatives, or privileges at any other health care institution including any hospital, clinic, skilled nursing facility, or managed care organization in this or any other state; Professional Liability Insurance; or participation in any Federal Healthcare Program.
4.3.7 **Previous Affiliations.** Information regarding the Applicant’s current and prior affiliations during the past ten (10) years.

4.3.8 **Request.** The Medical Staff category and Privileges requested.

4.3.9 **Legal Actions.** The status, and if applicable, resolution of any past or current criminal charges against the Applicant (other than routine traffic offenses).

4.3.10 **Professional References.** The names of at least three (3) Practitioners with personal knowledge of the Applicant’s ability to practice and who has had the opportunity to evaluate applicant within the last 2 years. Professional recommendations shall include information regarding the Applicant’s: medical/clinical knowledge; technical/clinical skills; clinical judgment; interpersonal skills; communication skills and professionalism. Professional recommendations may be in the form of written documentation reflecting informed opinions on the Applicant’s scope and level of performance or a written peer evaluation of Practitioner-specific data collected from various sources for the purpose of validating current competence.

4.3.11 **Conflict of Interest.** Such information as required by the Hospital’s conflict of interest policy, if applicable.

4.3.12 **Regulatory Actions.** Information as to whether the Applicant has been the subject of investigation by a Federal Healthcare Program and, if so, the outcome of such investigation.

4.3.13 **Proof of Identity.** Applicants must provide a form of government-issued color photo identification to verify that he/she is, in fact, the individual requesting Privileges (e.g. a passport or driver’s license).

4.3.14 **Acknowledgements and Agreements.** Statements notifying the Applicant of the information set forth in §4.4.

4.3.15 **Other.** Such other information as the Board may require from time to time.

4.3.16 **Signature.** The Applicant’s signature.

4.4 **Effects of Application.** An Applicant will be given the opportunity to go through the qualifications and other requirements for Medical Staff appointment and/or Privileges with a Hospital/Medical Staff representative in person, by telephone, or in writing. Upon receipt of the application and required application fee, a credentials file will be created and maintained by the Hospital. By signing and submitting an application for Medical Staff appointment and/or Privileges, the Applicant:

4.4.1 Acknowledges and attests that the application is correct and complete, and that any material misstatement or omission is grounds for a denial or termination of appointment and/or Privileges.

4.4.2 Agrees to appear for personal interviews, if required, in support of his/her application.
4.4.3 Agrees to the provisions set forth in Article XIV regarding authorization to obtain and release information, confidentiality of information, immunity for reviews and actions taken, and the right to secure releases for obtaining and sharing information.

4.4.4 Understands and agrees that if Medical Staff appointment and/or requested Privileges are denied based upon the Applicant's competence or conduct, the Applicant may be subject to reporting to the National Practitioner Data Bank and/or State authorities.

4.4.5 Agrees to fulfill his/her Medical Staff obligations including, but not limited to, practicing in an ethical manner and providing continuous care to patients.

4.4.6 Agrees to notify Medical Staff Services immediately if any information contained in the application changes. The foregoing obligation shall be a continuing obligation of the Applicant so long as he/she is an Appointee to the Medical Staff and/or has Privileges at the Hospital.

4.4.7 Agrees to be bound by the terms of and to comply in all respects with the Medical Staff Bylaws, Policies, and Rules & Regulations, the Medical Staff Code of Conduct, and the Hospital’s bylaws, corporate compliance plan, Notice of Privacy Practices and other applicable policies and procedures if he/she is granted appointment and/or Privileges; and, to be bound by the terms thereof in all matters relating to consideration of his/her application without regard to whether the Applicant is granted appointment and/or Privileges.

4.4.8 Agrees that when an Adverse action or recommendation is made with respect to his/her Medical Staff appointment and/or Privileges, the Applicant will exhaust the administrative remedies afforded by these Bylaws before resorting to formal legal action.

4.5 Burden of Providing Information. The Applicant is responsible for producing information to properly evaluate his/her qualifications for Medical Staff appointment and/or Privileges including, but not limited to, experience, background, training, demonstrated competence, utilization patterns, work habits (which include the ability to work cooperatively with others), and/or ability to exercise the Privileges requested; to resolve any doubts or conflicts; and, to clarify information as requested by appropriate Medical Staff or Board authorities.

4.6 Processing the Application.

4.6.1 The application shall be submitted to Medical Staff Services for processing. Medical Staff Services shall be responsible for collecting and verifying all qualification information received, and for promptly notifying the Applicant of any problems with obtaining required information. Upon notification of any problems or concerns, the Applicant must obtain and furnish the required information. If, after the Applicant submits his/her application, he/she fails to furnish requested information within sixty (60) days of written request therefore, the application shall be deemed to have been voluntarily withdrawn without right to a hearing or appellate review, and the Applicant shall be so informed.

4.6.2 Medical Staff Services shall perform primary source verification and query the National Practitioner Data Bank and any other data bank as permitted or required by law. Medical Staff Services shall also check the OIG Cumulative Sanction report, the General Services Administration List of Parties Excluded from Federal Procurement and Non-Procurement Programs, and any other appropriate sources to determine whether the Applicant has been
convicted of a health care related offense, or debarred, excluded, or otherwise made ineligible for participation in a Federal Healthcare Program. Medical Staff Services shall perform background checks consisting of SSN trace and validation, criminal history reports from county, state and federal districts. Drug screening will be performed at appointment and reappointment. When the collection and verification process is accomplished, Medical Staff Services shall transmit the completed application and all related materials to the appropriate medical director and/or Service Chief as follows:

(a) Pathology – Medical Director of Pathology
(b) Radiology – Medical Director of Radiology
(c) Emergency Room – Medical Director of Emergency Room
(d) Physician Practices – Medical Director of Physician Practices
(e) Inpatient Care – Chief of Medicine
(f) Surgery – Chief of Surgery

4.6.3 The appropriate medical director and/or Service Chief is responsible for reviewing the application and any related documentation; and, for preparing a written report evaluating the evidence of the Applicant's training, experience, and demonstrated ability and stating how the Applicant's skills are expected to contribute to the quality of patient care and the clinical and educational activities of the Service. This report shall be forwarded to the Medical Executive Committee and must state the reviewer’s opinion as to approval or denial of, and any special limitations on, appointment, Medical Staff category, Service assignment, and/or Privileges. Before submitting his/her report to the MEC, the medical director and/or Service Chief may, at his/her discretion, conduct an interview with the Applicant.

4.6.4 After receipt of the medical director’s and/or Service Chief’s report, the MEC is responsible for reviewing the report and related application materials. The MEC shall vote on the application and, on the basis thereof, may take any of the following actions:

(a) **Defer Action:** A decision by the MEC to defer any action on the application must be revisited, except for good cause, within thirty (30) days with subsequent recommendation as to approval or denial of, or any special limitations on, appointment, Medical Staff category, Service assignment, and/or Privileges. The Chief Executive Officer shall promptly send the Applicant written notice of a decision to defer action on his/her application.

(b) **Favorable Recommendation:** If the MEC makes a favorable recommendation regarding all aspects of the application, the MEC shall promptly forward its recommendation, together with all related documentation, to the Board.

(c) **Adverse Recommendation:** If the MEC's recommendation is Adverse to the Applicant, the Chief Executive Officer shall inform the Applicant of the recommendation by Special Notice, and the Applicant shall then be entitled, if applicable, to the procedural rights set forth in the Fair Hearing Policy. No such Adverse recommendation shall be required to be forwarded to the Board until
after the Applicant has exercised, or has been deemed to have waived, his/her right to a hearing, if any, as provided for in the Fair Hearing Policy.

4.6.5 The Board may take any of the following actions with regard to an application for Medical Staff appointment and/or Privileges:

(a) **Favorable MEC Recommendation**: The Board may adopt or reject any portion of the MEC's recommendation that was favorable to an Applicant or refer the recommendation back to the MEC for additional consideration, but must state the reason(s) for the requested reconsideration and set a time limit within which a subsequent recommendation must be made. If the Board's action is favorable, the action shall be effective as its final decision. If the Board's decision is Adverse to the Applicant, the CEO shall so notify the Applicant by Special Notice and the Applicant shall be entitled, if applicable, to the procedural rights provided for in the Fair Hearing Policy.

(b) **Without Benefit of MEC Recommendation**: If the MEC fails to make a recommendation within the time required, the Board may, after informing the MEC of the Board's intent and allowing a reasonable period of time for response by the MEC, make its own determination using the same type of criteria considered by the MEC. If the Board's decision is Adverse to the Applicant, the CEO shall notify the Applicant by Special Notice and the Applicant shall be entitled, if applicable, to the procedural rights provided for in the Fair Hearing Policy.

(c) **Adverse MEC Recommendation**: If the Board is to receive an Adverse MEC recommendation, the Chief Executive Officer shall withhold the recommendation and not forward it to the Board until after the Chief Executive Officer notifies the Applicant, by Special Notice, of the recommendation and the Applicant's right, if applicable, to the procedural rights provided for in the Fair Hearing Policy, and the Applicant either exercises or waives such rights.

4.6.6 Whenever the Board’s proposed decision is contrary to the recommendation of the MEC, there shall be a further review of the recommendation by the Joint Conference Committee, called specifically to hear the controversy. This committee shall, after due consideration, make its recommendation to the Board. The Board may then render a final decision.

4.6.7 The Board, through the Chief Executive Officer, shall give notice of its final decision to the Applicant, by Special Notice, and to the Chief of Staff. The Chief of Staff shall, in turn, transmit the decision to the appropriate medical director and/or Service Chief. A decision and notice to grant appointment and/or Privileges shall include, as applicable: the Medical Staff category to which the Applicant is appointed; the Service to which he/she is assigned; the Privileges he/she may exercise; and any special conditions attached to the appointment and/or Privileges.

4.6.8 The following time periods are considered guidelines and do not create any rights for an Applicant to have his/her application processed within these precise periods; provided; however, that this provision shall not apply to the time periods contained in the Fair Hearing Policy. When the Fair Hearing Policy is activated by an Adverse recommendation or action as provided herein, the time requirements set forth therein shall govern the continued processing of the application.
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<tr>
<th><strong>Individual/Group</strong></th>
<th><strong>Time</strong></th>
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<tr>
<td>Medical Staff Services</td>
<td>60 days</td>
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<td>Medical Director/Service Chief</td>
<td>30 days</td>
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<td>Medical Executive Committee</td>
<td>Next regular meeting</td>
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<td>Board</td>
<td>Next regular meeting</td>
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4.6.9 Due to the limited nature of an appointment without Privileges, such Applicants shall only be required to provide such information as the MEC and Board deem necessary and appropriate. If time constraints so require, an application for appointment without Privileges may be acted upon by the Board (which may delegate this authority to the CEO) upon recommendation of the MEC chair (Chief of Staff). Denial of an application for appointment without Privileges shall not trigger procedural rights pursuant to the Fair Hearing Policy, nor shall it create a reportable event for purposes of State or Federal law.

4.7 **Reappointment and/or Regrant of Privileges**

4.7.1 A Practitioner shall be notified no later than six (6) months prior to the date of expiration of his/her appointment and/or Privileges. No later than ninety (90) days before the expiration date, the Practitioner must furnish to Medical Staff Services the following reappointment materials in writing and on a form approved by the Board:

(a) All information required by §4.3 necessary to bring his/her file current.

(b) An attestation that required continuing medical and/or professional training and/or education have been completed; or, submit upon request from the MEC, a record of continuing medical and/or professional training and education completed outside of the Hospital during the current appointment/Privilege period.

(c) Low volume providers (24 encounters or less) will be required to provide two peer evaluations and a quality report from their primary workplace.

(d) Any requests for additional or reduced Privileges, with the basis therefore.

(e) Any requests for a change in Medical Staff category with the basis therefore.

The Practitioner’s ongoing professional practice evaluation (“OPPE”) data, including but not limited to morbidity and mortality data, if available, shall also be reviewed and considered.

4.7.2 Medical Staff Services shall verify the information provided on the application for reappointment/regrant of Privileges, query the same data banks and programs as with an initial application for appointment and/or Privileges, and notify the Practitioner of any deficiencies, inadequacies, or verification problems. The Practitioner then has the burden of producing adequate information and resolving any doubts about the data. Upon completion of the necessary corrections, if any, and verification, Medical Staff Services shall forward the application for reappointment and/or regrant of Privileges and the related materials to the appropriate medical director and/or Service Chief as set forth in §4.6.2.
4.7.3 The medical director and/or Service Chief shall review the application and related materials and must evaluate the information contained in the Practitioner's file to assess the Practitioner's continuing satisfaction of the qualifications contained in these Bylaws and whether the requested Medical Staff category, Service, and Privileges are appropriate. The medical director and/or Service Chief shall issue a written report to the Medical Executive Committee regarding the same.

4.7.4 Upon receipt of the medical director's and/or Service Chief’s written report, the MEC shall review the report, the application and related materials, the Practitioner’s file, and any other relevant information available to the MEC, and shall either defer action on the application for reappointment and/or regrant of Privileges or prepare a written report with recommendation for approval or denial of, and any special limitations on, reappointment Medical Staff category, Service assignment, and Privileges consistent with the process set forth in §4.6.4.

4.7.5 The final Board determination regarding applications for reappointment/regrant of Privileges shall follow the process set forth in §4.6.5 and §4.6.6.

4.7.6 If the process set forth in this section has not been completed by the end of the appointment/Privilege period due to the Hospital's delay, the Practitioner will be considered for temporary Privileges but only if circumstances exist justifying a finding of important patient care need, pursuant to §6.4.1. If the delay is due to the Practitioner's failure to provide information, his/her appointment and/or Privileges shall end on the expiration date of the current appointment/Privilege period. If the Practitioner submits an application within ninety (90) days after the date his/her appointment and Privileges are terminated, the application will be treated as an application for reappointment/regrant of Privileges. If the Practitioner submits an application thereafter, it will be treated as an initial application for appointment/Privileges.

4.7.7 For purposes of reappointment/regrant of Privileges, the terms "Applicant" and "appointment/Privileges" as used in §4.6 shall be read, as "Practitioner" and "reappointment/regrant of Privileges," respectively.

4.8 Request for Change in Appointment and/or Privileges. A Practitioner may, either in connection with reappointment/regrant of Privileges or at any other time, request changes to his/her Medical Staff category and/or Privileges by submitting a written request to Medical Staff Services on the prescribed form. An application for a change in appointment and/or Privileges is processed in the same manner as an application for reappointment/regrant of Privileges.

4.9 Expedited Credentialing. The appropriate medical director and/or Service Chief, together with a representative of Medical Staff Services, will review each completed application for appointment, reappointment and/or Privileges and will categorize the application according to the criteria set forth in §4.9.1. Completed applications meeting the criteria set forth in § 4.9.1 are eligible for expedited credentialing. All other applications will be managed through the routine credentialing process. The decision to use expedited credentialing is totally discretionary on the part of the Hospital. No Applicant has any entitlement to have his/her application reviewed through an expedited credentialing process.

