Medical Staff Bylaws

COMMUNITY HOSPITALS AND WELLNESS CENTERS
Montpelier Hospital

A Medical Staff Document

TABLE OF CONTENTS

Page

DEFINITIONS

The following definitions shall apply to terms used in these Bylaws:

"Accredited Hospital" means a hospital that is accredited by the Centers for Medicare and Medicaid Services (CMS) or an entity that has deeming authority from CMS.

"Advanced Practice Provider" or **"APP"** means those physician assistants, advanced practice registered nurses, and other allied health professionals, as designated in the APP Policy, who have applied for and/or been granted Privileges to practice at the Hospital either independently, or in collaboration with or under the supervision of a Physician, Dentist, or Podiatrist, as applicable, with Medical Staff appointment and Privileges at the Hospital.

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

"Affiliate Hospital" means Community Hospitals and Wellness Centers Bryan Hospital (Bryan) located in Bryan, Ohio.

"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 his/her appointment is to a Medical Staff category without Privileges or unless otherwise provided in these Bylaws.

"Board of Directors" or **"Board"** means the Board of Directors of the Hospital. A reference to the Board of Directors or Board may also mean any committee of the Board or any individual authorized by the Board to act on its behalf in certain matters.

"Bylaws" or **"Medical Staff Bylaws"** means this document, and amendments thereto, that constitutes the basic governing document of the Medical Staff.

"Chief Executive Officer" or **"CEO"** means the president of the Hospital.

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

"Clinical Privileges" or **"Privileges"** means the authorization granted by the Board to a Practitioner or APP to render specific patient care, treatment, and/or services at/for the Hospital, within defined limits, based upon the individual's professional license, education, training, experience, competency, ability, and judgment.

"Dentist" means an individual who has received a doctor of dental medicine (D.M.D.) or doctor of dental surgery (D.D.S.) degree and who is currently licensed to practice dentistry in the State of Ohio, unless otherwise provided herein, and whose practice is in the area of oral and maxillofacial surgery or the area of general dentistry or a specialty thereof.

"Emergency Room Call" means a process whereby patients who do not have an attending Practitioner may be provided medical/other professional services by a Practitioner(s) scheduled to be available to provide such services and who is capable of admitting and providing the level of medical/other professional care required during a patient's hospitalization.

"*Ex Officio*" means appointment to a body by virtue of an office or position held and, unless otherwise expressly provided, without voting rights. Whenever an individual holds a position by virtue of the individual's *Ex Officio* capacity, then the term shall also include that individual's designee unless the context of the term provides otherwise.

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

"Good Standing" means a Practitioner with Medical Staff appointment and/or Privileges at the Hospital who has not received a suspension or restriction of his/her appointment and/or Privileges in the previous twelve (12) months. An automatic suspension for delinquent medical records that has been appropriately resolved shall not adversely affect the Medical Staff Appointee's Good Standing status.

"Hospital" means Community Hospitals and Wellness Centers Montpelier (Montpelier) Hospital located in Montpelier, Ohio; as well as Montpelier's provider-based locations.

"Joint Advisory Committee" means the Board committee composed of an equal number of Board members and Medical Staff members as set forth in Community Hospitals and Wellness Centers Code of Regulations. In the event the provision regarding the Joint Advisory Committee is changed from time to time in the applicable section of Community Hospitals and Wellness Center's Code of Regulations, then this definition shall automatically be likewise amended.

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

"Medical Staff" means all Physicians, Dentists, Psychologists, and Podiatrists who have been granted Medical Staff appointment at the Hospital with such responsibilities, Prerogatives, and Privileges as defined in the category to which each has been appointed.

"Medical Staff Policy(ies)" means those additional Medical Staff governing documents recommended by the Medical Executive Committee and approved by the Board that serve to implement these Bylaws.

"Medical Staff Year" means the period from January 15 to January 14 of the following year.

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

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

"Physician" means an individual who has received a doctor of medicine degree (M.D.) or doctor of osteopathic medicine degree (D.O.) and who is currently licensed to practice medicine in the State of Ohio unless otherwise provided herein.

"Podiatrist" means an individual who has received a doctor of podiatric medicine (D.P.M.) degree and who is currently licensed to practice podiatry in the State of Ohio unless otherwise provided herein.

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

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

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

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

"Rules & Regulations" means the compendium of rules and regulations recommended by the Medical Executive Committee and approved by the Board to govern specific Medical Staff related patient care issues that arise at the Hospital.

"Special Notice" means written notification sent by certified mail, return receipt requested, or by personal delivery service with signed acknowledgement of receipt.

"Telemedicine" means the use of medical information exchanged from one site to another via electronic communication to improve patients' health status. Telemedicine is a subcategory of telehealth.

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

Unless otherwise provided, 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.

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

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 its Practitioners**.**

ARTICLE 1
MEDICAL STAFF APPOINTMENT AND PRIVILEGES

SECTION 1.1. PURPOSE

The purposes of this Medical Staff are to:

a. Be the formal organizational structure through which the benefits of membership on the Medical Staff may be obtained by individual Practitioners and the obligations of Medical Staff membership are fulfilled and enforced.

b. Serve as the primary means for accountability to the Board for the appropriateness of the professional performance and conduct of Practitioners and APPs.

c. Provide a means through which the Medical Staff will participate in the Hospital's policy-making and planning process including providing advice and input to the Hospital regarding:

   i. annual evaluation of the Hospital's performance in relation to its mission, vision, and goals.

   ii. sources of clinical services to be provided at the Hospital by consultation, contractual arrangements, or other agreements.

   iii. the Hospital's annual budget.

   iv. development and implementation of plans for allowing efficient patient flow throughout the Hospital.

   v. development and implementation of written policies and procedures for donating and procuring organs and tissues.

   vi. development and review of clinical practice guidelines.

   vii. development of ongoing processes for the management of conflict between leadership groups within the Hospital.

d. Account for the oversight of care, treatment, and services provided by all Practitioners and APPs with Clinical Privileges by the following activities:

   i. performance of credentials evaluations for, as applicable, appointment and reappointment to the Medical Staff and/or the granting/regranting of Clinical Privileges to be exercised based upon the verification and evaluation of credentials, character, and performance.

ii. performance of utilization review to assure appropriate allocation of the Hospital's resources to provide high-quality patient care in a cost effective manner.

iii. performance of retrospective and concurrent review and evaluation of the quality and appropriateness of patient care as provided through participation in the Hospital's professional practice evaluation and quality improvement programs.

e. Develop and adopt Medical Staff Bylaws, Policies, and Rules and Regulations, which facilitate self-governance subject to the ultimate authority of the Board.

f. Account to the Board for the quality and efficiency of patient care, treatment, and services rendered in the Hospital through regular reports and recommendations concerning the implementation, operation, and results of quality improvement activities as provided by the quality improvement plan and provide:

i. leadership in activities related to patient safety; and,

ii. oversight in the process of analyzing and improving patient satisfaction.

g. Be actively involved in the measurement, assessment, and improvement of the following:

i. Use of medications.

ii. Use of blood and blood components.

iii. Operative and other procedures.

iv. Appropriateness of clinical practice.

v. Significant departures from established patterns of clinical practice.

vi. The use of developed criteria for autopsies.

SECTION 1.2. NATURE OF MEDICAL STAFF APPOINTMENT AND PRIVILEGES

Appointment to the Medical Staff of the Hospital and Privileges shall be extended only to professionally competent Physicians, Psychologists, Dentists and Podiatrists who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and associated policies of the Medical Staff.

SECTION 1.3. QUALIFICATIONS FOR APPOINTMENT AND PRIVILEGES

1.3.1. Qualifications. Competency, as that term is used throughout these Bylaws, shall be based on assessment in the following general areas: patient care and procedural skills;

medical/clinical knowledge; practice-based learning and improvement; interpersonal and communication skills; professionalism; and systems-based practice. Unless otherwise provided in the Bylaws, to be eligible to apply for appointment to the Medical Staff and/or Privileges, a Practitioner must satisfy the following qualifications:

a. Have and maintain a current, valid license to practice medicine, dentistry, podiatry, or psychiatry in Ohio and, as applicable, a current, valid Drug Enforcement Administration (DEA) and Ohio controlled substance registrations.

b. Possess and maintain current, valid Professional Liability Insurance coverage in a form and in amounts satisfactory to the Hospital.

c. Be eligible to participate in Federal Health Programs.

d. Have successfully completed an accredited residency training program (Accreditation Council for Graduate Medical Education or American Osteopathic Association ("ACGME/AOA"), of at least three (3) years (or as otherwise provided in the applicable privilege set), in the specialty in which the applicant seeks Privileges; or a dental surgery training program accredited by the American Association of Oral and Maxillofacial Surgery and/or the Commission on Dental Education of the American Dental Association; or a podiatric surgical residency program accredited by the Council on Podiatry Education of the American Podiatry Association; or a graduate program in psychology from an educational institution accredited by the State Board of Education and acceptable to the State Board of Psychology. In lieu of the requirement for postgraduate training as provided above, evidence of seven (7) years of clinical experience in an Accredited Hospital may be submitted together with documentation as to fields of work, duties, and responsibilities.

e. Provide documentation of board certification if required by the applicable privilege set in accordance with the requirements set forth in such privilege set.

f. Document the following:

   i. Background, experience, training, and demonstrated current competence.
   ii. Adherence to the ethics of their profession.
   iii. Good reputation and character.
   iv. Current ability to perform the Privileges requested safely and competently with or without a reasonable accommodation.
   v. Ability to work cooperatively and harmoniously so that all patients treated by them at the Hospital will receive quality care and the Hospital and its Medical Staff will be able to operate in an orderly manner.
   vi. Communication skills (ability to speak, understand, read, and legibly write the English language and to prepare medical records entries and other required documentation).

vii. Compliance with the Hospital's conflict of interest policy, if any, as applicable.

1.3.2. No Entitlement to Appointment. No individual shall be entitled to appointment to the Medical Staff or to exercise particular Privileges in the Hospital merely because he or she:

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

b. Is a member of any particular professional organization.

c. Has had in the past, or currently has, medical staff appointment or privileges at any other hospital or other health care facility.

d. Resides in the geographic service area of the Hospital.

e. Is affiliated with, or under contract to, any managed care plan, insurance plan, health maintenance organization, preferred provider organization, or other entity.

f. Is employed by or contracts with the Hospital.

1.3.3. Nondiscrimination. No Practitioner shall be denied Medical Staff appointment and/or Privileges on the basis of race; color; sex (including pregnancy); sexual orientation; gender identity; gender expression; transgender status; age (40 and older); religion; marital, familial, or health status; national origin; ancestry; disability; genetic information; veteran or military status; or any other characteristic or class protected by applicable law.

SECTION 1.4. TERM OF APPOINTMENT AND PRIVILEGES

1.4.1. Appointments to the Medical Staff and grants of Clinical Privileges shall be for a period of not more than two (2) years, except that:

a. The exact period of time (not to exceed two years) may vary depending upon the processing schedule of the Medical Staff office. Appointments and/or grants of Privileges for periods of time less than two (2) years shall not be deemed Adverse.

b. The Board, after considering the recommendations of the Credentials Committee and the MEC, may set a more frequent reappraisal period for the exercise of particular Privileges by a Practitioner.

c. Corrective action involving appointment and/or Clinical Privileges may be initiated and taken in the interim under the appropriate provisions of these Bylaws.

d. In the case of a Practitioner providing professional services by contract/employment (see Section 1.5), termination or expiration of the contract/employment may result in a shorter period of appointment and/or Privileges.

SECTION 1.5. PRACTITIONERS PROVIDING PROFESSIONAL SERVICES BY CONTRACT OR EMPLOYMENT

1.5.1. Qualifications and Selection. A Practitioner who is or who will be providing specified professional services pursuant to a contract/employment with the Hospital must meet the same appointment and Privileges qualifications, must be evaluated for appointment, reappointment, and Clinical Privileges in the same manner, and must fulfill all of the applicable obligations as any other applicant or Appointee. No Practitioner, including those contracted with or employed by the Hospital, may provide any professional clinical care, treatment, or 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.

1.5.2. Effect of Adverse Change in Appointment or Clinical Privileges. The effect of an Adverse change in Medical Staff appointment or Clinical Privileges on continuation of the contract or employment is governed solely by the terms of the contract or employment arrangement; or, if the contract or employment arrangement is silent on the matter, will be as determined by the Board after soliciting and considering the recommendations of the MEC.

1.5.3. Effect of Contract/Employment Expiration or Termination

a. The effect of expiration or other termination of a contract or employment upon a Practitioner's Medical Staff appointment and Clinical Privileges shall be governed solely by the terms of the Practitioner's contract/employment with the Hospital, if the same addresses the issue.

b. If the contract or employment arrangement is silent on the matter, then contract/employment expiration or other termination alone will not affect the Practitioner's appointment or Clinical Privileges, except that the Practitioner may not thereafter exercise any Clinical Privileges for which exclusive contractual arrangements have been made as provided in Section 1.5.4.

c. Termination of Medical Staff appointment and Clinical Privileges pursuant to this section or a limitation on Clinical Privileges pursuant to an exclusive contract as provided in Section 1.5.4 shall not give rise to the procedural rights afforded by Article 8 except as otherwise provided in Section 1.5.4.

d. If the basis of such termination or limitation is such that the Hospital would be obligated to report the Practitioner's actions to the State Medical Board of Ohio (or other applicable state licensing entity) or the National Practitioner Data Bank, the Practitioner shall be entitled to the procedural rights afforded by Article 8 solely with respect to those issues that formed the basis of the reporting requirement.

1.5.4. Exclusive Contract. If the Hospital/Board approves an exclusive contract for a particular service(s), any Practitioner previously privileged to provide such service(s) in the Hospital and who is not a party to the exclusive contract (or otherwise employed by or contracted with the group that holds the exclusive contract with the Hospital) will no longer be permitted to exercise those Privileges as of the effective date of the exclusive contract, irrespective of any

remaining time on his/her current Privilege period. When the ability to exercise Privileges is terminated solely on this ground then, to the extent the Practitioner seeks to have a hearing pursuant to Article 8, such hearing shall be limited to the issue of whether the Practitioner's Privileges come within the scope of said exclusive contract.

SECTION 1.6. MEDICO ADMINISTRATIVE OFFICERS

1.6.1. Medical Staff Appointment, Clinical Privileges, and Obligations. Medico-administrative officers must achieve and maintain Medical Staff appointment and Clinical Privileges, appropriate to his/her clinical responsibilities, and discharge Medical Staff obligations, appropriate to his/her Medical Staff category and/or Privileges, in the same manner applicable to all other Appointees.

1.6.2. Effect of Removal From Position or Adverse Change in Appointment Status or Clinical Privileges

a. A medico-administrative officer employed by the Hospital in a purely administrative capacity, with no clinical duties, is subject to the regular personnel policies of the Hospital and to the terms of his/her contract or other conditions of employment, and need not be an Appointee. Termination of a medico-administrative officer's administrative duties does not give rise to any rights under Article 8.

b. However, should said Practitioner have any clinical duties, he/she must be an Appointee with Clinical Privileges pursuant to the requirements of these Bylaws. The effect of removal of a medico-administrative officer from his/her position on the Practitioner's Medical Staff appointment and Privileges shall be the same as set forth in Section 1.5.3. The effect of an Adverse change in the Practitioner's Medical Staff appointment and/or Privileges on his/her medico-administrative position shall be the same as set forth in Section 1.5.2.

SECTION 1.7. RESPONSIBILITIES OF PRACTITIONERS WITH MEDICAL STAFF APPOINTMENT/PRIVILEGES

1.7.1. Unless otherwise provided in these Bylaws, each Practitioner, as a condition of initial and continued appointment and/or grant/regrant of Privileges, shall as applicable to the Medical Staff appointment and/or Privileges granted to each such Practitioner specifically agree to:

a. Provide appropriate and continuous care of his/her patients and be responsible for the actions of APPs under his/her supervision or with whom he/she collaborates.

b. Assist the Hospital in fulfilling its responsibilities for providing emergency and charitable care consistent with requirements adopted by the Medical Staff/MEC and approved by the Board.

c. Designate another Appointee with comparable Privileges who will agree to provide back-up coverage for the applicant's patients in the event the applicant is not available (Privileges may be granted conditional upon this information being made available).

d. Abide by the Bylaws and Rules & Regulations, and other policies and procedures of the Medical Staff and the Hospital.

e. Abide by the terms of the Hospital's Compliance Program.

f. Abide by the Hospital's Notice of Privacy Practices prepared and distributed to patients as required by the federal patient privacy regulations.

g. Provide new or updated information to the Medical Staff Office, during the course of an appointment/Privilege period and as it occurs, on any changes in the information that was provided in the Practitioner's most recent application for appointment and/or Privileges.

h. If granted Privileges, to use the Hospital and its facilities sufficiently to allow appropriate Medical Staff committees to evaluate continuing current competence and to provide such additional/supplemental competency information from other facilities at which the Practitioner has privileges as reasonably requested.

i. Complete medical and other required records in a complete, timely, and legible manner for all patients.

j. Work cooperatively and professionally with other Practitioners, Medical Staff leadership, Hospital administration, and other Hospital personnel and APPs.

k. Act in an ethical, professional, and courteous manner and to cooperate and work collegially with the Medical Staff leadership and Hospital management and personnel in accordance with these Bylaws.