4.9.1 Criteria: Applications eligible for expedited credentialing reflect all of the following:

(a) Complete application with all requested information returned promptly.
(b) No negative or questionable recommendations.

(c) No discrepancies in information received from the Applicant, verification sources, or references.

(d) Completion of a usual education/training sequence.

(e) No disciplinary actions or legal sanctions of any kind including, but not limited to: no challenges to licensure or registration; no involuntary limitation, reduction, denial, suspension, or termination of appointment and/or privileges; and no NPDB reportable events.

(f) No unusual pattern or excessive number of professional liability actions resulting in a final judgment against the Practitioner.

(g) Unremarkable medical staff/employment history (e.g. no unexplained gaps, etc.).

(h) Request for reasonable Privileges consistent with specialty, experience, training, and current competence and in compliance with all other applicable credentialing, privileging and appointment criteria.

(i) Never sanctioned by a third-party payer or Federal Healthcare Program.

(j) Never convicted of a felony.

(k) History of an ability to relate to others in a professional, collegial manner.

4.9.2 Expedited Credentialing Process. The expedited credentialing process shall be as follows:

(a) Medical Staff Services receives and processes the completed application in accordance with the applicable procedures set forth in these Bylaws.

(b) The appropriate medical director and/or Service Chief reviews the completed and verified application for appointment/reappointment and/or Privileges/regrant of Privileges and forwards a report with findings to the Medical Executive Committee.

(c) The Medical Executive Committee reviews the completed and verified application for appointment/reappointment and/or Privileges/regrant of Privileges in addition to the report/findings of the medical director and/or Service Chief.

(d) The Medical Executive Committee forwards its report and recommendation to a subcommittee of the Board consisting of not less than two (2) Board members ("Subcommittee").

(e) The Subcommittee may meet at the same time as the Medical Executive Committee meeting and conduct its review immediately after receiving a favorable recommendation from the Medical Executive Committee. In the alternative, the Subcommittee may meet separately after the Medical Executive Committee has met and made a favorable recommendation.
(f) The Subcommittee shall review expedited credentialing applications on behalf of the Board, perform a final review of the completed and verified application for appointment/reappointment and/or Privileges/regrant of Privileges and, pursuant to policy adopted by the Board, grant such appointment/reappointment and/or Privileges/regrant of Privileges effective as of the date the Subcommittee approves the application.

(g) If the Subcommittee's decision differs from the Medical Executive Committee's; or, if at any time a negative opinion/recommendation is made or the reviewers are otherwise not all in agreement, the application shall be ineligible for expedited credentialing and subject to processing in accordance with the routine credentialing procedure.

(h) The Subcommittee shall maintain separate minutes of all actions taken by it. Actions of the Subcommittee shall be reported to the Board at its next regularly scheduled meeting.

4.10 Resignations and Terminations.

4.10.1 Resignation of Medical Staff Appointment and/or Privileges. Resignation of Medical Staff appointment and/or Privileges, and the reason for such resignation, shall be submitted in writing to the Medical Executive Committee who shall notify the Board through the Chief Executive Officer. The Chief Executive Officer will notify the Practitioner of the Board's receipt of his/her resignation. Notification of the resignation shall also be communicated to all appropriate Hospital personnel.

4.10.2 Termination of Medical Staff Appointment and/or Privileges. In those cases when a Practitioner moves away from the area without submitting a forwarding address or the Practitioner's written intentions with regard to his/her Medical Staff appointment and/or Privileges, the Practitioner’s Medical Staff appointment and/or Privileges shall be automatically terminated upon recommendation of the MEC and approval by the Board. If a forwarding address is known, the Practitioner will be asked his/her intentions with regard to Medical Staff appointment and/or Privileges and, if the Practitioner does not respond within thirty (30) days, the Practitioner's name will be submitted to the MEC and Board for approval of termination. The Chief Executive Officer will inform the Practitioner of the approved termination by Special Notice.

4.10.3 No Right to Fair Hearing. Resignation or termination of Medical Staff appointment and/or Privileges under this section does not give rise to any procedural rights pursuant to the Fair Hearing Policy provided the resignation/termination is determined by the Board to be voluntary.

4.10.4 Reapplication after Adverse and Certain Other Credentialing Decisions.

(a) Except as otherwise provided in the Medical Staff Bylaws, or as otherwise recommended by the MEC and approved by the Board in light of exceptional circumstances, a Practitioner will not be eligible to reapply for Medical Staff appointment and/or Privileges for a period of one (1) year from the later of (a) the date of the action or (b) the final court decision, as applicable, in the following situations:
(i) The Practitioner has received a final Adverse decision regarding his/her application for appointment or Privileges or his/her current appointment or Privileges.

(ii) The Practitioner has had his/her appointment and Privileges automatically terminated as provided in §7.5.3.

(iii) The Practitioner has resigned his/her appointment or Privileges while under investigation for professional behavior or quality of care concerns.
ARTICLE V
CATEGORIES OF THE MEDICAL STAFF

5.1 The Medical Staff

5.1.1 The Medical Staff is divided into the Active, Courtesy, Consulting, and Consulting Peer Review categories. Appointees to any Medical Staff category shall possess the basic qualifications set forth in these Medical Staff Bylaws and any specific qualifications set forth in the applicable category and shall agree to the conditions set forth in these Medical Staff Bylaws.

5.2 Active Medical Staff

5.2.1 Qualifications.

(a) Only those Practitioners who have served for at least two (2) years on the Courtesy Medical Staff, with or without Privileges, shall be eligible to apply for appointment to the Active Medical Staff, with or without Privileges, with the exception that Practitioners who serve as a medical director shall not be required to have served on the Courtesy Medical Staff prior to requesting Active appointment.

(b) The Active Medical Staff, with or without Privileges, shall consist of Practitioners who meet the general qualifications for Medical Staff appointment and Privileges set forth in §3.4.1 or for appointment without Privileges set forth in §3.4.2, as applicable, and who meet one (1) of the following requirements:

(i) Demonstrate an interest in assisting the Hospital and Medical Staff in meeting the patient care mission by having regular Patient Encounters, corresponding to the expectations of the requested Privileges, in the Hospital and participating in the transaction of Medical Staff affairs;

(ii) Serve in a medico-administrative position at the Hospital (e.g. medical director); OR,

(iii) Request appointment to the category based upon a demonstration of genuine concern and interest in the Hospital by way of other substantial involvement in Hospital and Medical Staff activities.

(c) Upon review at the time of the Practitioner’s reappointment, failure to have met the designated requirements for the preceding appointment period shall result in transfer of the Appointee to another appropriate category. A transfer required under this section may be waived by the Board upon recommendation of the MEC if the Practitioner makes a satisfactory showing of unusual circumstances unlikely to occur again in his/her practice that were the basis of the failure to satisfy the applicable requirement(s). At the time of reappointment, if the Practitioner has failed to meet the requirements that formed the basis for his/her appointment, and the Practitioner is not otherwise transferred pursuant to the above paragraph, the Practitioner’s appointment (and Privileges, if applicable) will terminate at the end of the current appointment period.
5.2.2 **Prerogatives (with Privileges).** Appointees to the Active category with Privileges may:

(a) Exercise such Privileges as are granted by the Board.

(b) Vote on all matters presented to the Medical Staff and at meetings of the Service to which assigned.

(c) Hold Medical Staff office, serve as a Service Chief, medical director, and/or committee chair in accordance with any qualifying criteria set forth elsewhere in the Bylaws or Medical Staff Policies.

(d) Serve as a committee member in accordance with any qualifying criteria set forth elsewhere in the Bylaws or Medical Staff Policies and vote on all matters presented at meetings of the committees to which assigned.

5.2.3 **Prerogatives (without Privileges).** Appointees to the Active category without Privileges may:

(a) Not be granted Privileges at the Hospital.

(b) Vote on all matters presented to the Medical Staff and at meetings of the Service to which assigned.

(c) Hold Medical Staff office and/or serve as a committee chair in accordance with any qualifying criteria set forth elsewhere in the Bylaws or Medical Staff Policies.

(d) Not serve as a Service Chief or medical director.

(e) Serve as a committee member in accordance with any qualifying criteria set forth elsewhere in the Bylaws or Medical Staff Policies and vote on all matters presented at meetings of the committees to which assigned.

(f) Visit their hospitalized patients; provided that active Appointees without Privileges may not write orders or progress notes, make notations in the medical record, or otherwise actively participate in the provision of care or management of patients at the Hospital.

(g) Use the Hospital’s diagnostic facilities.

5.2.4 **Responsibilities.** Appointees to the Active category with or without Privileges will:

(a) Fulfill the requirements set forth in §3.5, as applicable.

(b) Contribute to the organizational and administrative affairs of the Medical Staff and faithfully perform the duties of any office or position to which elected or appointed.

(c) Actively participate as requested or required in activities and functions of the Medical Staff, including quality/performance improvement and peer review, credentialing, risk, and utilization management, medical records completion, monitoring activities, and the discharge of other Medical Staff functions as may be required.
(d) Satisfy the attendance requirements set forth in §12.8. Failure to attend a total of fifty percent (50%) of the Medical Staff meetings during the Appointee’s two (2) year appointment period will result in a reduction of Medical Staff category from Active to Courtesy at the end of the Appointee’s current appointment period. In such event, the Appointee shall not be eligible to reapply for Active appointment for a period of two (2) years.

Example: There are four Medical Staff meetings annually. Physician attends one medical staff meeting the first 12-month period and is fined $100.00 (because he/she was required to attend 2/4 meetings in the 12-month period pursuant to §12.8). The Physician attends three meetings in the second twelve month period (no fine). The Physician is not transferred to the Courtesy category at the end of his/her appointment period because he/she did attend a total of 50% of the Medical Staff meetings during the Appointee’s two (2) year appointment period (i.e. 4/8 overall).

(e) Comply with any applicable Medical Staff or Hospital policies or procedures.

(f) Timely pay annual Medical Staff dues.

(g) Attend educational meetings.

(h) Maintain and update all required information in the Appointee’s credential file during his/her appointment/Privilege period and timely apply for reappointment and/or regrant of Privileges.

(i) In addition to the responsibilities set forth above, Active Appointees with Privileges will have the following additional responsibilities:

   (i) Practitioners employed by FCMH Medical/Surgical Associates shall participate in emergency room call and provide outpatient emergency room follow-up.

   (ii) Successfully complete a FPPE period and OPPE reviews.

5.3 **Courtesy Staff**

5.3.1 **Qualifications.**

(a) TheCourtesy Medical Staff, with or without Privileges, is reserved for Medical Staff Appointees who do not meet the eligibility requirements for the Active category or who choose not to pursue Active appointment. Courtesy Appointees shall meet the general qualifications for Medical Staff appointment and Privileges set forth in §3.4.1 or for appointment without Privileges set forth in §3.4.2, as applicable.

(b) A Practitioner may request appointment to the Active Medical Staff, with or without Privileges, following at least two (2) years of service on the Courtesy Medical Staff.

5.3.2 **Prerogatives (with Privileges).** Appointees to the Courtesy category with Privileges may:
(a) Exercise such Clinical Privileges as are granted.

(b) Attend Medical Staff meetings and Service meetings to which they are assigned, as well as attend any Medical Staff or Hospital education programs.

(c) May vote on matters of policy and quality.

(d) Not hold Medical Staff office or serve as a Service Chief, medical director, or committee chair.

(e) Serve on a committee(s) to which assigned with voting rights.

5.3.3 **Prerogatives (without Privileges).** Appointees to the Courtesy category without Privileges may:

(a) Not be granted Privileges at the Hospital.

(b) Attend Medical Staff meetings and Service meetings to which they are assigned as well as attend any Medical Staff or Hospital education programs.

(c) Not vote on Medical Staff or Service matters.

(d) Not hold Medical Staff office or serve as a Service Chief, medical director, or committee chair.

(e) Serve on a committee(s) to which assigned with voting rights.

(f) Visit their hospitalized patients; provided that courtesy Appointees without Privileges may not write orders or progress notes, make notations in the medical record, or otherwise actively participate in the provision of care or management of patients at the Hospital.

(g) Use the Hospital’s diagnostic facilities.

5.3.4 **Responsibilities.** Appointees to the Courtesy category with or without Privileges shall:

(a) Fulfill the requirements set forth in §3.5, as applicable.

(b) Contribute to the organizational and administrative affairs of the Medical Staff.

(c) Actively participate as requested or required in activities and functions of the Medical Staff including quality/performance improvement and peer review, credentialing, risk, and utilization management, medical records completion, monitoring activities, and the discharge of other Medical Staff functions as may be required.

(d) Complete annual educational requirements of the Hospital.

(e) Comply with any applicable Medical Staff or Hospital polices or procedures.

(f) Timely pay annual dues.
(g) Maintain and update all required information in the Appointee’s credential file during his/her appointment/Privilege period and timely apply for reappointment/regrant of Privileges.

(h) In addition to the responsibilities set forth above, Courtesy Appointees with Privileges will have the following additional responsibilities:

(i) Practitioners employed by FCMH Medical/Surgical Associates shall participate in emergency room call and provide outpatient emergency room follow-up.

(ii) Successfully complete a FPPE period and OPPE reviews.

5.4 Consulting Medical Staff

5.4.1 Qualifications. A Consulting Medical Staff Appointee must:

(a) Meet the general qualifications for Medical Staff appointment and Privileges set forth in §3.4.1.

(b) Possess specialized skills needed at the Hospital for a specific project or for consultation on an occasional basis when requested by an Active or Courtesy Medical Staff Appointee.

(c) Demonstrate participation on the active medical staff at another accredited hospital requiring performance improvement/quality assessment activities similar to those of this Hospital. The Practitioner shall also hold at such other hospital the same Privileges, without restriction, that he/she is requesting at Hospital. An exception to this qualification may be made by the Board provided the Practitioner is otherwise qualified by education, training and experience to provide the requested service.

5.4.2 Prerogatives. Members of the Consulting Medical Staff may:

(a) Exercise the Privileges granted.

(b) Attend meetings of the Medical Staff (without vote); applicable Service meetings (without vote); and committee meetings to which assigned (with vote).

(c) Attend educational programs of the Medical Staff.

(d) Not hold Medical Staff office or serve as a Service Chief, medical director, or committee chair.

5.4.3 Responsibilities. A Consulting Medical Staff Appointee shall:

(a) Fulfill the requirements of Medical Staff appointment and Privileges set forth in §3.5.

(b) Promptly pay all Medical Staff dues and assessments.
5.5 Consulting Peer Review Medical Staff.

5.5.1 Qualifications. A Consulting Peer Review Medical Staff Appointee must:

(a) Practice either locally or in another city and state in which he/she has a valid license to practice.

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

(c) Demonstrate participation on the active medical staff at another accredited hospital requiring performance improvement/quality assessment activities similar to those of Hospital.

5.5.2 Prerogatives. A Consulting Peer Review Medical Staff Appointee may:

(a) Review selected medical record components, organizational 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) Not be granted Privileges.

(c) Attend Medical Staff, Service, and committee meetings without vote.

(d) Not hold Medical Staff office or serve as a Service Chief, medical director, or committee chair.

5.5.3 Responsibilities. A Consulting Peer Review Medical Staff Appointee shall:

(a) Perform such duties as are requested and which he/she agrees to perform.

(b) Not be charged Medical Staff dues.
ARTICLE VI
CLINICAL PRIVILEGES

6.1 Limitation of Clinical Privileges

Practitioners shall exercise only those Privileges at the Hospital specifically granted to the Practitioner by the Board, or as otherwise provided in these Medical Staff Bylaws, and must be acting within the scope of his or her license, certificate, or other legal credentials authorizing him or her to practice in the State of Ohio and consistent with any restrictions thereon.

6.2 Clinical Privileges Shall be Specifically Delineated

6.2.1 Delineation. All Privileges granted to Practitioners shall be delineated with sufficient specificity and clarity to ensure that a Practitioner does not treat a patient in the Hospital outside the Practitioner’s area of demonstrated competence.

6.2.2 Requests. Each application for appointment or reappointment to the Medical Staff must contain a request for the specific Privileges desired by the Applicant. Specific requests must also be submitted for Privileges only (e.g. temporary Privileges) and for new or modified Privileges during a current appointment/Privilege period.

6.2.3 Special Conditions,

(a) Dentists and Oral Surgeons. Dentists and Oral Surgeons may admit patients to the Hospital. A Dentist with the requisite qualifications may be granted the Privilege of performing a history and physical examination regarding dental issues. An Oral Surgeon with the requisite qualifications may be granted the Privilege of performing a history and physical examination and assessing the medical, surgical, and anesthetic risks of the proposed operation or procedure to the patient but only in those instances where the patient has no known current medical problems. A Physician Appointee of the Medical Staff must perform a basic medical appraisal on an oral surgery or dental patient, and be responsible for the care of any medical problem present at admission/registration or that may arise during hospitalization of the patient. Clinical Privileges exercised by Dentists and Oral Surgeons shall be under the overall supervision of the Chief of Surgery.

(b) Podiatrists. A Podiatrist may admit patients to the Hospital. A Podiatrist with the requisite qualifications may be granted the Clinical Privilege of performing a history and physical examination regarding podiatric issues; however, a Physician Appointee of the Medical Staff must perform a basic medical appraisal for each podiatric patient, and be responsible for the care of any medical problem present at admission/registration or that may arise during hospitalization of the patient. Clinical Privileges exercised by Podiatrists shall be under the overall supervision of the Chief of Surgery.

(c) Psychologists. Psychologists may not admit or co-admit patients to the Hospital. Psychologists may treat only those patients who have been admitted by a Physician-Appointee to the Medical Staff and must maintain a consultative relationship with the attending Physician during the course of treatment of the patient. Clinical Privileges exercised by Psychologists shall be under the overall supervision of the Chief of Medicine.
6.2.4 The scope and extent of the Clinical Privileges that each Dentist, Oral Surgeon, Podiatrist, and Psychologist may exercise shall be specifically delineated and granted in the same manner as all other Privileges.

6.2.5 At the time of the admission/registration of a dental or podiatric patient, a patient being treated by a Psychologist, or an oral surgery patient with pre-existing medical problems, a Physician-Appointee to the Medical Staff shall be responsible for the history, physical examination, and care of any medical problem that may be present at the time of admission/registration or during hospitalization. At or before the time of admission/registration of such patients, it is the responsibility of the Dentist, Oral Surgeon, Podiatrist, or Psychologist to obtain a medical consult in accordance with the above provisions.

6.2.6 The Dentist, Oral Surgeon, Podiatrist, or Psychologist is solely responsible for the dental, podiatric, or psychological history, examination, diagnosis, operative report, and dental, podiatric, or psychological discharge summary. The Dentist, Oral Surgeon, Podiatrist, or Psychologist is responsible for the discharge and completion of medical records as such relate to his or her care of the patient at the time of release. If there is a medical problem, the attending Physician shall participate in the discharge of the patient and the completion of the medical records.

6.3 Determination of Privileges

6.3.1 Each Practitioner shall have the burden of establishing his or her qualifications and competency for the Clinical Privileges requested.

6.3.2 Requests for Clinical Privileges will be considered only when accompanied by evidence of education, training, experience, and demonstrated current competence as specified by the Hospital in its Board-approved criteria for Clinical Privileges.

6.3.3 In the event a request for Privileges is submitted for which no Board-approved criteria have been established the process set forth in the Hospital’s New Technology, Clinical Privileges, and Procedures Policy, as such Policy may be amended from time to time, shall be implemented.

6.4 Temporary Clinical Privileges

Temporary Privileges may be granted by the Chief Executive Officer, acting on behalf of the Board, upon recommendation of the Chief of Staff. Temporary Privileges may be granted in only two (2) circumstances: (1) to fulfill an important patient care need, and (2) when an initial Applicant for new Privileges is awaiting review and approval of a complete and clean application by the Medical Executive Committee and Board.

6.4.1 Important Patient Care Need

(a) Temporary Privileges may be granted to a Practitioner (including a Practitioner who temporarily comes to the Hospital to learn (be proctored on) or to teach (proctor) a procedure) on a case-by-case basis when an important patient care need exists that mandates immediate authorization to practice for a limited period of time.
(b) Temporary Privileges to meet an important patient care need may be granted upon verification of the Applicant’s current licensure, DEA, NPDB, OIG exclusion list, current certificate of insurance, basic letter of attestation that practitioner is competent and current competence (education). Temporary Privileges may be granted in this circumstance for an initial period of thirty (30) days and may be renewed for additional thirty (30) day periods as necessary to fulfill the important patient care need.

6.4.2 Clean Application Awaiting Approval

(a) Temporary Privileges may be granted to an Applicant for new Privileges who is waiting for review and recommendation by the Medical Executive Committee and approval by the Board of a complete application that raises no concerns consistent with the requirements set forth in §4.1 - §4.6.3. Along with the completed application, the record must establish:

(i) that the Applicant has no current or previously successful challenges to his/her licensure or registration; has not been subject to involuntary termination from a medical staff appointment at any other organization; and, has not been subject to any involuntary limitation, reduction, denial, or loss of privileges.

(ii) a five (5) year malpractice history without indemnity payments.

(iii) favorable results from a query to the National Practitioner Data Bank and no sanctions by the OIG.

(b) Temporary Privileges may be granted in this circumstance for a period not to exceed the pendency of the application or one hundred twenty (120) days, whichever is less.

(c) Under no circumstances may temporary Privileges be initially granted or renewed if the application is still pending because the Applicant has not responded in a satisfactory manner to a request for clarification of a matter or for additional information.

6.4.3 Temporary Privileges Upon Reappointment/Regrant of Privileges

With the exception noted in §4.7.6, temporary Privileges are not to be used upon reappointment/regrant of Privileges and may not be granted in the following situations:

(a) The Practitioner fails to provide all information necessary for the processing of his/her reappointment/regrant of Privileges in a timely manner.

(b) The Medical Staff fails to verify performance data and information in a timely manner.

6.4.4 Special Requirements

Special requirements of consultation and reporting may be imposed upon Practitioners granted temporary Privileges. Under all circumstances, Practitioners requesting
temporary Privileges shall agree to abide by the Medical Staff Bylaws, Policies, Rules & Regulations, and applicable Hospital policies in all matters relating to such Privileges.

6.5 *Locum Tenens* Privileges

Practitioners seeking *locum tenens* Privileges shall submit an application for such Privileges and shall have such application processed in accordance with Article IV. An approved application for *locum tenens* Privileges shall be valid for a period of two (2) years. In the event a Practitioner seeks to act in the capacity of a *locum tenens* more than once during this two (2) year period, the Practitioner will not be required to submit a new application; rather, the Practitioner will only be required to update the information given in the prior approved application and such other information as is deemed necessary by the Chief of Staff similar to the process for reappointment/regrant of Privileges. In exceptional circumstances, a *locum tenens* Practitioner may initially qualify for temporary Privileges pursuant to §6.4 above.

6.6 *Emergency* Privileges

Should an emergency medical condition arise with respect to a patient at the Hospital, any Practitioner, to the degree permitted by his or her license and regardless of Medical Staff status or Clinical Privileges, shall be permitted to do and shall be assisted by the Hospital’s personnel in doing everything possible to save the life of a patient or to save a patient from serious harm using every resource of the Hospital necessary, including the calling of any consultation necessary and desirable. When the emergency necessitating this action is no longer present, the Practitioner acting pursuant to this section must relinquish care of the patient to the Practitioner of record.

6.7 *Disaster* Privileges

6.7.1 If the Hospital emergency management plan has been activated in response to a disaster and the Hospital is unable to meet immediate patient needs, the Chief Executive Officer, Chief of Staff, and/or other designated individuals identified in the Hospital’s emergency management plan may, on a case-by-case basis, grant disaster Privileges to licensed, volunteer Practitioners to provide patient care after verification of a valid government-issued picture identification in addition to at least one (1) of the following:

(a) Primary source verification of licensure.

(b) Current license to practice.

(c) A current Hospital photo identification (ID) card.

(d) A current picture identification card from a health care organization that identifies professional designation.

(e) Identification indicating that the individual is a member of the Disaster Medical Assistance Team, Medical Reserve Corps, Emergency System for Advance Registration of Volunteer Health Professionals, or another recognized state or federal response organization or group that addresses disasters.

(f) Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity).
6.7.2 The Chief of Staff, or applicable Service Chief and/or medical director shall oversee the professional practice of volunteer Practitioners granted disaster Privileges. All Practitioners granted disaster Privileges must at all times while at the Hospital wear an identification badge.

6.7.3 Primary source verification of licensure will begin as soon as the immediate situation is under control and, in all but extraordinary circumstances, will be completed within seventy-two (72) hours from the time the volunteer Practitioner presents to the Hospital. Under extraordinary circumstances where this time frame cannot be met, Medical Staff Services will document the following: why primary source verification could not be performed in the required time frame; evidence of the Practitioner’s demonstrated ability to continue to provide adequate care, treatment, and services; and an attempt to rectify the situation as soon as possible.

6.7.4 The CEO shall make a decision regarding the continuation of disaster Privileges originally granted within seventy-two (72) hours from the time the volunteer Practitioner presents to the Hospital.

6.7.5 Once the immediate situation has passed and a determination has been made consistent with the Hospital’s disaster plan that the disaster is over, the Practitioner’s disaster Privileges will terminate immediately.

6.8 Telemedicine Privileges

6.8.1 Practitioners who are responsible for the patient’s care, treatment, and services via a telemedicine link shall be credentialed and privileged to do so by the Hospital in accordance with the Bylaws, accreditation requirements, and applicable law. If the Hospital has a pressing clinical need and the Practitioner can supply that service through a telemedicine link, the Practitioner may be evaluated for temporary Privileges in accordance with the procedures set forth in §6.4.

6.8.2 Practitioners providing telemedicine services to Hospital patients shall be credentialed and privileged to do so through one of the following mechanisms:

(a) The Practitioner shall be credentialed and privileged by the Hospital in accordance with the applicable procedure set forth in these Bylaws.

(b) The Practitioner shall be credentialed and privileged by the Hospital in accordance with the applicable procedure set forth in these Bylaws with the exception that the credentialing information and/or privileging decision from the distant site may be relied upon by the Medical Staff and Board in making its recommendations/decision provided that the Hospital has entered into a written agreement with the distant site and all of the following requirements are met.

(i) The distant site is a Medicare participating hospital or a facility that qualifies as a “distant site telemedicine entity.” A “distant site telemedicine entity” is defined as an entity that (1) provides telemedicine

(g) Identification by a current Hospital employee or Medical Staff Appointee(s) who possesses personal knowledge regarding the volunteer Practitioner’s ability to act as a licensed independent practitioner during a disaster.
services, (2) is not a Medicare participating hospital, and (3) provides contracted services in a manner that enables hospitals using its services to meet all applicable conditions of participation, particularly those requirements related to the credentialing and privileging of practitioners providing telemedicine services to the patients of the hospital.

a) When the distant site is a Medicare participating hospital, the written agreement shall specify that it is the responsibility of the governing body of the distant site hospital to meet the requirements of 42 C.F.R. 485.616 (c)(1)(i)-(vii), as that provision may be amended from time to time, with regard to the distant site hospital Practitioners providing telemedicine services.

b) When the distant site is a “distant site telemedicine entity” the written agreement shall specify that the distant site telemedicine entity is a contractor of services to the Hospital and, as such, furnishes the contracted services in a manner that permits the Hospital to comply with all applicable conditions of participation for the contracted services including, but not limited to, 42 C.F.R. 485.616 (c)(1)(i)-(vii) with regard to the distant site telemedicine entity Practitioners providing telemedicine services. The written agreement shall further specify that the distant site telemedicine entity’s medical staff credentialing and privileging process and standards will, at minimum, meet the standards at 42 C.F.R. 485.616 (c)(1)(i)-(vii), as that provision may be amended from time to time.

(ii) The individual distant site Practitioner is privileged at the distant site for those services to be provided to Hospital patients via telemedicine link and the Hospital is provided with a current list of his/her privileges at the distant site.

(iii) The individual distant site Practitioner holds an appropriate license issued by the State Medical Board of Ohio or other appropriate licensing entity.

(iv) The Hospital maintains documentation of its internal review of the performance of each distant site Practitioner and sends the distant site such performance information for use in the distant site’s periodic appraisal of the distant site Practitioner. At a minimum, this information must include:

a) All adverse events that result from the telemedicine services provided by the distant site Practitioner to Hospital patients; and,

b) All complaints the Hospital receives about the distant site Practitioner.

6.9 Termination of Temporary, Locum Tenens, Emergency, Disaster or Telemedicine Privileges.
6.9.1 **Termination.** The Chief Executive Officer, Chief Medical Officer, or the Chief of Staff, may, at any time, terminate any or all of a Practitioner's temporary, *locum tenens,* emergency, disaster, or telemedicine Privileges. In addition, any individual identified in the Hospital’s disaster plan with the authority to grant disaster Privileges shall also have the authority to terminate disaster Privileges. Where the life or well-being of a patient is determined to be endangered, the Practitioner’s Privileges may be terminated by any person entitled to impose summary suspensions pursuant to the Bylaws.

6.9.2 **Procedural Due Process Rights.** A Practitioner who has been granted *locum tenens,* temporary, emergency, disaster, or telemedicine Privileges is not an Appointee to the Medical Staff and is not entitled to the procedural due process rights afforded to Appointees. A Practitioner shall not be entitled to the procedural due process rights set forth in the Fair Hearing Policy because the Practitioner's request for *locum tenens,* temporary, emergency, disaster, or telemedicine Privileges are refused, in whole or in part, or because all or any portion of such Privileges are terminated, not renewed, restricted, suspended or otherwise limited, modified or monitored in any way.

6.9.3 **Patient Care.** In the event a Practitioner's Privileges are revoked, the Practitioner's patients then in the Hospital shall be assigned to another Practitioner by the Chief of Staff. The wishes of the patient will be considered, where feasible, in choosing a substitute Practitioner.