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

ARTICLE 2
CATEGORIES OF THE MEDICAL STAFF

SECTION 2.1. ACTIVE MEDICAL STAFF CATEGORY

2.1.1. Qualifications. To qualify for appointment and reappointment to the active Medical Staff, a Practitioner must:

a. Meet the qualifications for Medical Staff appointment and Privileges set forth in §1.3.1.

b. Reside or have a business office that is within sufficiently close proximity to the Hospital to enable him/her to provide continuous care to his/her patients, or make arrangements that are satisfactory to the MEC for alternative Practitioner coverage for patients for whom he/she is responsible.

c. Meet one (1) of the following criteria:

i. Be involved in a minimum of twenty-five (25) Patient Encounters at the Hospital annually; **OR,**

ii. Provide medico-administrative services to the Hospital (in which case the appointment may be made with or without Privileges, as applicable, in accordance with §1.6).

2.1.2. Prerogatives. Except as otherwise provided, the Prerogatives of an Appointee to the active Medical Staff are as follows:

a. Exercise such Privileges as are granted to him or her pursuant to these Bylaws.

b. Attend general and special meetings of the Medical Staff and vote on Medical Staff matters.

c. Attend Medical Staff and Hospital education programs.

d. Be eligible to hold Medical Staff office and to serve on or chair Medical Staff committees with the right to vote, unless otherwise specified in these Bylaws.

2.1.3. Responsibilities. In addition to §1.7.1 of the Bylaws, an Appointee to the active Medical Staff must, as applicable to the Medical Staff appointment and/or Privileges granted to each such Appointee:

a. Contribute to the organization and administrative affairs of the Medical Staff including quality/performance improvement, risk management and monitoring activities, and other Medical Staff functions as may be required from time to time.

b. Participate in the Emergency Room and other specialty on-call coverage programs as determined by the Medical Executive Committee.

c. Fulfill any meeting attendance requirements as established by these Bylaws.

2.1.4. Automatic Transfer from Active Medical Staff Category. After two (2) consecutive years in which a Practitioner who was appointed to the Medical Staff pursuant to §2.1.1 (c)(i) fails to meet the minimum Patient Encounter requirements, the Appointee shall be automatically transferred to an appropriate Medical Staff category, if any, for which the Practitioner is qualified; or, terminated from the Medical Staff absent a showing by the Practitioner, satisfactory to the MEC and Board, that the situation was due to unusual circumstances unlikely to reoccur in the next appointment/Privilege period. Such transfer or termination shall not give rise to the procedural rights afforded by Article 8.

SECTION 2.2. COURTESY MEDICAL STAFF CATEGORY

2.2.1. Qualifications. To qualify for appointment and reappointment to the courtesy Medical Staff, a Practitioner must:

a. Meet the qualifications set forth in §1.3.1.

b. Satisfy one (1) of the following criteria:

i. Have not less than two (2) but not more than twenty-four (24) Patient Encounters per appointment/Privilege period; **OR,**

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

iii. Are requesting appointment and Privileges for the sole purpose of providing specialty/consulting services in a specialty area in which there is a need at the Hospital; **OR,**

iv. Are requesting appointment and Privileges for the sole purpose of providing on-site professional Emergency, Radiology, Pathology, or Hospitalist services for the Hospital; **OR,**

v. Are requesting appointment and Privileges for the sole purpose of proctoring a procedure at the Hospital.

2.2.2. Prerogatives. Except as otherwise provided, the Prerogatives of an Appointee to the courtesy Medical Staff are as follows:

a. Exercise such Privileges as are granted to him or her pursuant to these Bylaws.

b. Attend general meetings of the Medical Staff but may not vote or hold Medical Staff office.

c. Attend Medical Staff and Hospital educational programs.

d. Be eligible to serve on Medical Staff committees with the right to vote, unless otherwise specified in these Bylaws.

e. Is not permitted to chair a Medical Staff committee.

2.2.3. Responsibilities. In addition to §1.7.1 of the Bylaws, an Appointee to the courtesy Medical Staff must:

a. Contribute to the organization and administrative affairs of the Medical Staff including quality/performance improvement, risk management, and monitoring activities and other Medical Staff functions as may be required from time to time.

b. Participate in the Emergency Room and other specialty on-call coverage programs as determined by the Medical Executive Committee; provided, however, if a Practitioner is an Appointee to the courtesy category for the sole purpose of proctoring other Practitioners, then the Practitioner shall not be obligated to participate in any on-call responsibilities.

c. Fulfill any meeting attendance requirements as established by these Bylaws.

2.2.4. Automatic Transfer from Courtesy Medical Staff Category. After two (2) consecutive years in which a Practitioner who was appointed to the Medical Staff pursuant to §2.2.1(b)(i):

a. Exceeds the Patient Encounter requirements (and provided that such Practitioner does not otherwise qualify for continued appointment to the courtesy Medical Staff pursuant to (b)(ii)-(v) above), the Practitioner shall be transferred to the active Medical Staff absent a showing by the Practitioner, satisfactory to the MEC and Board, that the number of encounters was unusual and would not be expected to occur in the upcoming appointment/Privilege period.

b. Fails to meet the requirements for Patient Encounters (and provided that such Practitioner does not otherwise qualify for continued appointment to the courtesy Medical Staff pursuant to (b)(ii)-(v) above), the Practitioner will be transferred to another Medical Staff category for which he/she is eligible, if any, or terminated from the Medical Staff in the absence of a showing by the Practitioner, satisfactory to the MEC and Board, that the situation was due to unusual circumstances unlikely to occur in the next appointment/Privilege period.

c. Such transfer or termination shall not give rise to the procedural rights afforded by Article 8.

SECTION 2.3. CONSULTING PEER REVIEW MEDICAL STAFF CATEGORY

2.3.1. Qualifications. A consulting peer review Appointee must:

a. Practice either locally or in another city or state in which he/she has a current, valid license to practice.

b. Be a current appointee to the active medical staff of another Accredited Hospital and have practiced for a period of not less than five (5) years.

c. 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.

d. Satisfy the Hospital's Professional Liability Insurance requirements.

e. Satisfy such other qualifications, if any, as are set forth in the Peer Review/Professional Practice Evaluation Policy, as such policy may be amended from time to time; or, as otherwise determined necessary by the Medical Executive Committee in order to provide the services being requested.

2.3.2. Prerogatives. Consulting peer review Appointees are:

a. Not granted Privileges.

b. Not eligible to hold office or vote on Medical Staff matters.

c. Not eligible to serve as a Medical Staff committee member or chair or vote on committee matters.

d. Eligible to attend Medical Staff meetings and Medical Staff committee meetings as a guest upon request.

2.3.3. Responsibilities. Consulting peer review Appointees must:

a. Abide by these Bylaws, the Rules & Regulations, and Hospital/Medical Staff policies and procedures as applicable.

b. Be willing to accept consulting peer review assignments for the limited purpose of evaluating Practitioners' credentials and reviewing selected medical records and other related peer review documents in order to render an opinion on the quality of health care rendered to patients at the Hospital; or, otherwise perform related peer review services as specifically requested.

c. Be willing to participate in the Medical Staff hearing/appeal process if requested to do so.

d. Perform such other duties as are set forth in the Medical Staff Peer Review/Professional Practice Evaluation Policy, as such policy may be amended from time to time, and as otherwise requested of him/her and which he/she agrees to perform

e. A consulting peer review Medical Staff Appointee shall not otherwise be required to fulfill the obligations set forth in §1.7-1.

2.3.4. Appointment to the consulting peer review Medical Staff category shall be solely for the purpose of conducting peer review in a particular case or situation and shall terminate upon the Practitioner's completion of his/her duties in connection with the peer review matter without any procedural rights under Article 8.

SECTION 2.4. AFFILIATE MEDICAL STAFF CATEGORY

2.4.1. Qualifications. The affiliate Medical Staff shall consist of Practitioners who:

a. Have an active appointment at an Affiliate Hospital; and, do not otherwise hold Medical Staff appointment (with or without Privileges) at this Hospital. Appointments to the affiliate Medical Staff under these circumstances shall be automatic upon appointment to the active Medical Staff at an Affiliate Hospital and shall be without Privileges; **OR,**

b. Have an appointment at an Affiliate Hospital in a category other than the active Medical Staff category; do not otherwise hold Medical Staff appointment (with or without Privileges) at the Hospital; and agree to serve as a member of a peer review committee at the Hospital.

2.4.2. Prerogatives. Affiliate Medical Staff Appointees may:

a. Not be granted Privileges at the Hospital.

b. Visit his/her patients who are in the Hospital and review his/her patients' Hospital medical records' consistent with the Hospital's medical records/HIPAA policies.

c. Not admit patients, write orders or progress notes, make notations in the medical record, or otherwise participate in the provision of care or management of the patients at the Hospital.

d. Hold Medical Staff office.

e. Serve as chair or a member of Medical Staff committees with the right to vote, unless otherwise specified in these Bylaws.

f. Attend Medical Staff meetings and vote on Medical Staff matters.

g. Attend educational programs sponsored by the Hospital and/or the Medical Staff.