6.10 **Professional Practice Evaluation**

6.10.1 **Focused Professional Practice Evaluation.** The Hospital’s FPPE process is set forth, in detail, in the Professional Practice Evaluation Policy and shall be implemented for: (a) all Practitioners requesting initial Privileges; (b) all existing Practitioners requesting new Privileges during the course of an appointment/Privilege period; and (c) evaluating the performance of Practitioners when issues affecting the provision of safe, high quality patient care are identified. The FPPE period shall be used to determine the Practitioner’s current clinical competence and ability to perform the requested Privileges.

6.10.2 **Ongoing Professional Practice Evaluation.** Upon conclusion of the FPPE period, OPPE shall be conducted on all Practitioners with Privileges. The Hospital’s OPPE process is set forth, in detail, in the Professional Practice Evaluation Policy and requires the Hospital to gather, maintain and review data on the performance of all Practitioners with Privileges on an ongoing basis.
ARTICLE VII
CORRECTIVE ACTION, SUMMARY SUSPENSION, AUTOMATIC SUSPENSION & TERMINATION

7.1 Collegial Intervention

Prior to initiating corrective action against an Appointee for professional conduct or competency concerns, the Medical Staff leaders or Board (through the CEO as its administrative agent) may elect to attempt to resolve the concern(s) informally.

7.1.1 In such event, the following process should but is not required to be considered:

(a) Initially, the applicable medical director, if any, should meet with the Appointee in an attempt to resolve the issue(s). If there is no medical director, or if the applicable medical director is unable to resolve the issue(s), the matter should be forwarded for review and collegial intervention to the applicable Service Chief for informal resolution.

(b) If the applicable Service Chief is unable to resolve the issue(s), the matter should be forwarded for review and collegial intervention to the CEO, Chief of Staff, and/or designated Medical Staff committee (other than the MEC) or committee member for informal resolution.

(c) If such individuals and/or committee(s) (as applicable) are unable to resolve the issue(s), the matter should be referred to the MEC for formal corrective action.

7.1.2 A written record of efforts to informally resolve the matter at each level (regardless of whether the matter is or is not resolved), shall be prepared by the primary individual involved in such remediation and forwarded to the MEC for retention in the Appointee's confidential peer review file.

7.1.3 Resolution of an issue pursuant to this section shall not constitute a formal corrective action process.

7.1.4 Nothing in this section shall be construed as obligating the Hospital or Medical Staff leaders to engage in collegial intervention/informal remediation prior to implementing formal corrective action on the basis of a single incident.

7.2 Corrective Action

7.2.1 Whenever the activities, professional competence, or professional or personal conduct of an Appointee with Clinical Privileges is/are considered to be:

(a) In violation of the goals of the Medical Staff or Hospital;

(b) Below applicable standards of care;

(c) In violation of the Medical Staff Bylaws, Rules & Regulations, or policies of the Medical Staff or Hospital,

(d) A threat of immediate harm to a patient in the Hospital;
(e) Disruptive to the operations of the Medical Staff or Hospital;

(f) Unethical as defined by the Ohio State Medical Board or other appropriate licensing entity;

(g) Detrimental to patient safety or to the quality or efficiency of patient care in the Hospital; or,

(h) Damaging to the Medical Staff’s or Hospital’s reputation

Corrective action against the Appointee may be requested by a Medical Staff officer, Service Chief, medical director, standing Medical Staff committee or chair thereof, the Chief Medical Officer, the CEO, or the Board or chair thereof in accordance with these Medical Staff Bylaws.

7.2.2 All requests for corrective action shall be made in writing, which writing may be reflected by minutes, to the Medical Executive Committee and shall make reference to the specific activities or conduct which constitute the grounds for the request. In the event the request for corrective action is initiated by the MEC, it shall reflect the basis for its recommendation in its minutes.

7.2.3 Upon receipt of a request for corrective action, the Medical Executive Committee shall act on the request.

7.2.4 If the Medical Executive Committee concludes an investigation is warranted, it shall direct an investigation to be undertaken.

7.2.5 A matter shall be deemed to be under formal investigation upon the following event, whichever occurs first:

(a) The Appointee is notified (either verbally or upon proof of receipt of Special Notice) that a request for corrective action has been submitted to the MEC.

(b) The start of the MEC meeting at which a request for corrective action is to be presented. In such event, Special Notice shall be provided to the Appointee immediately following the meeting.

Once a matter is under formal investigation, the matter shall remain under formal investigation until such time as the MEC rejects the request for correction action, closes the investigation, or a final decision is rendered by the Board.

7.2.6 The Medical Executive Committee may conduct the investigation itself; assign the task to a Medical Staff officer, a Service Chief, medical director, or to an appropriate standing or ad hoc committee of the Medical Staff; or, refer the matter to the Board for investigation and resolution.

7.2.7 In the event the investigation is assigned to an ad hoc committee:

(a) No member of the ad hoc committee shall be in significant direct economic competition with the Practitioner under investigation.
(b) The Chief of Staff and the Chief of the Service in which the affected Appointee has Privileges shall serve on the *ad hoc* committee; provided, however, that:

(i) If the request for corrective action involves the Service Chief or medical director, the Medical Executive Committee will appoint another Active Medical Staff Appointee from the Service concerned to serve on the *ad hoc* committee.

(ii) If the request for investigation involves the Chief of Staff, the Medical Executive Committee will appoint another Active Medical Staff Appointee to serve on the *ad hoc* committee.

7.2.8 The investigating individual/group will proceed to investigate the allegations contained in the request for corrective action. It shall be the purpose of the investigating individual/group to attempt to ascertain the facts surrounding the request for corrective action.

7.2.9 The Appointee shall be notified that the investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating individual/group deems appropriate. If desired, the investigating individual/group shall have the right to interview the Practitioner. This investigative process is not a "hearing" as that term is used in the Fair Hearing Policy and shall not entitle the Appointee to the procedural rights provided in the Fair Hearing Policy. The investigative process may also include without limitation, a meeting with the individual or group who made the request; and/or with other individuals who may have knowledge of or information relevant to the events involved.

7.2.10 If the investigating group or individual has reason to believe that the conduct of the Appointee 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 an *ad hoc* Practitioner Effectiveness Committee (composed of one (1) or more members designated by the MEC) or require the Practitioner to submit to an impartial physical or mental evaluation within a specified time and pursuant to guidelines set forth in the Practitioner Effectiveness Policy. The MEC shall name the independent, third party Practitioner(s) who will conduct the examination at the Appointee’s expense.

7.2.11 If the investigation is conducted by a group or individual other than the MEC or the Board, that group or individual shall submit a written report of the investigation, which may be reflected by minutes, to the MEC within thirty (30) days after its receipt of the assignment to investigate. The thirty (30) day requirement may be extended by the Medical Executive Committee upon request by the investigating individual/group and demonstration of good cause. The *ad hoc* committee report should contain a recommendation on what action, if any, should be taken regarding the request for corrective action.

7.2.12 The MEC may, at any time in its discretion, and shall, at the request of the Board, terminate the investigative process and proceed with action as provided below.
7.2.13 As soon as practical after the conclusion of the investigation, the MEC shall take action which may include, without limitation, the following:

(a) Determining no corrective action be taken.

(b) Deferring action for a reasonable time where circumstances warrant.

(c) Issuing a letter of admonition, warning, reprimand, or censure. In the event such letter is issued, the affected Appointee may make a written response which will be placed in the Appointee’s credentials file.

(d) Recommending the imposition of terms of focused professional practice evaluation that limit the Appointee’s ability to exercise previously exercised Privileges.

(e) Recommending reduction, suspension, or revocation of all or any part of the Appointee's Privileges.

(f) Recommending reduction of Medical Staff category or limitation of any Medical Staff Prerogatives directly related to the Appointee’s delivery of patient care.

(g) Recommending suspension or revocation of the Practitioner's Medical Staff appointment.

7.2.14 Effect of MEC Action.

(a) Adverse Recommendation. When the MEC’s recommendation is Adverse to the Appointee, the Chief Executive Officer shall inform the Appointee by Special Notice, and the Appointee shall be entitled, upon timely and proper request, to the procedural rights contained in the Fair Hearing Policy.

(i) If the Appointee does not exercise his/her rights under the Fair Hearing Policy, the MEC will forward its recommendation to the Board, and the decision of the Board will be deemed final action.

(ii) If the Appointee exercises his/her rights under the Fair Hearing Policy, then the procedure set forth in the Fair Hearing Policy shall govern the remainder of this process.

(b) Failure to Act/Referral to Board. If the MEC (i) refers the matter to the Board; or (ii) fails to act on a request for corrective action within an appropriate time as determined by the Board, the Board may proceed with its own investigation or determination, as applicable, to the circumstances. In the case of (ii), the Board shall make such determination after informing the MEC of the Board's intent and allowing a reasonable period of time for response by the MEC. If the Board's action is not Adverse to the Appointee, the action shall be effective as its final decision and the CEO shall inform the Appointee of the Board’s decision by Special Notice. If the Board's decision is Adverse to the Appointee, the CEO shall inform the Appointee by Special Notice and the Appointee shall be entitled, upon timely and proper request, to the procedural rights set forth in the Fair Hearing Policy.
7.2.15 Other Action. 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 §7.3, §7.4, or §7.5 this Article.

7.3 Summary Suspension

7.3.1 Whenever a Practitioner’s conduct requires that immediate action be taken to protect the life of any patient or to reduce the substantial likelihood of imminent danger to the health or safety of any patient, employee, or other person present in the Hospital, any of the following individuals or groups (after consultation with the CEO) shall have the authority to summarly suspend the Medical Staff appointment and all, or any portion, of the Privileges of such Practitioner:

(a) Chief Executive Officer (upon recommendation or in consultation with any of the following individuals or groups)

(b) Chief Medical Officer (after consultation with the CEO)

(c) Chief of Staff (after consultation with the CEO)

(d) Service Chief or medical director (after consultation with the CEO)

(e) Medical Executive Committee (after consultation with the CEO)

(f) Board, its executive committee, or chair thereof (after consultation with the CEO)

If the circumstances regarding the summary suspension are such that it is unreasonable or impractical for the Chief Executive Officer to consult with any of the individuals or groups listed above prior to imposing the summary suspension, then the Chief Executive Officer may impose the summary suspension without obtaining such recommendation or consultation.

7.3.2 Such summary suspension shall become effective immediately upon imposition, and the Chief Executive Officer or Chief Medical Officer shall promptly give Special Notice of the summary suspension to the Practitioner.

7.3.3 Within five (5) days of such summary suspension, a meeting of the Medical Executive Committee shall be convened to review and consider the action taken. No such meeting shall be required if the suspension was imposed by the Medical Executive Committee. Such a meeting of the MEC shall not be considered a “hearing” as contemplated in the Fair Hearing Policy, even if the Practitioner involved attends the meeting, and no procedural requirements 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 a 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.
7.3.4 Not later than ten (10) days following the original imposition of the summary suspension, the Practitioner shall be advised, by Special Notice, of the MEC's determination or, in the case of a summary suspension imposed by the Board/CEO, of the MEC's recommendation as to whether such suspension should be lifted, modified, or continued, and of the Practitioner's rights, if any, under the Fair Hearing Policy.

(a) If the MEC’s recommendation to the Board/CEO is to lift the summary suspension and cease all further corrective action, such recommendation shall be transmitted immediately, together with all related documentation, to the Board for action.

7.3.5 A summary suspension that is lifted within fourteen (14) days of its original imposition on the ground that corrective action was not required shall not be deemed an Adverse action for purposes of the Fair Hearing Policy and a statement to that effect shall be placed in the Practitioner’s credentials file.

7.3.6 A summary suspension that remains in effect for fifteen (15) days or longer shall be deemed Adverse for purpose of the Fair Hearing Policy.

7.4 Automatic Suspension or Limitation

7.4.1 It shall be the duty of the Chief of Staff to cooperate with the Chief Executive Officer and/or the Chief Medical Officer to enforce all automatic suspensions or limitations of Medical Staff appointment and/or Privileges.

7.4.2 An automatic suspension or limitation pursuant to this section does not give rise to any rights under the Medical Staff Bylaws or the Fair Hearing Policy.

7.4.3 Automatic suspension or limitation does not preclude other corrective action, which may be taken in accordance with these Bylaws.

7.4.4 Failure to comply with the following requirements shall result in automatic suspension or limitation of a Practitioner’s appointment and/or Privileges, as applicable

(a) License. Any action taken with respect to the Practitioner’s license as follows.

(i) Limitation/Restriction. Whenever a Practitioner’s license, certificate, or other legal credential is limited or restricted by the applicable licensing or certifying authority, those Clinical Privileges that are within the scope of said limitation or restriction shall be immediately and automatically limited or restricted consistent with such action.

(ii) Suspension. Whenever a Practitioner’s license, certificate, or other legal credential is suspended, the Practitioner’s Medical Staff appointment and Clinical Privileges shall be automatically suspended effective upon and for at least the term of the suspension.

(iii) Probation. Whenever a Practitioner is placed on probation by the applicable licensing or certifying authority, such probationary requirements, to the extent applicable, shall also be imposed upon the Clinical Privileges of the Practitioner during the term of the probation.
(b) **Drug Enforcement Administration.** A Practitioner whose United States Drug Enforcement Administration (DEA) certificate is revoked, suspended, or limited shall immediately and automatically be divested of, or limited as to, the right to prescribe medications covered by the certificate as of the date such action becomes effective and throughout its term. Whenever a Practitioner’s DEA certificate is subject to probation, the Practitioner’s right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term. Any Privileges requiring an active DEA certificate shall be likewise automatically suspended.

(c) **Failure to Abide by the Medical Staff Bylaws.** Failure to abide by the Medical Staff Bylaws, Policies, and/or Rules & Regulations shall result in the imposition of an automatic suspension to the extent that such Medical Staff Bylaws, Policies, and/or Rules & Regulations authorize the imposition of an automatic suspension for such action.

(d) **Failure to Pay Medical Staff Dues or Fines.** Failure of any Practitioner to pay Medical Staff dues or fines within sixty (60) day of the date such dues or fines are due shall result in the automatic suspension of the Practitioner’s Clinical Privileges until such time as the dues or fines are paid.

(e) **Federal Healthcare Program.** Whenever a Practitioner is suspended from participating in a Federal Healthcare Program, the Practitioner's appointment and Privileges shall be immediately and automatically suspended.

(f) **Professional Liability Insurance.** Failure of a Practitioner to maintain Professional Liability Insurance in the amount required by the Board and sufficient to cover the Clinical Privileges granted shall result in immediate automatic suspension of a Practitioner’s Clinical Privileges until the required Professional Liability Insurance is restored or the Practitioner’s appointment and Privileges are automatically terminated pursuant to §7.5.3 (d). The Practitioner must notify Medical Staff Services immediately of any change in his/her Professional Liability Insurance carrier or coverage. For purposes of this section, the failure of a Practitioner to provide proof of Professional Liability Insurance shall constitute a failure to meet the requirements of this paragraph.