2.4.3. Responsibilities. Each Appointee to the affiliate Medical Staff shall:

a. Treat employees, patients, visitors, APPs, and other Practitioners in a dignified and courteous manner.

b. Act in an ethical and professional manner.

c. Attend meetings of the Medical Staff committees to which he/she is appointed and actively participate thereon.

d. Satisfy the responsibilities set forth in §1.7.1 to the extent applicable to a Medical Staff appointment without Privileges.

e. Promptly pay Medical Staff dues, fees, and assessments, if applicable.

SECTION 2.5. COMMUNITY MEDICAL STAFF CATEGORY

2.5.1. Qualifications. The community Medical Staff shall consist of Practitioners who:

a. Desire to be affiliated with the Hospital, but do not intend to establish a clinical practice at the Hospital.

b. Have an office-based practice serving patients in the community the Hospital serves.

c. Satisfy the qualifications set forth in §1.3-1 to the extent applicable to a Medical Staff appointment without Privileges.

2.5.2. Prerogatives. Community Medical Staff Appointees may:

a. Not be granted Privileges at the Hospital.

b. Visit his/her patients who are in the Hospital and review his/her patients' Hospital medical records' consistent with the Hospital's medical records/HIPAA policies.

c. Not admit patients, write orders or progress notes, make notations in the medical record, or otherwise participate in the provision of care or management of the patients at the Hospital.

d. Not hold Medical Staff office.

e. Not chair a Medical Staff committee.

f. Not vote on Medical Staff matters with the exception set forth in subsection (g).

g. Serve as a member of Medical Staff committees with the right to vote, unless otherwise specified in these Bylaws.

h. Attend Medical Staff meetings.

i. Attend educational programs sponsored by the Hospital or Medical Staff.

2.5.3. Responsibilities. Each Appointee to the community Medical Staff shall:

a. Treat employees, patients, visitors, APPs, and other Practitioners in a dignified and courteous manner.

b. Act in an ethical and professional manner.

c. Attend meetings of the Medical Staff committees to which he/she is appointed and actively participate thereon.

d. Satisfy the responsibilities set forth in §1.7.1 to the extent applicable to a Medical Staff appointment without Privileges.

e. Promptly pay Medical Staff dues, fees, and assessments.

SECTION 2.6. HONORARY MEDICAL STAFF CATEGORY

2.6.1. Qualifications. The honorary Medical Staff category shall consist of Practitioners the Medical Staff wishes to honor. They shall be appointed by the Board upon recommendation of the Medical Executive Committee.

2.6.2. Prerogatives. Except as otherwise provided, the Prerogatives of an Appointee to the Honorary Medical Staff are as follows:

a. Attend Medical Staff and health care education programs.

b. Serve on committees as requested by the Chief of Staff or the Medical Executive Committee; and, to the extent they accept such appointment, may vote as to that committee.

c. Not be eligible to hold Medical Staff office, to vote (except as otherwise provided in §2.5.2 (b)), or to serve as a chair of a Medical Staff committee.

2.6.3. Responsibilities. Appointees to the Honorary Medical Staff category shall have no assigned responsibilities.

SECTION 2.7. CHANGE OF MEDICAL STAFF CATEGORY

Provided an Appointee meets the qualifications for a different category, an Appointee's Medical Staff category may be changed by the Board, upon recommendation of the MEC (either by request

of the Appointee or by the MEC's own initiative in accordance with these Bylaws), at any time during an Appointee's term of appointment.

ARTICLE 3
PRIVILEGES

SECTION 3.1. MOONLIGHTING RESIDENT PRIVILEGES

3.1.1. Conditions

a. Moonlighting Privileges may be granted to a resident who satisfies the qualifications set forth in §3.1.3 only in the circumstances and under the conditions described in this Section.

b. Special requirements of consultation and reporting may be imposed at such time as moonlighting Privileges are granted.

c. Under all circumstances, the resident requesting moonlighting Privileges must agree, in writing, to abide by the Medical Staff Bylaws, Policies, and Rules & Regulations, and the policies of the Hospital in all matters relating to his/her activities in the Hospital.

d. Residents on J-1 visas are not permitted to request moonlighting Privileges.

e. A moonlighting resident must request and be granted Privileges prior to providing any clinical care, treatment, or services to patients at the Hospital outside his/her residency program.

f. Moonlighting must not interfere with the ability of the resident to otherwise achieve the goals and objectives of his/her residency education/training program.

g. The moonlighting resident will be subject to Focused Professional Practice Evaluation and Ongoing Professional Practice Evaluation with respect to the moonlighting Privileges granted in accordance with the procedures set forth in applicable Medical Staff policies.

h. Permission for moonlighting may be withdrawn if the moonlighting resident's program director believes the resident's education/training is negatively impacted as a result of his/her moonlighting activities.

3.1.2. Processing a Request for Moonlighting Privileges

a. A resident seeking moonlighting Privileges shall submit an application and shall have such application processed in accordance with the routine credentialing and privileging process set forth in Article 4, to the extent applicable.

b. Eligible residents are granted moonlighting Privileges without a Medical Staff appointment. Privileges may be granted for a period of up to two (2) years as recommended by the MEC and approved by the Board.

3.1.3. Qualifications for Emergency Medicine Moonlighting Resident Privileges

a. Are requesting Privileges to provide clinical care, treatment, and/or services to patients at the Hospital outside their residency program.

b. Have and maintain a current, valid medical license (not a training certificate) from the State Medical Board of Ohio and satisfy the additional qualifications set forth in §1.3.1 (b), (c), and (f).

c. Satisfactory completion of at least two (2) years of postgraduate training in an approved and accredited Emergency Medicine Residency Program.

d. Must obtain written approval from the residency program director to moonlight in the Hospital's Emergency Department outside of the resident's residency training program.

e. The applicant must have evaluated a minimum of 500 patients in the Emergency Department setting. The applicant must also maintain competency in all critical care procedures required by the residency program.

f. Are in good standing in his/her residency program as verified by the director of such program.

SECTION 3.2. EMERGENCY PRIVILEGES

In the case of emergency in which serious permanent harm or aggravation of injury or disease is imminent, or in which the life of a patient is in immediate danger, any Practitioner is authorized, when better alternative sources of care are not available within the necessary time frame, to do everything possible to save the patient's life or to save the patient from serious harm, to the degree permitted by the Practitioner's license but regardless of his/her Medical Staff category or Privileges. A Practitioner providing services in an emergency situation that are outside of his or her usual scope of Privileges is obligated to summon all consultative assistance deemed necessary and to arrange for appropriate follow-up care.

SECTION 3.3. DISASTER PRIVILEGES

3.3.1. Eligibility for Disaster Privileges

a. In circumstances of a disaster when the emergency medical plan has been activated and the Hospital is unable to meet patient needs, disaster Privileges may be granted to qualified volunteer Practitioners for up to thirty (30) days. The Chief Executive Officer or the Chief of Staff may grant such disaster Privileges on a case-by-case basis after verification of a valid government-issued photo identification issued by a state or federal agency (*i.e.* driver's license or passport) and at least one of the following: (i) current licensure; (ii) primary source verification of licensure (iii) a current hospital identification card that clearly identifies the individual's professional designation, (iv) identification indicating the individual is a member

of a Disaster Medical Assistance Team ("DMAT"), the Medical Reserve Corp ("MRC"), the Emergency System for Advance Registration of Volunteer Health Professionals ("ESAR-VHP"), or other recognized state or federal response organization or group; (v) identification indicating the individual has been granted authority to render patient care, treatment, or services in disaster circumstances by a government agency, (vi) confirmation of the identity of the volunteer Practitioner and his/her qualifications by a Hospital employee or Practitioner with Privileges at the Hospital.

b. It is anticipated that disaster Privileges may be granted to in-state and out-of-state volunteer Practitioners in response to such a disaster, as necessary, in accordance with applicable Ohio licensure laws, rules, and regulations.

3.3.2. Identification and Management

a. All volunteer Practitioners who receive disaster Privileges must at all times while at the Hospital wear an identification badge, with photograph, from the facility at which they otherwise hold privileges. If the volunteer Practitioner does not have such identification, he or she will be issued a badge identifying him or her and designating the volunteer Practitioner as an emergency provider.

b. The activities of volunteer Practitioners who receive disaster Privileges shall be managed by and under the supervision of the Chief of Staff or an appropriate designee (*e.g.*, the chair of the Emergency Medicine Service).

3.3.3. Verification

a. Primary source verification of licensure will begin as soon as the immediate situation is under control; and, in the absence of extraordinary circumstances, is to be completed within seventy-two (72) hours from the time the volunteer Practitioner presents to the Hospital.

b. In extraordinary circumstances where verification cannot be completed within this time frame, and provided the volunteer Practitioner has been exercising disaster Privileges, the Medical Staff Office must document: 1) why primary source verification could not be performed in the required time frame; 2) evidence of the volunteer Practitioner's demonstrated ability to continue to provide adequate care, treatment, and services; and 3) attempts to rectify the situation as soon as possible.

c. Within seventy-two (72) hours from the time the volunteer Practitioner begins exercising disaster Privileges, the Chief Executive Officer or Chief of Staff must make a decision, based upon the information obtained during that time, related to the continuation of the disaster Privileges initially granted.

d. At such time as circumstances allow, the remainder of the verification process shall be done in the same manner as set forth with respect to temporary Privileges to meet an important patient care need.

3.3.4. Termination of Disaster Privileges. Disaster Privileges shall cease upon alleviation of the circumstances of disaster as determined by the Chief Executive Officer.

SECTION 3.4. TEMPORARY PRIVILEGES

3.4.1. Conditions. Temporary Privileges may be granted only in the circumstances and under the conditions described in §3.4.2-§3.4.4 below. Special requirements of consultation and reporting may be imposed by the Chief of Staff or Vice Chief of Staff. Under all circumstances, the Practitioner requesting temporary Privileges must agree in writing to abide by these Bylaws, the Rules & Regulations, and policies of the Medical Staff and those of the Hospital in all matters relating to his or her activities in the Hospital.

3.4.2. Circumstances. Upon written recommendation of the Chief of Staff or Vice Chief of Staff, the CEO may grant temporary Privileges on a case-by-case basis in the following circumstances:

3.4.3. Pendency of a Completed Application

a. To an applicant for new Privileges awaiting review and approval by the MEC and Board but only after: receipt of a completed application for Medical Staff appointment and/or Privileges (including a request for the specific temporary Privileges desired) that raises no concerns consistent with the requirements set forth in §1.3 and Article 4.

b. Along with the completed application, the record must establish that the applicant has no current or previously successful challenges to licensure or registration; has not been subject to involuntary termination from a Medical Staff appointment at any other organization; has not been subject to any involuntary limitation, reduction, denial, or loss of privileges; and has not been suspended or terminated from any Federal Health Program.

c. Temporary Privileges may be granted in this circumstance for a period not to exceed the pendency of the application (*i.e.*, completion of review and action on the application by the MEC and Board) or one hundred twenty (120) days whichever is less. 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.

3.4.4. Important Patient Care Need

a. To a Practitioner when necessary to fulfill an important patient care, treatment, or service need(s) but only after:

i. Receipt of a written request for the specific Privileges desired.

ii. Verification of appropriate current licensure and, if applicable to the Privileges requested, DEA/controlled substances registration.

iii. Verification of appropriate Professional Liability Insurance.

iv. Receipt of a fully positive written or documented oral reference specific to the Practitioner's current competence for the Privileges being requested from a responsible medical staff authority at the Practitioner's current hospital affiliation.

v. Completion of National Practitioner Data Bank query and queries applicable to the Practitioner's ability to participate in Federal Health Programs (*e.g.*, OIG, *etc.*).

b. Temporary Privileges may be granted in this circumstance for an initial period of up to thirty (30) days and may be renewed for additional periods not to exceed thirty (30) days as necessary to fulfill the important patient care, treatment, or service need(s).

SECTION 3.5. TELEMEDICINE PRIVILEGES

3.5.1. Request. A Practitioner may apply for Privileges in telemedicine without applying for appointment to the Medical Staff. Prior to a Practitioner providing telemedicine services (including the rendering of a diagnosis or other clinical care, treatment, and/or services) to patients at the Hospital, the Practitioner must be credentialed and granted appropriate Privileges by the Hospital in accordance with the Bylaws, accreditation standards, and applicable laws, rules, and regulations. A Practitioner providing services via a telemedicine link shall be credentialed in one of the following ways:

3.5.2. Pursuant to Article 4 of Bylaws. The Hospital may fully credential and grant Privileges to the Practitioner according to the applicable procedure set forth in Article 4.

3.5.3. Reliance Upon Distant Site's Credentialing Information and/or Privileging Decision to Make Hospital Privileging Decision. The Practitioner is credentialed and privileged by the Hospital in accordance with the applicable procedure set forth in Article 4 with the exception that the Medical Staff and Board may use the credentialing information and/or the privileging decision from the distant site to make a final privileging recommendation/decision if the Hospital has entered into a written agreement with the distant site and all of the following requirements are met:

a. 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 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 Medicare conditions of participation, particularly those requirements related to the credentialing and privileging of practitioners providing telemedicine services to the patients of the hospital.

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

ii. 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)-(c)(1)(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)-(c)(1)(vii) as those provisions may be amended from time to time.

b. The distant site is TJC accredited.

c. Each 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 and any subsequent changes thereto.

d. Each distant site Practitioner holds an appropriate license (or telemedicine certificate) issued by the State Medical Board of Ohio or other appropriate licensing entity in addition to an appropriate license in the State in which the Practitioner is located, if other than Ohio.

e. 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:

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

ii. All complaints the Hospital receives about the distant site Practitioner.

3.5.4. Temporary Privileges. A Practitioner may be eligible for temporary Privileges, as provided in §3.4, while the Practitioner's application for telemedicine Privileges is being processed.

SECTION 3.6. TERMINATION OF TEMPORARY, DISASTER, TELEMEDICINE, AND MOONLIGHTING PRIVILEGES

3.6.1. Termination. The Chief Executive Officer or Chief of Staff may at any time terminate all, or any portion, of a Practitioner's temporary, disaster, or telemedicine Privileges, or a resident's moonlighting Privileges. Where the life or well-being of a patient is determined to be endangered, the Practitioner's temporary, disaster, or telemedicine Privileges, or resident's moonlighting Privileges may be terminated by any person entitled to impose a summary suspension pursuant to the Bylaws.

3.6.2. Procedural Due Process Rights. A Practitioner who has been granted temporary, disaster, or telemedicine Privileges, or a resident who has been granted moonlighting Privileges is not an Appointee to the Medical Staff and is not entitled to the procedural due process rights afforded to Appointees. A Practitioner or resident shall not be entitled to the procedural due process rights set forth herein because the Practitioner's request for temporary, disaster, or telemedicine Privileges, or the resident's request for moonlighting Privileges is 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.

3.6.3. Patient Care. In the event a Practitioner's temporary, disaster, or telemedicine Privileges, or a resident's moonlighting Privileges are revoked, the Practitioner's or resident'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.

SECTION 3.7. EMPLOYMENT OF, SUPERVISION OF, AND/OR COLLABORATION WITH ADVANCED PRACTICE PROVIDERS

Any Practitioner who employs, supervises, or collaborates with an APP who is granted Privileges to provide care, treatment, and/or services at the Hospital shall be responsible for the direction and supervision of, or collaboration with, the APP in accordance with the APP's supervision agreement or standard care arrangement, as applicable, the APP's privilege set, the APP Policy and other applicable Medical Staff/Hospital policies, and applicable laws, rules, and regulations. All Practitioners employing, supervising, or collaborating with APPs are advised to consult the Medical Staff's APP Policy for details concerning the practice of APPs in the Hospital and Appointees' responsibilities related thereto.

SECTION 3.8. SPECIAL CONDITIONS FOR PSYCHOLOGISTS

Psychologists shall not be authorized to admit or co-admit patients to the Hospital. In the inpatient setting, Psychologists shall be authorized to treat only those patients who have been admitted by a Physician Appointee and must maintain a consultative relationship with such Physician Appointee during the course of treatment of the patient. The Psychologist shall be responsible for the psychological care of the patient, including a psychological history and record. The Psychologist

may write orders within the scope of his/her license consistent with the Privileges granted and in accordance with the Medical Staff Rules & Regulations or applicable Hospital/Medical Staff policies. A Psychologist is not authorized to prescribe drugs, perform surgical procedures, or practice outside the scope of the Privileges granted. In outpatient settings, Psychologists may diagnose and treat their patients psychological illness within the scope of the Privileges granted. Psychologists must ensure that their patients receive referral for appropriate medical care.

SECTION 3.9. PROFESSIONAL PRACTICE EVALUATION

3.9.1. Focused Professional Practice Evaluation. The Focused Professional Practice Evaluation ("FPPE") process is set forth, in detail, in the Peer Review/Professional Practice Evaluation Policy, as such policy may be amended from time to time, and shall be implemented: (a) for all Practitioners requesting initial Privileges; (b) for existing Practitioners requesting new Privileges during the course of an appointment/Privilege period; and (c) in response to concerns regarding a Practitioner's ability to competently exercise the Privileges granted. The FPPE period shall be used to determine the Practitioner's current clinical competence and ability to perform the Privileges requested/granted.