(g) **Completion of Medical Records.** Failure of a Practitioner to complete medical records as provided for in applicable Medical Staff Policy, shall result in an automatic suspension of the Practitioner’s Privileges consistent with such Policy.

7.4.5 **Impact of Automatic Suspension/Limitation.** During such period of time when a Practitioner's appointment and/or Privileges are automatically suspended or limited pursuant to §7.4.4 (a) – (f) above, he/she may not, as applicable, exercise any appointment Prerogatives or any Privileges at the Hospital, participate in on-call coverage, schedule surgery, otherwise provide professional services within the Hospital for patients, or admit patients under the name of another Practitioner. A Practitioner whose appointment and/or Privileges are automatically suspended or limited pursuant to §7.4.4 (g) is subject to the same limitations except that such Practitioner may:
Attend to the management of any patient under his/her care whose admission or outpatient procedure was scheduled prior to the effective date of the automatic suspension and which occurs within forty-eight (48) hours of such suspension.

7.4.6 Action Following Imposition. At its next regular meeting after imposition of an automatic suspension, or sooner if the MEC deems it appropriate, the MEC shall convene to determine if corrective action is necessary in accordance with §7.2. The lifting of the action or inaction that gave rise to an automatic suspension or limitation of the Practitioner's appointment and/or Privileges shall result in the automatic reinstatement of such appointment and/or Privileges; provided, however, that to the extent the suspension or limitation remained in effect for a period of more than thirty (30) days, the Practitioner shall be obligated to provide such information as Medical Staff Services shall reasonably request to assure that all information in the Practitioner's credentials file is current.

7.5 Automatic Termination

7.5.1 It shall be the duty of the Chief of Staff to cooperate with the Chief Executive Officer and/or the Chief Medical Officer to enforce all automatic terminations of Medical Staff appointment and Privileges.

7.5.2 An automatic termination pursuant to this section does not give rise to any rights under the Medical Staff Bylaws or the Fair Hearing Policy.

7.5.3 Failure to comply with the following requirements shall result in automatic termination of a Practitioner’s appointment and Privileges.

(a) License Revocation. Whenever a Practitioner’s license, certificate, or other legal credential authorizing the Practitioner to practice in the State of Ohio is revoked, the Practitioner’s Medical Staff appointment and Clinical Privileges shall be immediately and automatically terminated.

(b) Abandonment of Practice. In the event a Practitioner abandons his or her practice at the Hospital, the Practitioner’s Medical Staff appointment and Clinical Privileges shall be automatically terminated pursuant to the process set forth in §4.10.2.

(c) Failure to Return from Leave of Absence. In the event an Appointee fails to return from a LOA, or fails to provide requested documentation as provided in these Medical Staff Bylaws, the Appointee’s Medical Staff appointment and Clinical Privileges shall be automatically terminated unless otherwise provided in §3.8.7.

(d)Professional Liability Insurance. If within sixty (60) days of an automatic suspension pursuant to §7.4.4 (f), the Practitioner does not provide evidence of the required Professional Liability Insurance coverage (including tail coverage for any period during which insurance was not maintained), the Practitioner’s Medical Staff appointment and Privileges shall automatically terminate as of the sixty-first (61st) day.
(e) **Federal Healthcare Program.** Whenever a Practitioner is excluded from participating in a Federal Healthcare Program, the Practitioner's Medical Staff appointment and Privileges shall be automatically terminated.

(f) **Plea of Guilty to Certain Offenses.** If a Practitioner pleads guilty or no contest to, or is found guilty of a felony 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, the Practitioner's Medical Staff appointment and Privileges shall be immediately and automatically terminated; provided, if the behavior which triggered the conviction is based upon the Practitioner's impairment, then the matter shall be referred to an *ad hoc* Practitioner Effectiveness Committee (composed of one (1) or more members designated by the MEC) for consideration and recommendation to the MEC as to what action should be taken.

7.6 **Continuity of Patient Care**

Upon the imposition of summary suspension, automatic suspension, or automatic termination, the Chief of Staff or the appropriate Service Chief and/or medical director shall provide for alternative coverage for the affected Practitioner's Hospital patients. The wishes of the patient shall be considered, where feasible, in choosing a substitute Practitioner. The affected Practitioner shall confer with the substitute Practitioner(s) to the extent necessary to safeguard the patient.
ARTICLE VIII
HEARING AND APPELLATE REVIEW

8.1 Effect of Adverse Recommendation or Action

8.1.1 By Medical Executive Committee

Unless otherwise provided in the Bylaws or Fair Hearing Policy, when an Applicant or Appointee receives notice of an Adverse recommendation by the Medical Executive Committee, he/she is entitled, if applicable, and upon timely and proper request, to a hearing and appellate review in accordance with the procedures set forth in the Fair Hearing Policy.

8.1.2 By Board

Unless otherwise provided in the Bylaws or Fair Hearing Policy, when an Applicant or Appointee receives notice of an Adverse recommendation or action taken by the Board, and such decision is not based on a prior Adverse recommendation of the Medical Executive Committee with respect to which the Applicant or Appointee was entitled to a hearing, he/she is entitled, if applicable, and upon timely and proper request, to a hearing and appellate review in accordance with the procedures set forth in the Fair Hearing Policy.

8.2 Process for Hearing and Appellate Review

8.2.1 Upon receipt of a timely and proper request therefore, a hearing shall be scheduled by the CEO.

8.2.2 The hearing shall be conducted by either (i) a hearing officer; or (ii) a hearing panel, as determined by whichever body, the MEC or Board, made the Adverse recommendation or took the Adverse action that is the basis for the hearing.

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

(b) A hearing panel shall consist of not less than three (3) individuals and shall be chosen by the MEC or the Board, whichever body made the Adverse recommendation or took the Adverse action that is the basis for the hearing. The panel members may either be Practitioners or individuals from outside of the Hospital or a combination thereof, as determined by the MEC or the Board, as appropriate.

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

8.2.4 Appellate review, if any, shall be scheduled by the Board chair who will determine whether the appellate review shall be conducted by the Board as a whole or by an appellate review committee in accordance with the details set forth in the Fair Hearing Policy.
ARTICLE IX
MEDICAL STAFF OFFICERS

9.1 Officers of the Medical Staff

9.1.1 The elected officers of the Medical Staff shall be:

(a) Chief of Staff

(b) Chief of Staff Elect

(c) Past Chief of Staff

9.1.2 In addition to the elected Medical Staff officers, one (1) Member-at-Large shall be appointed to the MEC. Such MEC Member-at-Large shall be considered an appointed Medical Staff officer.

9.2 Qualifications of Elected Officers and MEC Members-at-Large

Elected officers and MEC Member(s)-at-Large must be Appointees to the Active Medical Staff in Good Standing and be board certified at the time of nomination and election. Elected officers and MEC Members-at-Large must remain Appointees to the Active Medical Staff in Good Standing and maintain board certification during their term. Failure to continuously satisfy the qualifications for the office or position shall immediately create a vacancy in the office or position involved.

9.3 Nomination of Elected Officers

9.3.1 The Medical Executive Committee shall nominate one (1) or more nominees for the offices of Chief of Staff Elect and shall communicate the nominees to the voting Appointees at least thirty (30) days prior to the annual meeting. In the case of a special election, the Medical Executive Committee shall communicate the nominees to all voting Appointees at least thirty (30) days prior to the special election.

9.3.2 Further nominations may be made by any voting Appointee provided: 1) the candidate consents, and 2) meets the qualifications to be an officer.

9.3.3 All nominees shall, at least seven (7) days prior to the date of election, disclose in writing to the Medical Executive Committee and Board those personal, professional, or financial affiliations or relationships of which they are reasonably aware could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff.

9.3.4 A final ballot will be communicated to all voting Appointees.

9.4 Election of Officers and Appointment of MEC Member-at-Large

9.4.1 The election for Medical Staff officers shall be held annually.

(a) The Chief of Staff-Elect shall be elected at the annual meeting of the Medical Staff.
(b) Voting shall be by secret written ballot at the meeting. Only Appointees to the Active Medical Staff shall be eligible to vote. Absentee ballots will be accepted up to the day before the annual Medical Staff meeting. The absentee ballot must have the Appointee’s signature and be verified by Medical Staff Services.

(c) A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate for the office receives a majority vote on the first ballot, a run-off election shall be held immediately between the two (2) candidates receiving the highest number of votes.

(d) Upon completion of his/her term, the Chief of Staff-Elect shall automatically succeed to the office of Chief of Staff and the Chief of Staff shall automatically succeed to the office of Past Chief of Staff.

9.4.2 The MEC Member-at-Large shall be selected from a list of eligible Practitioners on a rotational basis based upon the eligible Practitioners’ original appointment dates. Prior to appointment to the position, the MEC Member-at-Large candidate shall disclose in writing to the Medical Executive Committee and Board those personal, professional, or financial affiliations or relationships of which he/she is reasonably aware could foreseeably result in a conflict of interest with his/her activities or responsibilities on behalf of the Medical Staff.

9.5 Term

9.5.1 All elected officers and the appointed MEC Member-at-Large shall serve a one (1) year term unless otherwise provided in these Bylaws. Each elected officer and the appointed MEC Member-at-Large shall serve until the end of his/her term or until a successor is elected/appointed, unless he/she sooner resigns or is removed from his/her office or position.

9.5.2 Elected officers and the MEC Member-at-Large shall take office or assume his/her position on the 1st of January following their election or appointment, as applicable.

9.5.3 No elected officer or MEC Member-at-Large may succeed himself/herself in their current office or the position for additional terms unless otherwise provided in these Bylaws.

9.6 Vacancies

9.6.1 Vacancies in elected office or a MEC Member-at-Large position occur upon the death, disability, resignation, or removal of the officer/member, or failure to continuously satisfy the qualifications for the office/position.

9.6.2 Vacancies, other than that of the Chief of Staff, shall be filled by appointment by the Medical Executive Committee until the next regular election/appointment.

9.6.3 If there is a vacancy in the office of Chief of Staff, the Chief of Staff Elect or Past Chief of Staff, as determined by the Medical Executive Committee, shall serve out the Chief of Staff’s remaining term.

(a) If the Chief of Staff Elect is selected by the MEC, he/she shall serve out the Chief of Staff’s remaining term followed by the Chief of Staff Elect’s own one
(1) year term as Chief of Staff. If the MEC appoints an interim Chief of Staff Elect pursuant to Section 9.6.2 he/she shall serve until the end of the current term after which he/she shall be eligible to be elected for a subsequent term as Chief of Staff Elect.

(b) If the Past Chief of Staff is selected, he/she shall serve out the Chief of Staff’s remaining term. The Past Chief of Staff may thereafter resume his/her position as Past Chief of Staff for an additional one (1) year term. If the Past Chief of Staff does not wish to resume the Past Chief of Staff position for an additional one (1) year term, the office will remain vacant until the next regular term.

9.7 **Elected Officer and MEC Member-at-Large Orientation**

9.7.1 Elected officers, the MEC Member-at-Large, and other Medical Staff leaders, as deemed appropriate by the Medical Executive Committee, shall receive orientation to the following:

(a) The Hospital’s mission and vision.

(b) The Hospital’s safety and quality goals.

(c) The Hospital’s structure and the decision making process.

(d) The development of the Hospital’s budget as well as the interpretation of the Hospital’s financial statements.

(e) The population served by the Hospital and any issues related to that population.

(f) The individual and interdependent responsibilities and accountabilities of the Board, the Chief Executive Officer, Chief Medical Officer, and leaders of the Medical Staff as they relate to supporting the mission of the Hospital and to providing safe and quality care.

(g) Applicable laws and regulations.

Additional leadership development and training may be offered through an off-site leadership educational retreat, off-site seminar training, access to audio conferences and/or other training sessions.

9.8 **Duties of Elected Officers and MEC Member-at-Large**

9.8.1 **Chief of Staff.** The Chief of Staff shall serve as the chief administrative officer to the Medical Staff to:

(a) Coordinate and cooperate with the Chief Executive Officer and Chief Medical Officer on all matters of mutual concern in the Hospital.

(b) Call, preside at, and be responsible for the agenda of all general and special meetings of the Medical Staff.

(c) Call, preside at, and be responsible for the agenda of all general and special meetings of the Medical Executive Committee and be its chair.
(d) Serve as an *Ex Officio* member of all committees of the Medical Staff, with or without vote as designated.

(e) Be responsible for the enforcement of the Medical Staff Bylaws, Policies, and Rules & Regulations, and for implementation of sanctions when such are indicated, and for the Medical Staff’s compliance with procedural safeguards in all instances when corrective action has been requested against a Practitioner.

(f) Appoint members to and chairs of all committees of the Medical Staff, except as otherwise provided by these Medical Staff Bylaws.

(g) Represent the views, policies, and needs of the Medical Staff to the Chief Executive Officer, Chief Medical Officer, and to the Board and attend all Board meetings, as a non-voting member, when so requested to represent the Medical Staff and facilitate communication with the Board as to issues of safety and quality and Medical Staff concerns and recommendations.

(h) Receive and interpret the policies of the Board to the Medical Staff and report to the Board on performance and maintenance of quality with respect to the Medical Staff’s delegated responsibility to provide medical care.

(i) Be the spokesperson for the Medical Staff in its external professional and public relations.

(j) Perform such other duties as the Medical Staff Bylaws, Policies, and Rules & Regulations may require.

(k) In collaboration with the Chief of Staff Elect be accountable for all funds of the Medical Staff. This may include assistance/cooperation with audits by the Vice President of Finance of the Hospital, if requested.

9.8.2 Chief of Staff Elect. The Chief of Staff Elect:

(a) May assume the duties and responsibilities of the Chief of Staff in the Chief of Staff’s temporary absence; provided, however, that in such event his/her actions are subject to ratification by the Medical Executive Committee.

(b) Shall serve as a member of the Medical Executive Committee.

(c) Shall, in collaboration with the Chief of Staff, be accountable for all funds of the Medical Staff. This may include assistance/cooperation with audits by the Vice President of Finance of the Hospital, if requested.

(d) Represent the views, policies, and needs of the Medical Staff to the Chief of Staff, Chief Executive Officer, Chief Medical Officer, and to the Board and attend all Board meetings, as a non-voting member, when so requested to represent the Medical Staff and facilitate communication with the Board as to issues of safety and quality and Medical Staff concerns and recommendations.

(e) Perform such other duties as may be assigned by the Chief of Staff or the Medical Executive Committee.
9.8.3 **Past Chief of Staff.** The Past Chief of Staff shall:

(a) Support the Chief of Staff to provide continuity during the transition of the leadership roles.

(b) Automatically succeed the Chief of Staff when the latter fails to serve for any reason.

(c) Serve as a member of the Medical Executive Committee.

(d) Perform such other duties as may be assigned by the Chief of Staff or the Medical Executive Committee.

9.8.4 **Member-At-Large:** The Member-at-Large shall:

(a) Serve as an advisor to the Chief of Staff.

(b) Serve as a member of the Medical Executive Committee.

(c) Perform such other duties as may be assigned by the Chief of Staff or the Medical Executive Committee.

9.9 **Resignation and Removal from Elected Office or Member-at-Large Position**

9.9.1 **Resignation:** Any elected officer of the Medical Staff or MEC Member-at-Large may resign at any time by giving written notice to the Medical Executive Committee. Such resignation takes effect on the date of receipt or at any later time specified therein.

9.9.2 **Removal From Office or MEC Member-at-Large Position**

(a) **Mechanism:** An elected officer of the Medical Staff or MEC Member-at-Large may be removed by a majority vote of the Board or a two-thirds (2/3) vote by secret ballot of the Active Medical Staff Appointees in Good Standing attending and voting at a special meeting called for that purpose. Results of such vote shall be reported to the Medical Executive Committee. The elected officer or Member-at-Large shall have the opportunity to speak on his/her own behalf prior to the vote being taken. The removal of an elected Medical Staff officer or MEC Member-at-Large does not give rise to any rights under the Fair Hearing Policy.

(b) **Automatic Suspension:** An elected Medical Staff officer or Member-at-Large shall automatically be suspended from acting in his or her capacity as an officer or Member-at-Large upon the imposition of a summary suspension, an automatic suspension, or upon initiation of formal corrective action under Article VII.

(c) **Automatic Removal From Office/Position:** Notwithstanding (a) above, an elected Medical Staff officer or Member-at-Large shall automatically be removed from his/her office or position for failure to continuously satisfy the qualifications for the office or position.

(d) **Grounds:** Permissible grounds for removal of an elected Medical Staff officer or Member-at-Large include, but are not limited to:
Failure to perform the duties of the office/position held in a timely and appropriate manner.

Failure to continuously satisfy the qualifications for the office/position.

The imposition of a summary suspension, an automatic suspension, automatic termination, or any other corrective action undertaken against the elected officer/Member-at-Large which results in a final Adverse decision.

Conduct or statements inimical or damaging to the best interests of the Medical Staff or the Hospital or to their goals, programs, or public image.

Inability to fully or competently fulfill the duties of the position.
ARTICLE X
COMMITTEES

10.1 Medical Staff Committees: General Information

10.1.1 Committees of the Medical Staff shall be designated as standing or special.

10.1.2 Standing committees shall be those committees created in these Medical Staff Bylaws. Special committees shall be those committees that the Medical Executive Committee shall from time to time determine to be necessary and create.

10.1.3 The Chief Executive Officer shall serve as an Ex Officio member of all committees of the Medical Staff without vote unless otherwise designated.

10.1.4 The Chief of Staff shall serve as an Ex Officio member of all committees of the Medical Staff with or without vote as designated.

10.1.5 All committee members and the chair, unless specifically provided otherwise, are appointed and may be removed by the Chief of Staff in consultation with the MEC.

10.2 Medical Staff Committees: Term, Prior Removal, and Vacancies

10.2.1 Unless otherwise specified herein, all committee appointments shall be for the Medical Staff Year.

10.2.2 An Appointee serving on a committee, except one serving Ex Officio, may be removed from the committee for failure to maintain Good Standing as an Appointee, for failure to satisfy the attendance requirements specified in these Medical Staff Bylaws, or by action of the Medical Executive Committee.

10.2.3 Any Ex Officio member of a Medical Staff committee ceases to be such if the individual ceases to hold the designated position that is the basis of Ex Officio membership.

10.2.4 A vacancy in any committee is filled for the unexpired portion of the term in the same manner in which the original appointment is made.

10.3 Medical Staff Committees: Chair

10.3.1 Unless otherwise specified herein, the chair of each committee shall be an Appointee to the Active Medical Staff and shall be appointed by the Chief of Staff. Each chair should have served for at least one (1) year on the committee or otherwise have experience in the functions assigned to the committee.

10.3.2 When necessary to accomplish a function or task assigned to a committee, the committee chair may call upon outside consultants or special advisors with expertise in the subject matter involved, after consultation with the Chief of Staff and with the Chief Executive Officer when Hospital administrative or patient care services are at issue.

10.3.3 Each committee chair may appoint a vice chair of the committee to chair any meeting from which the chair is absent. Each committee chair, vice chair, or other authorized person chairing a meeting has the right to participate in discussion of and to vote on issues presented to the committee.
10.4 Medical Staff Committees: Authority and Manner of Acting

10.4.1 All committees of the Medical Staff, except the Medical Executive Committee, are subject to the authority of, and shall report to the Medical Executive Committee.

10.4.2 Any person serving as a member of a Medical Staff committee shall be entitled to vote on any matter before the committee for consideration. However, committee members serving Ex Officio shall not be entitled to vote unless otherwise specifically provided.

10.4.3 Unless otherwise provided in these Medical Staff Bylaws or directed in writing by the Medical Executive Committee, any committee may propose any action to the Medical Executive Committee by the vote of a majority of its members present at a meeting in which a quorum is present.

10.4.4 Committees are authorized to perform such functions as are specified in the Medical Staff Bylaws, Policies, and/or Rules & Regulations, or as may be directed by the Medical Executive Committee.

10.4.5 All committees shall prepare and file minutes of all meetings with the Director of the Medical Staff.

10.4.6 Any standing committee may elect to perform any of its specifically designated functions by constituting a subcommittee for that purpose and reporting such action to the Medical Executive Committee. Any such subcommittee may include individuals in addition to or other than members of the standing committee. Such additional members are appointed by the committee chair after consultation with the Chief of Staff in the case of Medical Staff Appointees, and with the approval of the Chief Executive Officer when administrative staff appointments are to be made.

10.5 Medical Staff Committees: Attendance Requirements

If appointed to a Medical Staff committee, the Practitioner shall attend at least sixty-six percent (66%) of the committee meetings.

10.6 Standing Medical Staff Committees

10.6.1 Medical Executive Committee

(a) Composition

(i) The Medical Executive Committee shall consist of the following voting members: Chief of Staff, Chief of Staff Elect, Past Chief of Staff, , and Member-at-Large. The Chief Executive Officer, the Chief Nursing Officer, and the Medical Staff Services Director shall serve as Ex Officio members, without vote.

(ii) A majority of the voting members of the Medical Executive Committee shall be Physician Appointees who have hospital privileges No Active Medical Staff Appointee shall be ineligible for membership on the Medical Executive Committee solely because of his or her professional specialty.
Chair
The Chief of Staff will be the chair of the Medical Executive Committee.

Duties and Responsibilities
The duties of the Medical Executive Committee as delegated by the Medical Staff shall include, but are not limited to:

(i) Acting for the Medical Staff in intervals between Medical Staff meetings.
(ii) Serving as a liaison between the Medical Staff and Hospital administration.
(iii) Receiving and acting upon reports and recommendations from Medical Staff committees, Services, and assigned activity groups.
(iv) Implementing approved policies of the Medical Staff.
(v) Reviewing and recommending action on all applications for Medical Staff appointment/reappointment and changes in Medical Staff category.
(vi) Reviewing and recommending action on all requests for Clinical Privileges/regrant of Privileges.
(vii) Developing, recommending, and consistently implementing policies and procedures for all credentialing activities of the Hospital.
(viii) Making recommendations to the Board regarding all matters pertaining to at least the following:

a) The structure of the Medical Staff.
b) The granting of Medical Staff appointment/reappointment and Clinical Privileges/regrant of Privileges.
c) The mechanism used to review credentials and to delineate individual Clinical Privileges.
d) Individual recommendations for Medical Staff appointment/reappointment and Privileges/regrant of Privileges; assignment to Medical Staff category and Service; delineation of Clinical Privileges, and corrective action.
e) The organization of the quality assessment and improvement activities of the Medical Staff, as well as the mechanism used to conduct, evaluate, and revise such activities.
f) The mechanism by which Medical Staff appointment and/or Privileges may be terminated.
g) The mechanism for fair hearing procedures.
(ix) Fulfilling the Medical Staff’s accountability to the Board for the quality of the overall medical care rendered to the patients cared for within the Hospital.

(x) Assuring Medical Staff compliance with the applicable standards of The Joint Commission and regulatory agencies.

(xi) Coordinating the activities and general policies of the various Services.

(xii) Recommending action to the Chief Executive Officer on matters of medico administrative nature, including Hospital management and planning matters.

(xiii) Accounting to the Board by written reports on the quality and efficiency of medical care provided to patients cared for within the Hospital, including a summary of specific findings, action, and follow up.

(xiv) Providing opportunities for pertinent continuing education of the Medical Staff that is based in part on the findings of Medical Staff quality assessment and improvement activities.

(xv) Informat the Medical Staff of new developments in diagnostic and therapeutic aspects of patient care.

(xvi) Reporting at each Medical Staff meeting.

(xvii) Undertaking all duties assigned to the Medical Executive Committee in the Medical Staff Bylaws, Policies, and/or Rules & Regulations, or as directed by the Board through the Chief Executive Officer.

(xviii) Reviewing, revising, and approving (subject to Board approval) the Medical Staff Policies and Rules and Regulations and communicating such Policies and Rules & Regulations, and amendments thereto, to the Medical Staff.

(xix) Requesting evaluations of Practitioners privileged through the Medical Staff process when there is question about a Practitioner’s ability to perform Privileges he or she has requested or currently holds.

(xx) Adopting and modifying criteria and standards, as needed, and recommending changes in Hospital procedures and Medical Staff practices that are identified by the analysis of review findings.

(xxi) Suggesting to Services and ancillary Hospital departments continual monitors or patient care evaluation studies as a result of utilization review findings. These would be addressed through the Hospital department’s quality assessment and improvement programs.

(xxii) Supervising the utilization review activities of Practitioners.
(xxiii) Reviewing mortality cases as defined in the Hospital’s mortality policy, as such policy may be amended from time to time.

(xxiv) Serving as the Hospital Ethics Committee; provided, however, that when serving as the Ethics Committee appropriate Hospital representatives shall be included in the review, discussion, and vote concerning the matter.

(xxv) Participating in the Hospital’s quality improvement program.

(d) Meetings and Reporting

(i) The Medical Executive Committee will meet at least ten (10) times per year at such time and place as the Medical Executive Committee shall determine. The agenda will be established by the Chief of Staff in collaboration with the Chief Medical Officer. The Medical Executive Committee will maintain a permanent record of its proceedings and actions.

(ii) The Medical Executive Committee shall communicate its discussions and actions that affect or define Medical Staff Policies, Rules and Regulations, or Medical Staff positions by monthly written summary reports made available to all Appointees and shall report on such discussion and actions at the general Medical Staff meetings.

(iii) The Medical Executive Committee’s other reporting obligations shall be as stated in the various sections of the Medical Staff Bylaws. In addition, copies of its minutes and reports shall be forwarded to the Chief Executive Officer and, as appropriate or required, to the Board.

10.7 Special Medical Staff Committees

10.7.1 The Medical Executive Committee may, from time to time, create special committees of the Medical Staff.

10.7.2 The creation of any such committee will include a statement of its composition, duties, and responsibilities, record keeping requirements, meeting requirements, and whether the committee is to be an ongoing committee or of limited duration.

10.8 Termination of Medical Staff Committees

10.8.1 A standing committee of the Medical Staff may be abolished by amendment of these Medical Staff Bylaws in accordance with the provisions of the Medical Staff Bylaws.

10.8.2 A special committee of the Medical Staff may be abolished by the imposition of the specific limitation upon its duration in accordance with these Medical Staff Bylaws, or at any time, by a resolution adopted by a majority of the Medical Executive Committee.

10.9 Hospital Committees

10.9.1 Rural Health Committee
(a) **Composition**

The composition of the Rural Health Committee shall include, but not be limited to, the Medical Director of the Rural Health Clinic/Patient Centered Medical Home (RHC/PCMH), RHC Physician, Allied Health Professional, Director of Medical Surgical Associates, Director of Risk Management/Medical Staff Services, and Director of Quality/Patient Safety. The Medical Director of the RHC/PCMH shall serve as chair of the Rural Health Committee and all committee members may vote.

(b) **Duties.** The duties of the Rural Health Committee shall include, but not be limited to:

(i) Reviewing RHC policies and procedures.
(ii) Conducting RHC evidence-based practice reviews.
(iii) Ensuring medical records are reviewed as required by RHC regulations.
(iv) Conducting an annual evaluation of the RHC program.
(v) Overseeing PCMH reviews and improvement plans.

(c) **Meetings and Reporting**

(i) The RHC will meet at least annually and as otherwise needed at the call of the committee chair.
(ii) A record of its proceedings and actions will be maintained.
(iii) The RHC will report quarterly to the Interdisciplinary Quality Review Committee.

10.10 **Board Committees**

10.10.1 **Joint Conference Committee**

(a) **Composition**

The composition of the Joint Conference Committee shall be as set forth in the Hospital code of regulations.

(b) **Duties and Responsibilities**

The Joint Conference Committee shall serve as a forum for assisting the Medical Staff and the Board in addressing various patient care, medico-administrative, and credentialing matters and shall be called upon as provided in these Medical Staff Bylaws and Policies.

(c) **Change to Hospital Bylaws**
In the event the provision regarding the Joint Conference Committee is changed from time to time in the applicable section of the Hospital’s code of regulations, this provision shall automatically be likewise amended.

10.11 Peer Review Committees / Confidentiality of Minutes and Records

10.11.1 The Medical Staff as a whole and each committee provided for by these Bylaws is hereby designated as a peer review committee as that term is defined by Ohio Revised Code 2305.25 and .251. Such committees shall be responsible for evaluating, maintaining, and/or monitoring the quality and utilization of health care services. All minutes and records of any committee relating to quality assessment/improvement and peer review activities shall be maintained separately. All minutes and records of these committees shall be treated as confidential to the full extent permitted by law.

10.11.2 In carrying out his or her duties under these Bylaws whether as a committee member, Medical Staff officer, Service Chief, medical director, or otherwise, each Medical Staff Appointee shall be acting in his or her capacity as a peer review committee member and designated agent of the Medical Staff.

10.11.3 Such peer review committees and its designated agents may, from time to time, and/or as specifically provided herein, appoint the Chief Executive Officer or other Hospital administrative personnel as their agent in carrying out such peer review duties.
ARTICLE XI
CLINICAL SERVICES, SERVICE CHIEFS, AND MEDICAL DIRECTORS

11.1 Medical Staff Structure
The Medical Staff shall be non-departmentalized.

11.2 Organization of Clinical Services
11.2.1 Services of the Medical Staff are:
   (a) Medicine
   (b) Surgery

11.2.2 The MEC may recommend to the Board the creation, elimination, or combination of Services for better organizational efficiency and improved patient care. Action taken by the Board pursuant to this section shall be effective on such date as determined by it and shall not require formal amendment of these Bylaws.

11.2.3 A Service Chief will be appointed for each Service by the Chief of Staff. Medical directors will be appointed for clinical areas within the Service by the Chief of Staff. Any qualified Active Appointee with Privileges in Good Standing may submit a request to the Chief of Staff to serve as a Chief of Service.