3.9.2. Resignation While Under FPPE for Quality of Care Concerns. If a Practitioner resigns while under an FPPE for quality of care/clinical competency concerns, then the Practitioner will be subject to reporting to the National Practitioner Data Bank.

3.9.3. Ongoing Professional Practice Evaluation. Upon conclusion of the FPPE period, Ongoing Professional Practice Evaluation ("OPPE") shall be conducted on all Practitioners with Privileges. The OPPE process is set forth, in detail, in the Peer Review/Professional Practice Evaluation Policy, as such policy may be amended from time to time, and requires the Hospital to gather, maintain, and review data on the performance of all Practitioners with Privileges on an ongoing basis.

SECTION 3.10. MEDICAL HISTORY AND PHYSICAL EXAMINATION REQUIREMENTS

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 inpatient 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 who is granted the Privileges to do so 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 services. Additional requirements regarding completion and documentation of the history and physical examination are set forth in Section 3.8 of these Bylaws and the Rules & Regulations.

SECTION 3.11. RECOGNITION OF A NEW SERVICE, PROCEDURE, OR TECHNIQUE

3.11.1. Need for Privilege Criteria. A Privilege set must be approved by the Board for all new services and procedures not currently being performed at the Hospital (and for new techniques with respect to existing procedures) except for those that are clinically or procedurally similar to an existing modality.

3.11.2. Considerations. The Board shall determine the Hospital's scope of patient care services based upon a recommendation from the MEC. Overall considerations for establishing new services and procedures (and for recognizing new techniques with respect to existing procedures) include, but are not limited to:

a. The Hospital's available resources and staff (*e.g.*, equipment required, staff skills/training required, *etc.*).

b. The Hospital's ability to appropriately monitor and review the competence of the performing Practitioner(s) (*e.g.*, risks to patients *etc.*).

c. The availability of another qualified Practitioner(s) with Privileges at the Hospital to provide coverage for the procedure when needed.

d. The quality and availability of training programs.

e. Whether such service or procedure currently, or in the future, would be more appropriately provided through a contractual arrangement with the Hospital.

f. Whether there is a community need for the service or procedure.

3.11.3. Privilege Requests for a New Service, Procedure, or Technique. Requests for Privileges for a service, procedure, or technique that has not yet been recognized by the Board shall be processed as follows:

a. The Practitioner must submit a written request for Privileges to the Medical Staff Office. The request should include a description of the Privileges being requested, the reason why the Practitioner believes the Hospital should recognize such Privileges, and any additional information that the Practitioner believes may be of assistance to the Hospital in evaluating the request. The Medical Staff Office will notify the Chief of Staff of such request.

b. The Credentials Committee will review requests for new services, procedures, and techniques taking into account the considerations set forth in §3.12.2 as well as what specialties are likely to request the proposed Privileges, positions of specialty societies, certifying boards, *etc.* with respect to the proposed Privileges, and criteria with respect to the proposed Privileges by other hospitals with similar resources and staffing (*e.g.*, indications when use of the new service, procedure, or technique

is appropriate, *etc.*). The Credentials Committee may convene an *ad hoc* committee to assist with this review.

i. If the Credentials Committee recommends that Privileges to perform the service, procedure, or technique be recognized at the Hospital, the committee will prepare a written report including the recommended standards to be met with respect to the following: education, training; fellowship/board certification status; experience; and type of professional practice evaluation (*e.g.* whether proctoring/monitoring should be required; and, if so, the number of cases/procedures to be included/performed during an appointment/Privilege period to establish current competency) required to perform the new service, procedure, or technique.

ii. If the Credentials Committee recommends that the service, procedure, or technique be included in an existing Privilege set, the committee will provide the basis for its determination.

iii. If the Credentials Committee recommends that Privileges to perform the service, procedure, or technique not be offered at the Hospital, the committee will prepare a written report detailing its findings.

iv. The Credentials Committee shall forward its report to the MEC.

c. Upon receipt of the Credentials Committee's report, the MEC will act. The recommendation of the MEC, whether favorable or not favorable, will be forwarded to the Board for review and action.

i. If the Board approves the proposed Privileges, the requesting Practitioner(s) may apply for such Privileges consistent with the process set forth in these Bylaws.

ii. If the Board does not approve the proposed Privileges, the requesting Practitioner(s) will be so notified. A decision by the Board not to recognize Privileges for a new service, procedure, or technique does not constitute an appealable event for purposes of the Bylaws.

SECTION 3.12. AMENDMENT OF EXISTING PRIVILEGE SETS

Proposed amendments to existing Privilege sets shall be reviewed by the Credentials Committee, recommended/not recommended by the MEC, and acted upon by the Board. A decision by the Board not to approve proposed amendments to an existing Privilege set does not constitute an appealable event for purpose of these Bylaws.

ARTICLE 4
APPLICATION PROCESS

SECTION 4.1. GENERAL

Except as otherwise specified herein, no Practitioner shall exercise Privileges in the Hospital unless and until that Practitioner applies for and is granted appropriate Privileges in accordance with these Bylaws. By applying or reapplying for Medical Staff appointment (or, in the case of Appointees to the honorary Medical Staff, by accepting an appointment to that category) and/or Privileges, the applicant acknowledges his/her responsibility to first review the Bylaws, Rules & Regulations, and applicable Hospital/Medical Staff policies and agrees that during all times that the Practitioner holds Medical Staff appointment and/or Privileges at the Hospital, the Practitioner will comply with the responsibilities of Medical Staff appointment and Privileges and with the Bylaws of the Medical Staff, Rules & Regulations, and related Hospital/Medical Staff policies as they exist and as they may be modified from time to time.

SECTION 4.2. BURDEN OF PRODUCING INFORMATION

In connection with all applications for Medical Staff appointment and/or Privileges, the applicant shall have the burden of producing information for an adequate evaluation of the applicant's qualifications and suitability for the Privileges and Medical Staff category requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information. This burden may include a request for a medical examination or psychological evaluation, at the applicant's expense and by an individual of the MEC's or Board's choosing, if deemed appropriate by the Medical Executive Committee or the Board.

SECTION 4.3. APPLICATION FOR APPOINTMENT WITHOUT PRIVILEGES

Due to the limited nature of a Medical Staff appointment without Privileges:

4.3.1. Affiliate. Appointments to the affiliate Medical Staff under the circumstances set forth in §2.4.1 (a) shall be automatic upon appointment to the active Medical Staff at an Affiliate Hospital and shall be without Privileges. Appointments to the affiliate Medical Staff under the circumstances set forth in §2.4.1 (b) shall be acted upon by the Hospital CEO upon recommendation of the Chief of Staff.

4.3.2. Community**.** Practitioners requesting appointment to the community Medical Staff will only be required to complete such application and provide such information as required by the community Medical Staff category and as the MEC and Board otherwise deem necessary. An application for appointment to the community Medical Staff shall be processed in accordance with the routine credentialing and appointment process**.**

4.3.3. Consulting Peer Review. Practitioners requesting appointment to the consulting peer review Medical Staff will only be required to complete such application and provide such information as required by the consulting peer review Medical Staff category and as the MEC and Board otherwise deem necessary. If time constraints so require, an application for consulting peer review appointment may be acted upon by the CEO upon recommendation of the Chief of Staff.

4.3.4. Honorary. Nominees to the honorary Medical Staff are not required to complete an application. Practitioners shall be appointed to the honorary Medical Staff upon recommendation of the MEC and approval of the Board.

4.3.5. Denial. Denial of a request for affiliate, community, consulting peer review, or honorary Medical Staff appointment without Privileges; or, suspension, limitation, or termination of such Medical Staff appointment without Privileges shall not trigger procedural rights nor shall it create a reportable event for purposes of federal or state law.

SECTION 4.4. APPLICATION FOR PRIVILEGES WITHOUT APPOINTMENT

Applications for Privileges without Medical Staff appointment shall be processed in accordance with the applicable procedure set forth in Article 3.