11.2.4 Each Service shall have its own rules and regulations pertaining thereto subject to review by the Medical Executive Committee and approval by the Board.

11.3 Service Chiefs and Medical Directors
11.3.1 Qualifications
Each Service Chief and medical director shall be appointed to the Active Medical Staff with Privileges and must be qualified by training or experience.

11.3.2 Selection
Each Service Chief and medical director shall be appointed by the Chief of Staff, subject to approval of the Medical Executive Committee.

11.3.3 Term
Each Service Chief and medical director shall be appointed for a one (1) year term. Service Chiefs and medical directors may succeed themselves in the position so long as they are carrying out the duties and responsibilities provided in these Medical Staff Bylaws to the satisfaction of the Appointees in the Service concerned, the Medical Executive Committee, and the Board.

11.3.4 Resignation and Removal
   (a) Resignation. Any Service Chief or medical director may resign at any time by giving written notice to the Medical Executive Committee. Such resignation takes effect on the date of receipt or at any later time specified therein.
(b) **Removal; Mechanism.** Removal of a Service Chief or medical director may be initiated at any time upon a majority vote of the Board or by a two-thirds (2/3) vote of all Active Appointees to the Service. No such removal shall be effective unless it has been ratified by the Medical Executive Committee and by the Board. The Service Chief or medical director shall have the opportunity to speak on his/her own behalf prior to the vote being taken. The removal of a Service Chief or medical director does not give rise to any rights under the Fair Hearing Policy.

(c) **Automatic Suspension from Position.** A Service Chief or medical director shall automatically be suspended from acting in his or her capacity as a Service Chief or medical director upon the imposition of a summary suspension, an automatic suspension, or upon initiation of formal corrective action under Article VII.

(d) **Automatic Termination from Position.** Notwithstanding (b) above, a Service Chief or medical director shall automatically be removed from his/her position for failure to continuously satisfy the qualifications for the position.

(e) **Grounds for Removal.** Permissible grounds for removal of a Service Chief or medical director include but are not limited to:

(i) Failure to perform the duties of the position held in a timely and appropriate manner.

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

(iii) The imposition of a summary suspension, an automatic suspension, automatic termination, or any other corrective action undertaken against the Service Chief or medical director which results in a final Adverse decision.

(iv) Conduct or statements inimical or damaging to the best interests of the Medical Staff or the Hospital or to their goals, programs, or public image.

(v) Inability to fully or competently fulfill the duties of the position

11.3.5 **Responsibilities**

(a) Service Chiefs and/or medical directors shall:

(i) Be accountable to the Medical Executive Committee for all professional and Medical Staff administrative activities within the Service.

(ii) Maintain ongoing surveillance of the professional performance of all Practitioners and AHPs who have Clinical Privileges in the Service and report regularly thereon to the Medical Executive Committee.

(iii) Assure that regular monitoring and evaluation of the quality and appropriateness of patient care rendered within the Service, including review of all deaths occurring in the Service, is carried out through
designated mechanisms and that the findings are reported to the Medical Executive Committee and the Medical Staff.

(iv) Be responsible for investigating and documenting quality assessment and improvement issues, findings, and resolutions through reports to the Medical Executive Committee.

(v) Be responsible for the enforcement of the Medical Staff Bylaws, Policies, Rules & Regulations, and Hospital governing documents within the Service.

(vi) Be responsible for the enforcement of Service rules & regulations.

(vii) Be responsible for implementation within the Service of actions taken by the Medical Executive Committee and the Medical Staff.

(viii) Develop and regularly review the criteria for granting Clinical Privileges in the Service.

(ix) Transmit to the Medical Executive Committee the Service’s criteria concerning Privileges for all Practitioners and AHPs in or applying to the Service and be responsible for providing an assessment of each Applicant seeking Clinical Privileges/regrant of Privileges in the Service.

(x) Be responsible for the oversight of teaching, education, and research programs in the Service, with at least part of the educational programs being based on findings of the Service’s monitoring and evaluation activities.

(xi) Participate in administration of the Service through cooperation with the Hospital’s nursing service and Hospital administration in matters affecting patient care (including, for example, personnel, supplies, special rules/regulations, standing orders, and techniques) and assessing and recommending to the relevant Hospital authority off-site sources for needed patient care services not provided by the Hospital.

(xii) Assist in the preparation of such annual reports, including budgetary planning, pertaining to the Service as may be required by the Medical Executive Committee, the Chief Executive Officer, or the Board.

(xiii) Appoint committees, as needed, to conduct Service functions.

(xiv) Fulfill such other duties as may be assigned by the Chief of Staff, the Medical Executive Committee, or the Board (through the Chief Executive Officer as its administrative agent).

11.4 Functions of Services

11.4.1 Each Service will function as a component of the Medical Staff under the authority of the Medical Executive Committee.
11.4.2 Each Service shall establish its own criteria, consistent with applicable Medical Staff/Hospital policy, for the granting of Clinical Privileges. These criteria shall be submitted for review by the Medical Executive Committee and approved by the Board.

11.5 Assignment of Services

11.5.1 The Medical Executive Committee shall recommend initial Service assignments for all Practitioners.

11.5.2 The exercise of Clinical Privileges by a Practitioner within any Service shall be subject to the rules and regulations of that Service and the authority of the Service Chief and/or medical director.

11.5.3 Practitioners shall have Clinical Privileges in one (1) or more Services in accordance with their education, training, experience, and demonstrated competence. Each Practitioner shall be assigned to one (1) clinical Service for the purpose of participating in the required functions of the Medical Staff, and for fulfilling all of the other obligations which go with Medical Staff appointment. This should be the Service in which the Practitioner’s practice is concentrated.
ARTICLE XII
MEETINGS

12.1 Annual Meeting of the Medical Staff

The annual meeting of the Medical Staff shall be held as a part of the regularly scheduled general Medical Staff meetings. The agenda of the annual meeting will include, but not be limited to, a summary of activities over the past year as presented in the quarterly newsletters, and election of officers. Those persons elected as officers shall assume their respective positions on the first day of the next Medical Staff Year. The current officers shall make such reports as may be necessary or desirable.

12.2 Meetings of the Medical Staff

Medical Staff meetings are held no less than ten times per year, including the annual meeting, at the discretion of the Medical Staff.

12.3 Committee and Service Meetings

Committee and Service meetings will be held in accordance with the provisions of these Medical Staff Bylaws and/or related Medical Staff Policies at the discretion of the Service Chief, medical director, or committee chair.

12.4 Special Meetings

12.4.1 Medical Staff Meetings

(a) Special meetings of the Medical Staff may be called at any time by the Chief of Staff, or at the request of the Medical Executive Committee, the Board, or any five (5) Appointees to the Active Medical Staff.

(b) Written or oral notice stating the place, day, and time of any special meeting shall be communicated to the voting members of the Medical Staff at least forty-eight (48) hours before the time set for the meeting.

(c) No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

12.4.2 Committee or Service Meetings

(a) Special meetings of a committee or Service may be called at any time by the chair or Service Chief thereof, by the Chief of Staff, by the Medical Executive Committee, by the Board, or by one-third (1/3) of the group’s voting members, but by no less than two (2) such members.

(b) Written or oral notice stating the place, day, and hour of any special meeting of a committee or Service shall be communicated to each voting member of such committee or Service not less than forty-eight (48) hours before the time set for the meeting.
(c) No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

12.5 **Quorum**

12.5.1 **Medical Staff Meetings**

Unless otherwise provided, the presence of not less than 25% of voting members of the Medical Staff shall constitute a quorum at any general or special meeting of the Medical Staff. See Section 12.10 for voting requirements. For action on peer review, credentialing, privileging, a quorum shall be defined as at least 25% of Active Appointees. For action on policy or quality, a quorum shall be defined as appointees present.

12.5.2 **Committee/Service Meetings:**

(a) Unless otherwise provided, for any regular or special meeting of a Service or Medical Staff committee, those voting members present, but not less than two (2), shall constitute a quorum.

(b) In the event that fifty percent (50%) of the voting members of a Service or Medical Staff committee are not present for decision making during an executive session, the issue or concerns to be addressed during the executive session shall be forwarded to the Medical Executive Committee for discussion and action.

(c) For Medical Executive Committee meetings, the presence of no less than three (3) voting officers eligible to vote is necessary for a quorum.

(d) Once a quorum is established, the business of the meeting may continue and all actions taken shall be binding.

(e) See Section 12.10 for voting requirements.

12.6 **Notice**

Unless otherwise provided, written, electronic, or oral notice stating the place, day, and hour of any meeting of the Medical Staff, committee, or Service shall be given to members not less than forty-eight (48) hours prior to such meeting by the person calling the meeting. Attendance at a meeting shall constitute a waiver of notice of such meeting.

12.7 **Minutes**

12.7.1 Minutes of each regular and special meeting of the Medical Staff, a committee, or a Service shall include a record of the attendance of the individuals present, the outcome of the vote taken on each matter, and the conclusions, recommendations, and actions of the group. These minutes shall be signed by the presiding officer and copies thereof shall be submitted for approval at the next meeting. A permanent file of the minutes of each meeting shall be maintained.

12.7.2 All minutes and records of any Medical Staff, committee or Service meeting relating to quality assessment and improvement or peer review activities shall be maintained.
separately. All such minutes and records shall be treated as confidential to the full extent permitted by law.

12.8 Attendance Requirements

12.8.1 Medical Staff Meetings

(a) Active Medical Staff Appointees are required to attend meetings of the Medical Staff. Failure to attend fifty percent (50%) of the Medical Staff meetings annually, unless excused by the MEC for good cause shown, will result in a $100.00 fine at the end of each applicable twelve (12) month period. Failure to pay such fine within sixty (60) days of the date due shall result in an automatic suspension of the Practitioner’s Privileges pursuant to §7.4.4(d) until such time as the fine is paid.

(b) Courtesy and Consulting Medical Staff Appointees shall be encouraged to attend meetings of the Medical Staff.

12.8.2 Committee or Service Meetings

(a) Members of any committee or Service must be willing to participate at a level which will allow committee action to occur. A Practitioner assigned to any Service who has attended a case that is to be formally and specifically presented for discussion at any meeting of a committee or Service shall be given notice of such meeting and shall be invited to be present. Should the Practitioner be absent from any meeting at which a case that he or she has attended is to be discussed, it shall be presented nevertheless unless the Practitioner is unavoidably absent and has requested that discussion be postponed. In no event shall postponement be granted for a period longer than the next regularly scheduled meeting.

12.9 Excused Absences

12.9.1 An Active Appointee who is unable to attend a meeting of the Medical Staff may submit the reasons for his or her absence in writing to the Medical Executive Committee either prior to the meeting or within seventy-two (72) hours after the meeting. If the Medical Executive Committee finds that good cause exists, the absence will be excused.

12.9.2 A Practitioner who is unable to attend a meeting of a committee or Service at which the Practitioner’s attendance is required may submit the reasons for his or her absence in writing to the Service Chief or committee chair either prior to the meeting or within seventy-two (72) hours after the meeting. If there is a finding that good cause exists, the absence will be excused.

12.10 Manner of Action

Except as otherwise expressly provided herein, the action of a majority of the voting members in Good Standing present at a meeting at which a quorum is present shall be the action of the Medical Staff, a committee, or Service.

12.11 Action Without a Meeting
Unless otherwise provided in the Bylaws, any action which may be taken or authorized at a Medical Staff, Service, or committee meeting may be authorized or taken without a meeting if the action is approved by not less than a majority of the members in Good Standing who would be entitled to vote at a meeting called for such purpose by ballot received prior to the deadline set forth in the notice advising of the purpose for which action is to be taken.

12.12 Meeting and Voting Options

12.12.1 Unless otherwise provided in the Bylaws, Practitioners may participate and act at any meeting in person, by absentee ballot, or by conference call or other communication equipment through which all persons participating in the meeting can communicate with each other. Participation by such means shall constitute attendance at the meeting.

12.12.2 Unless otherwise provided in the Bylaws, voting may occur in any of the following ways as determined by the chair of the respective committee, Service Chief; or, for voting by the Medical Staff, as determined by the Chief of Staff:

(a) Vote by hand ballot at a meeting at which a quorum is present.

(b) Vote by written ballot at a meeting at which a quorum is present.

(c) Vote without a meeting by written ballot or by electronic ballot provided such votes are received prior to the deadline date set forth in the notice advising of the purpose for which a vote is to be taken.

(d) Absentee written ballots provided the ballot(s) are signed, dated, and received prior to the deadline date set forth in the notice advising of the purpose for which a vote is to be taken.

12.12.3 Common sense, as determined by the Chief of Staff, Service Chief, or committee chair, as applicable, shall be applied in the conduct of meetings. To the extent there is a disagreement as to procedure, the latest edition of Robert's Rules of Order may be consulted for guidance.

12.13 Agenda

12.13.1 The agenda at any regular Medical Staff meeting may include but not be limited to:

(a) Call to order.

(b) Acceptance of the minutes of the last regular and of all special meetings.

(c) Reports which may include:

(i) .

(ii) Reports from committees.

(iii) Reports from Services.

(iv) Report from the Chief Executive Officer, which will include Board report, Hospital statistics, and other items of interest.
(v) Quality assessment and improvement report.

(d) Unfinished Business

(e) New Business

(f) Presentations

(g) Adjournment

12.13.2 The agenda at any special Medical Staff meeting shall be:

(a) Reading of notice calling the meeting.

(b) Transaction of business for which the meeting was called.

(c) Adjournment.

12.13.3 The Service Chief or committee chair shall, prior to a regular or special Service or committee meeting, establish a written agenda for such meeting and give notice of such agenda in a manner specified by the Medical Executive Committee.

12.14 Executive Session

An executive session may be convened, at any time, upon request of a majority of the voting members in Good Standing present at a Medical Staff, Service, or committee meeting, as applicable, or as otherwise deemed appropriate by the individual presiding over the meeting.
ARTICLE XIII
MEDICO ADMINISTRATIVE PERSONNEL

13.1 Defined

Medico-Administrative Officer means a Practitioner engaged by the Hospital either full- or part-time in an administratively responsible capacity, whose activities may include clinical responsibilities such as direct patient care, teaching, or supervision of the patient care activities of other Practitioners under the Medico-Administrative Officer's direction.

13.2 Medical Staff Appointment and Privileges

13.2.1 Any Practitioner performing exclusively administrative responsibilities with no clinical responsibility or function may but shall not be required to be appointed to the Medical Staff.

13.2.2 Any Practitioner performing administrative responsibilities who also has clinical responsibilities or functions must, at all times, be appointed to the Medical Staff and be granted appropriate Privileges. Applications for Medical Staff appointment/reappointment and Privileges/regrant of Privileges shall be governed by the provisions of these Medical Staff Bylaws.

13.2.3 A Medico-Administrative Officer who will be providing patient care must obtain Clinical Privileges appropriate to his/her clinical responsibilities and discharge Medical Staff obligations appropriate to his/her Medical Staff category and Privileges, in the same manner applicable to all other Practitioners.