SECTION 4.5. APPLICATIONS FOR INITIAL APPOINTMENT AND/OR PRIVILEGES

An application form shall be developed and revised, as needed, by the Medical Executive Committee. Each application for appointment to the Medical Staff and/or Privileges shall be in writing, submitted on the prescribed form with all provisions completed (or accompanied by an explanation of why information is incomplete), and signed by the applicant. When an applicant requests an application form, the applicant shall be given access to these Bylaws. The form shall require detailed information that shall include, but not be limited to, information concerning:

a. The applicant's qualifications including, but not limited to, education, professional training and experience, current licensure, current DEA registration (if necessary for the Privileges requested), photographic identification, and continuing education information related to the Privileges to be exercised by the applicant. The Hospital recognizes that not all Practitioners require DEA registration. Determination as to the Practitioners who are required to maintain DEA registration shall be on recommendation of the MEC to the Board.

b. For initial applications for Privileges, three (3) peers familiar with the applicant's current professional competence, ethical character, and ability to work with others who will provide written references regarding the applicant's current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism. These individuals must have had recent experience in working with the applicant. These references may not be from individuals associated or about to be associated with the applicant in professional practice or personally related to the applicant. At least one (1) reference shall be from a Practitioner in the same specialty area as the applicant with personal knowledge of the applicant's ability to practice. For applications for reappointment and/or regrant of Privileges, this requirement may be met by an appropriate endorsement from the Chief of Staff or Vice Chief of Staff based upon the Practitioner's performance within the Hospital.

c. Requested appointment category and/or Privileges.

d. Information as to whether the applicant's medical staff appointment and/or privileges have ever been voluntarily (while under investigation or to avoid investigation or an Adverse recommendation or action) or involuntarily relinquished, withdrawn, denied, revoked, suspended, subject to probationary or other conditions (that restricted the applicant's ability to exercise previously granted privileges), reduced, or not renewed at any other hospital or health care facility.

e. Information as to whether the applicant has ever voluntarily (to avoid an Adverse recommendation or action) or involuntarily withdrawn an application for appointment, reappointment and/or privileges/regrant of privileges, not including a voluntary personal decision by the applicant to change his/her medical staff category or request a lesser scope of privileges; or resigned his/her medical staff appointment and/or privileges while under investigation or to avoid investigation.

f. Information as to whether the applicant's license to practice any profession in any state, or DEA registration, or academic appointment is or has ever been voluntarily (while under investigation or to avoid investigation or an Adverse recommendation or action) involuntarily relinquished, suspended, modified, terminated, restricted, or is currently being challenged.

g. Documentation concerning the applicant's current Professional Liability Insurance coverage including the name of the insurance company, the amount and classification of such coverage, and whether said insurance coverage covers the Privileges requested.

h. Information concerning all professional liability litigation, final judgments, or settlements: (i) the substance of the allegations, (ii) the findings, (iii) the ultimate disposition, and (iv) any additional information the Medical Executive Committee or the Board may deem appropriate.

i. Information concerning any professional misconduct proceedings involving the applicant, in this state or any other state, and whether such proceedings are closed or still pending.

j. Information concerning a suspension or termination of the applicant for any period of time from any Federal Health Program, or any private or public medical insurance program in addition to information as to whether the applicant is currently, or has been, under investigation by a Federal Health Program.

k. Current information regarding the applicant's ability to exercise the Privileges requested competently and safely, with or without a reasonable accommodation, and to perform the duties and responsibilities of appointment/Privileges.

l. Information as to whether the applicant has ever been named as a defendant in a criminal action and/or convicted of a crime (with the exception of routine traffic tickets).

m. Complete chronological listing of the applicant's professional and educational appointments, employment, or positions.

n. Information on the citizenship or visa status of the applicant.

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

p. Performance Measurement Data including morbidity and mortality data, when available.

q. Designation of another Appointee with comparable Privileges who has agreed to provide back-up coverage for the applicant's patients in the event the applicant is not available (Privileges may be granted conditional upon this information being provided).

r. Information required pursuant to the Hospital's conflict of interest policy, if any, as applicable.

s. Such other information as the MEC may recommend and the Board may require from time to time.

SECTION 4.6. EFFECT OF APPLICATION

4.6.1. By signing and submitting an application for Medical Staff appointment and/or Privileges, each applicant:

a. Attests to the correctness and completeness of all information furnished and acknowledges that any significant misstatement in or omission from the application constitutes grounds for denial or termination of Medical Staff appointment and Privileges.

b. Confirms that he or she has been given access to the Medical Staff Bylaws and agrees to be bound by the terms thereof in all matters relating to consideration of the application, without regard to whether or not appointment to the Medical Staff and/or Privileges are granted.

c. Signifies his or her willingness to appear for interviews in regard to the application.

d. Authorizes, as needed, consultation with others who have been associated with the applicant or who may have information bearing on the applicant's competence,

qualifications, and performance, and authorizes such individuals and organizations to candidly provide all such information.

e. Consents, as needed, to inspection of records and documents that may be material to an evaluation of the applicant's qualifications and ability to carry out Privileges requested, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying.

f. Agrees to the immunity and release of liability provisions as set forth in Article 10.

g. Pledges to maintain an ethical practice, including refraining from illegal inducements for patient referral, providing continuous quality care for his or her patients, seeking consultation whenever necessary, refraining from providing "ghost" surgical or medical services (billing for services the Practitioner did not provide, including supervisory services), and refraining from delegating patient care responsibility to non-qualified or inadequately supervised health care providers.

h. 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.

i. Agrees to notify the Medical Staff Office 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.

j. 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.

k. Acknowledges his/her obligation to satisfy the applicable Medical Staff responsibilities set forth in these Bylaws and the designated Medical Staff category.

l. Agrees to be bound by the terms of and to comply in all respects with these Bylaws, the Medical Staff Rules and Regulations, and Hospital/Medical Staff policies.

SECTION 4.7. VERIFICATION OF INFORMATION

4.7.1. The applicant shall deliver a completed application and the application fee to the Medical Staff Office. Steps shall be taken to ensure that the Practitioner requesting appointment and/or Privileges is the same individual identified in the application.

4.7.2. The Medical Staff Office shall conduct all necessary primary source verifications relying upon such resources as the AMA Physician Masterfile and any and all other designated equivalent sources or selected entities as authorized by the Hospital's accrediting entity.

4.7.3. The Medical Staff Office shall query the National Practitioner Data Bank and any other data bank as permitted or required by law. The Medical Staff Office 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 Health Program.

4.7.4. The applicant shall be notified of any problems in obtaining the information required, and it shall be the applicant's obligation to obtain the required information and provide it to the Medical Staff Office. When collection and verification is accomplished, the Medical Staff Office shall notify the Credentials Committee that the completed application and accompanying materials are available for review.

SECTION 4.8. PROCESSING OF APPLICATION

4.8.1. Credentials Committee Action

a. Review. The Credentials Committee shall review the application and accompanying documentation, and may conduct a personal interview with the applicant at the Credentials Committee's discretion. The Credentials Committee may seek additional information through the Medical Staff Office. If the applicant is to provide additional information or a release/authorization to allow Hospital/Medical Staff representatives to obtain such information, the Medical Staff Office shall notify the applicant, in writing, of the request for additional information or release/authorization required and the time frame for response. Failure by the applicant, without good cause, to respond in a satisfactory manner within thirty (30) days after written notification will be deemed a voluntary withdrawal of the application.

b. The Credentials Committee shall evaluate all matters deemed relevant to a recommendation regarding Medical Staff appointment and/or Privileges, categorize the application as follows, and forward to the Medical Executive Committee.

i. Category 1. A completed application that does not raise concerns as identified in the criteria for category 2 may be treated as a category 1 application. The MEC reviews the application, together with all accompanying data, and forwards a report with findings and a recommendation to a subcommittee of the Board consisting of not less than two (2) voting Board members ("Subcommittee"). The Subcommittee reviews the application, recommendation, and accompanying data and, pursuant to policy adopted by the Board, acts upon the application for appointment/reappointment and/or Privileges/regrant of Privileges. The effective date of the Medical Staff appointment and/or Privileges is the date

the Subcommittee acts upon the application and approves the request therefore. If at any time during the above reviews, a negative recommendation is made or the reviewers are otherwise not in agreement that the application should be processed as a category 1 application, the application shall be processed as a category 2 application. No applicant is entitled to have his or her application processed as a category 1 application.

ii. Category 2. If one or more of the following criteria are identified in the course of review of a completed application, the application will be treated as a category 2. The Credentials Committee, MEC, and Board of Directors review applications in category 2. The Credentials Committee, MEC, or Board may request that an appropriate subject matter expert assess selected applications. Criteria for category 2 applications include, but are not necessarily limited to, the following:

a. The Credentials Committee, MEC, or Subcommittee has requested that the application not be processed as a category 1.

b. The applicant is found to have experienced an involuntary termination of medical staff appointment or involuntary limitation, reduction, denial, or loss of privileges at another organization.

c. The applicant is, or has been, under investigation by a state medical/other professional board or has had prior disciplinary actions or legal sanctions related to licensure or registration, DEA, or alleged criminal activity.

d. The applicant has had two (2) or more professional liability cases or one final adverse judgment in a professional liability action filed within the past five (5) years.

e. The applicant changed medical schools or residency programs or has unaccounted gaps in training or practice.

f. The applicant has practiced or been licensed in three (3) or more states or has had a substantial number of health care organization affiliations in multiple areas during the past five (5) years (with the exception of *locum tenens* or telemedicine Practitioners).

g. The applicant has one or more reference responses that raise concerns or questions.

h. There is a discrepancy between information received from the applicant and references or verified information.

i. Applicant has an adverse National Practitioner Data Bank report or state medical/other professional board report.

j. The request for Privileges is not reasonable based upon the applicant's experience, training, and competence, and/or is not in compliance with applicable criteria

k. The Privileges requested vary from those traditionally requested by other Practitioners in the same specialty.

l. The applicant has been removed from a managed care panel for reasons of professional conduct or quality.