13.3 Effect of Removal from Position or Adverse Change in Appointment Status or Clinical Privileges

13.3.1 The effect of the removal from his/her medico-administrative position on a Medico-Administrative Officer’s Medical Staff appointment and Clinical Privileges, and the effect of an Adverse change in a Medico-Administrative Officer's Medical Staff appointment or Clinical Privileges (less than total revocation) on continuance in his/her position, will be governed solely by the terms of the contract between the Medico-Administrative Officer and the Hospital, if the contract addresses those points.

13.3.2 In the absence of a contract, or where the contract is silent on the matter, removal from the position alone will have no effect on appointment status or Clinical Privileges.

13.3.3 The effect of an Adverse change in appointment status or Clinical Privileges on continuance in the position will be as determined by the Board after soliciting and considering the recommendations of relevant components and leaders of the Medical Staff.

13.3.4 An Adverse change in appointment status or Clinical Privileges that is not triggered by removal from a Medico-Administrative Officer position may, if applicable, entitle the Medico-Administrative Officer to the procedural rights provided in these Bylaws and in the Fair Hearing Policy.
ARTICLE XIV
CONFIDENTIALITY, IMMUNITY FROM LIABILITY, AUTHORIZATIONS, AND RELEASES

14.1 Special Definitions.

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

14.1.1 "Information" means records of proceedings, minutes, interviews, records, reports, forms, memoranda, statements, investigations, examinations, hearings, meetings, recommendations, findings, evaluations, opinions, conclusions, actions, data and other disclosures or communications, whether in written or oral form, relating to any of the subject matter specified in §14.5.

14.1.2 "Representative" means the Hospital, the Hospital Board and any director or committee thereof, the Hospital Chief Executive Officer and other Hospital employees; the Medical Staff organization and any Practitioner with a Medical Staff appointment and/or Privileges, Medical Staff officer, Service Chief, medical director, or committee thereof; and any individual authorized by any of the foregoing to perform specific information gathering, analysis, use or disseminating functions.

14.1.3 "Third Parties" means any individual or organization providing Information to any Representative.

14.2 Authorizations and Conditions

14.2.1 By submitting an application for Medical Staff appointment or reappointment, or by applying for or exercising Privileges at the Hospital, a Practitioner:

(a) Authorizes Representatives and Third Parties to, as applicable, solicit, provide and act upon Information bearing on his/her professional ability and qualifications.

(b) Agrees to be bound by the provisions of this Article and to waive all legal claims against any Representative or Third Party who acts in accordance with the provisions of this Article.

(c) Acknowledges that the provisions of this Article are express conditions to his/her application for, acceptance of, and continuation of Medical Staff appointment and/or to his/her exercise of Privileges the Hospital.
14.3 Confidentiality of Information

Information with respect to any Practitioner submitted, collected or prepared by any Representative of this Hospital 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; evaluating the qualifications, competence, and performance of a Practitioner or acting upon matters relating to corrective action; reducing morbidity and mortality; contributing to teaching or clinical research; determining that health care services are professionally indicated and 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. Such Information shall not be disclosed or 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 in the Bylaws or 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 provisions provided herein is grounds for corrective action.

14.4 Practitioner’s Release from Liability

14.4.1 Submission of an application for Medical Staff appointment and/or for the exercise of Privileges at the Hospital constitutes a Practitioner’s express release of liability as follows:

(a) For Action Taken

No Representative or Third Party shall be liable to a Practitioner for damages or other relief for any action taken or statements or recommendations made within the scope of his/her duties as a Representative or Third Party, provided that such Representative or Third Party does not act on the basis of false Information knowing such Information to be false.

(b) For Gathering or Providing Information

No Representative or Third Party shall be liable to a Practitioner for damages or other relief by reason of gathering or providing Information, including otherwise privileged or confidential Information, to a Representative or to any other health care facility or organization of health professionals concerning a Practitioner who is or has been an Applicant or Appointee to the Medical Staff or who did or does exercise Clinical Privileges at this Hospital, provided that such Representative or Third Party is acting within his/her scope of duties and does not act on the basis of false Information knowing such Information to be false.

14.5 Activities

14.5.1 The confidentiality and immunity provided by the Medical Staff Bylaws and in this Article shall apply to all Information in connection with this Hospital’s or any other health care facility’s or organization’s activities concerning, but not limited to:

(a) Application for appointment and/or Clinical Privileges
(b) Application for reappointment/regrant of Privileges

(c) Corrective action

(d) Hearings and appellate reviews

(e) Performance improvement/quality assessment activities

(f) Medical care monitoring activities and evaluations

(g) Utilization review/management activities

(h) Claims reviews

(i) Profiles/profile analysis

(j) Peer review

(k) Risk management activities

(l) Any other Hospital, Service, committee, or Medical Staff activities related to monitoring, maintaining, or improving quality and efficient patient care and appropriate professional conduct.

14.5.2 The Information referred to in this Article may relate to a Practitioner’s professional qualifications, clinical ability, judgment, character, ability to fully and competently carry out the Clinical Privileges requested, professional ethics, or any other matter that might directly or indirectly affect patient care.

14.6 Releases

Each Practitioner or AHP shall, upon request of the Chief Executive Officer, execute general and specific releases in accordance with the tenor and import of the Medical Staff Bylaws and this Article, subject to such requirements, as may be applicable under federal law and the laws of this State. Execution of such releases shall not be deemed a prerequisite to the effectiveness of the Medical Staff Bylaws or this Article. Such releases will operate in addition to the provisions of the Bylaws and this Article. Failure to execute such releases in connection with a corrective action shall be construed as a failure to participate in the peer review process.

14.7 Cumulative Effect

Provisions in these Medical Staff Bylaws and in application forms relating to authorizations, confidentiality of information, and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof. A finding by a court of law or administrative agency with proper jurisdiction that all or any portion of any such provision is not enforceable shall not affect the legality or enforceability of the remainder of such provision or any other provision.
ARTICLE XV
ADOPTION, AMENDMENT, AND REPEAL OF MEDICAL STAFF POLICIES AND RULES &
REGULATIONS

15.1 Approval Procedure. The Medical Executive Committee shall adopt such Medical Staff Policies and Rules & Regulations as may be necessary to implement more specifically the general principles found within these Medical Staff Bylaws, subject to the approval of the Board. Such Medical Staff Policies and Rules & Regulations shall relate to the proper conduct of Medical Staff organizational activities, as well as embody the level of practice that is to be required of each Practitioner in the Hospital.

15.1.1 The Medical Executive Committee may adopt, amend, or repeal Medical Staff Policies and Rules & Regulations by majority affirmative vote subject to approval by the Board.

15.1.2 Such action shall become effective when approved by the Board.

(a) If the Board has determined not to accept a recommendation submitted to it by the Medical Executive Committee, the Medical Executive Committee may request a meeting of the Joint Conference Committee. Such meeting shall be for the purpose of further communicating the Board's rationale for its contemplated action and permitting the MEC, as applicable, to discuss the rationale for its recommendation. The CEO will schedule such meeting within fourteen (14) days after receipt of a request therefore from the MEC. Following receipt of the Joint Conference Committee’s recommendation, the Board may then take final action.

(b) The Board may adopt or amend the Medical Staff Policies or Rules & Regulations provided that the Board has first proposed its recommended changes to the MEC, as applicable, and the MEC has declined to adopt the proposed document(s) or amendment(s). In such event, the Board shall then present the recommended changes to the Joint Conference Committee for its recommendation prior to adopting the proposed document(s) or amendment(s).

15.2 Medical Staff Communication. When the MEC adopts, amends, or repeals a Medical Staff Policy or the Rules & Regulations, the MEC shall communicate such action to the Medical Staff and make the applicable documents available.

15.3 Medical Staff Challenge. Any Appointee may raise a challenge to any Medical Staff Policy or Rule/Regulation established by the Medical Executive Committee and approved by the Board. In order to raise such challenge, the Appointee must submit to the MEC a petition signed by not less than twenty percent (20%) of those Medical Staff Appointees in Good Standing who are eligible to vote. Upon receipt of the petition, the Medical Executive Committee shall either (a) provide the petitioners with information clarifying the intent of such Policy or Rule/Regulation; and/or (b) schedule a meeting with the petitioners to discuss the issue. In the event that the issue cannot be resolved to the satisfaction of the petitioners, the matter shall be brought before the Medical Staff for vote subject to final review and action by the Board.
ARTICLE XVI
ADOPTION, AMENDMENT, AND REPEAL OF MEDICAL STAFF BYLAWS

16.1 Approval Procedure.

16.1.1 The Medical Staff Bylaws may be adopted, amended, or repealed after presentation of the proposed Bylaws, or amendments thereto, at any regular or special meeting of the Medical Staff.

16.1.2 The proposed Bylaws or amendments thereto shall be referred to a special committee which shall report at the next regular meeting of the Medical Staff or at a special meeting of the Medical Staff called for such purpose.

16.1.3 The Medical Staff Bylaws may be adopted, amended, or repealed, in whole or in part, by the following combined action.

(a) The affirmative vote of a majority of the Active Medical Staff Appointees in Good Standing eligible to vote on this matter present at a meeting at which a quorum is present; provided, that at least ten (10) days written or electronic notice, accompanied by the proposed Medical Staff Bylaws and/or amendments, has been given of the intention to take such action.

(b) In the alternative, action may be taken without a meeting by ballot of the Active Appointees in Good Standing eligible to vote; provided, that at least ten (10) days written or electronic notice, accompanied by the proposed Medical Staff Bylaws and/or amendments, has been given of the intention to take such action. Ballots must be received prior to the deadline date set forth in the notice advising of the purpose for which a vote is to be taken. If the voting Appointee does not respond prior to the deadline date set forth in the notice, the vote will be considered an affirmative vote. A majority affirmative vote of those Appointees eligible to vote will be required to adopt, amend, or repeal the Medical Staff Bylaws in the manner set forth in this subsection (b).

(c) Such action shall become effective when approved by the Board.

(i) If the Board has determined not to accept a recommendation submitted to it by the Medical Staff, the Chief of Staff may request a meeting of the Joint Conference Committee. Such meeting shall be for the purpose of further communicating the Board's rationale for its contemplated action and permitting the Medical Staff, as applicable, to discuss the rationale for its recommendation. The CEO will schedule such meeting within fourteen (14) days after receipt of a request therefrom from the Chief of Staff. Following receipt of the Joint Conference Committee’s recommendation, the Board may then take final action.

(ii) The Board may adopt or amend the Medical Staff Bylaws provided that the Board has first proposed its recommended changes to the Medical Staff and the Medical Staff has declined to adopt the proposed document(s) or amendment(s). In such event, the Board shall then present the recommended changes to the Joint Conference Committee for
its recommendation prior to adopting the proposed document(s) or amendment(s).

16.2 **Technical Changes.** The Medical Executive Committee shall have the power to adopt such amendments to the Bylaws as are, in its judgment, technical or legal modifications or clarifications, reorganization, renumbering, or amendments made necessary because of punctuation, spelling, or other errors of grammar or expression, inaccurate cross-references, or to reflect changes in committee names. Such amendments shall be effective immediately and shall become permanent if not disapproved by the Board within sixty (60) days of adoption by the Medical Executive Committee. The action to amend shall require a majority affirmative vote of the MEC members. Following MEC approval, such amendments shall be communicated in writing to the Medical Staff and Board.

16.3 **Communication with Medical Staff.** Upon Board approval of adoption, amendment, or repeal of the Medical Staff Bylaws, such action shall be communicated to the Medical Staff in writing and the applicable documents shall be made available.
ARTICLE XVII  MISCELLANEOUS

17.1 **Effect of Adoption.** New or amended Medical Staff Bylaws, Policies, or Rules & Regulations shall replace any previous Medical Staff Bylaws, Policies, or Rules & Regulations and shall become effective upon approval by the Board. Such approval shall not constitute a delegation or abrogation of any of the powers vested in the Board.

17.2 **Biennial Review.** The Medical Staff Bylaws, Policies, and Rules & Regulations shall undergo a biennial review by a special committee formed for that purpose and said review shall be indicated as part of the minutes of that committee. Any recommended revisions shall be accomplished in accordance with the applicable procedure set forth in these Medical Staff Bylaws.

17.3 **Document Conflicts.** If there is a conflict between the Hospital's bylaws and the Medical Staff Bylaws, the Hospital's bylaws shall control; provided, however, that such conflict shall then be referred to the Joint Conference Committee for recommendation to the Board as to how such conflict can be resolved. If there is a conflict between the Medical Staff Bylaws and the Medical Staff Policies or Rules & Regulations, the Medical Staff Bylaws shall control; provided, however, that such conflict shall then be referred to the Medical Executive Committee for resolution of the conflict.

17.4 **Medical Staff/MEC Conflict Resolution.** In the event of a conflict between the Medical Staff, as reflected by a signed petition of not less than twenty percent (20%) of those Medical Staff Appointees in Good Standing eligible to vote, and the MEC, a meeting of the Medical Staff and MEC shall be convened to discuss issues of concern and resolution therefore. In the event that the issue(s) cannot be resolved to the mutual satisfaction of the parties, the matter shall be brought before the Medical Staff for vote subject to final review and action by the Board.

17.5 **Medical History and Physical Examination.** Patients shall, as applicable, receive a medical history and physical examination no more than thirty (30) days prior to, or within twenty-four (24) hours after, registration or admission, but prior to surgery or a procedure requiring anesthesia services. For a medical history and physical examination that was completed within thirty (30) days prior to registration or admission, an update documenting any changes in the patient's condition shall be completed within twenty-four (24) hours after registration or admission, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination shall be completed and documented by a Physician, an Oral Maxillofacial Surgeon, or other qualified licensed individual in accordance with State law and Hospital policy. The medical history and physical examination, and any updates thereto, shall be recorded in the patient's medical record within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia. Additional requirements regarding completion and documentation of the medical history and physical examination are set forth in the Medical Staff Rules and Regulations.
17.6 Internal Conflicts of Interest

17.6.1 In any instance where a Practitioner has or reasonably could be perceived to be biased or to have a conflict of interest in any matter that comes before the Medical Staff, a Service, or committee, the Practitioner shall not participate in the discussion or vote on the matter and shall absent himself/herself from the meeting during that time. The Practitioner may be asked and may answer any questions concerning the conflict before leaving. The Medical Staff officers, Service Chief, or committee chair may routinely inquire, prior to initiating discussion, as to whether any Practitioner has any bias or conflict of interest. Such bias or conflict of interest shall be called to the attention of the Medical Staff officers, Service Chief, or committee chair by any Practitioner with knowledge of the conflict.

17.6.2 A Service Chief or medical director shall have the duty to delegate review of applications for appointment, reappointment, and/or Privileges to another Service member if the Service Chief has a conflict of interest with the individual under review which could be reasonably perceived to create bias. The fact that a Service Chief and a member(s) of the Service are competitors shall not, in and of itself, constitute a conflict of interest requiring delegation.