4.8.2. Medical Executive Committee Action

a. At its next regular meeting after receipt of the Credentials Committee report and recommendation, or as soon thereafter as is practicable, the Medical Executive Committee shall consider the report and any other relevant information. The Medical Executive Committee may refer the matter back to the Credentials Committee with a request for additional information or further review, elect to interview the applicant, or defer action on the application. The MEC shall prepare a written report and recommendations (which may be set forth in meeting minutes) as to Medical Staff appointment, appointment category, Privileges, and any special conditions to be attached to appointment and/or Privileges, as applicable to the particular application. The reasons for each recommendation shall be stated.

i. Deferral. Action by the MEC to defer the application for further consideration must, except for good cause, be followed up within thirty (30) days with its report and recommendation.

ii. Favorable Recommendation. An MEC recommendation that is favorable to the applicant in all respects shall be forwarded to the CEO who shall promptly transmit it, together with all accompanying information, and the reports of the Credentials Committee and the MEC to the Board.

iii. Adverse Recommendation. If the MEC's recommendation is Adverse to the applicant, the Chief of Staff shall promptly advise the applicant in writing, by Special Notice, of the Adverse recommendation and of the applicant's procedural rights, if any, as provided in Article 8. 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 as provided for herein.

4.8.3. Board of Directors Action

a. Deferral. The Board may refer the application back to the MEC for additional information and note in the Board minutes the deferral and the grounds therefore.

b. On Favorable MEC Recommendation. The Board may adopt or reject, in whole or in part, a favorable MEC recommendation or refer the recommendation back to the

MEC for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation must be made back to the Board.

i. If the Board's action is favorable to the applicant, it shall be effective as its final decision.

ii. If the Board's action is Adverse to the applicant in any respect, the CEO shall promptly inform the applicant in writing, by Special Notice, of the Board's action and of the applicant's procedural rights, if any, as provided in Article 8.

c. Without Benefit of MEC Recommendation. If the Board, in its determination, does not receive a recommendation from the MEC in timely fashion the Board may, after notifying the MEC of its intent including a reasonable period of time for response, take action on its own initiative employing the same type of information usually considered by the Medical Staff authorities.

i. Favorable action by the Board shall be effective as the final decision.

ii. If the Board's action is Adverse in any respect, the CEO shall promptly so inform the applicant in writing, by Special Notice, of the Board's action and of the applicant's procedural rights, if any, as provided by Article 8.

d. After Procedural Rights. In the case of an Adverse MEC recommendation, the Board shall take final action in the matter as provided in Article 8.

SECTION 4.9. CONFLICT RESOLUTION

Whenever the Board determines that it will decide a matter contrary to the recommendation of the MEC, and the matter has not previously been submitted to the Joint Advisory Committee, the matter will be submitted to such Joint Advisory Committee for review and recommendation before the Board makes its decision.

SECTION 4.10. NOTICE OF FINAL DECISION

4.10.1. Notice. Notice of the final Board decision shall be given by the CEO to the Medical Staff Chief of Staff, the Medical Executive Committee, and to the applicant (by Special Notice).

4.10.2. Information Notice. A decision and notice to grant or regrant Medical Staff appointment and/or Privileges shall include, as applicable, the Medical Staff category to which the applicant is appointed, the Privileges granted, and any special conditions attached to the appointment and/or Privileges.

SECTION 4.11. REAPPLICATION

4.11.1. Except as otherwise provided in the Medical Staff Bylaws or as recommended by the MEC and approved by the Board in light of exceptional circumstances, a Practitioner:

a. whose Medical Staff appointment and Privileges are automatically terminated pursuant to §7.5.1 (a)-(e) shall not be eligible to reapply for Medical Staff appointment and/or Privileges for a period of at least one (1) year from the effective date of the automatic termination.

b. who has received a final Adverse decision regarding appointment/reappointment and/or Privileges/regrant of Privileges shall not be eligible to reapply for Medical Staff appointment and/or Privileges for a period of at least one (1) year from the latter of the date of the notice of the final Adverse decision or final court decision.

c. who has resigned his/her Medical Staff appointment and/or Privileges or withdrawn an application for appointment/reappointment and/or Privileges/regrant of Privileges to avoid an Adverse recommendation/decision or while under investigation or to avoid an investigation for professional behavior or clinical competency/quality of care concerns shall not be eligible to reapply for Medical Staff appointment and/or Privileges for a period of at least one (1) year from the effective date of the resignation or application withdrawal.

4.11.2. Any reapplication after the one (1) year waiting period will be processed as an initial application, and the Practitioner must submit such additional information as required by the MEC and the Board to show that any basis for the earlier automatic termination, Adverse decision, resignation, or withdrawal has been resolved.

SECTION 4.12. TIMELY PROCESSING OF APPLICATIONS

4.12.1. Applications for Medical Staff appointment and/or for Privileges shall be considered in a timely manner by all persons and committees required by these Bylaws to act thereon. The following time periods provide a guideline for routine processing of applications:

a. Verification of application and all accompanying documents: within thirty (30) days from receipt of all necessary documentation.

b. Review and recommendation by Credentials Committee: at the next Credentials Committee meeting after receipt of all necessary documentation.

c. Review and recommendation by Medical Executive Committee: at the next MEC meeting after receipt of all necessary documentation.

d. Board action: at the next Board meeting after receipt of all necessary documentation.

4.12.2. These time periods are considered guidelines and do not create any rights for an applicant to have his/her application processed within these precise periods. The time periods set forth in this section shall not apply to the time periods contained in the provisions of Article 8. When Article 8 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.

SECTION 4.13. APPLICATION FOR REAPPOINTMENT/REGRANT OF PRIVILEGES AND REQUESTS FOR MODIFICATIONS OF MEDICAL STAFF STATUS OR PRIVILEGES

4.13.1. Submission of Application. Prior to the expiration date of the Practitioner's current Medical Staff appointment/Privilege period, an application, approved by the Medical Executive Committee, for reappointment/regrant of Privileges shall be mailed or delivered to the Practitioner. The reapplication form shall include all information necessary to update and evaluate the qualifications of the Practitioner including, but not limited to, the information set forth in §1.3.1 and §4.5 as well as other relevant matters.

4.13.2. Procedure. When a Practitioner submits an application for reappointment/regrant of Privileges the Practitioner shall be subject to an in-depth review generally following the procedures set forth in Article 2 and this Article including relevant results of quality improvement review (*e.g.*, focused professional practice evaluation and ongoing professional practice evaluation) conducted during the prior appointment/Privilege period. The National Practitioner Data Bank and any other mandatory data banks shall be queried at the time of reappointment/regrant of Privileges and in conjunction with requests for additional Privileges during a current appointment/Privilege period. The application for reappointment/regrant of Privileges shall be processed in the same manner as an initial application for Medical Staff appointment/Privileges.

4.13.3. Failure to Return or Process Application by End of Current Appointment/Privilege Period

a. Failure to return the application for Medical Staff reappointment and/or regrant of Privileges by the expiration date of the Practitioner's current Medical Staff appointment and Privilege period is deemed a voluntary resignation and results in automatic termination of the Practitioner's Medical Staff appointment and Privileges at the expiration of the Practitioner's current appointment/Privilege term.

b. If an application for reappointment/regrant of Privileges has not been fully processed by the expiration date of the Practitioner's current appointment and/or Privilege period, the Practitioner's appointment and Privileges shall terminate as of the last date of his/her current appointment/Privilege period.

c. For any future consideration for appointment and/or Privileges, the Practitioner will need to submit a new, full application for Medical Staff appointment and/or Privileges including application fee. If the Practitioner qualifies, he/she may be granted temporary Privileges pursuant to §3.4.

SECTION 4.14. MODIFICATION OF MEDICAL STAFF APPOINTMENT AND/OR PRIVILEGES

4.14.1. Request for Modification

a. A Practitioner may, either in connection with reappointment/regrant of Privileges or at any other time, request modification of his/her Medical Staff category or Privileges by submitting a written request, on a form approved by the Medical Executive Committee, to the Medical Staff Office. Any such application may not be filed within one (1) year of the time a similar request has been denied.

b. Requests for new Privileges during a current appointment/Privilege period will require evidence of appropriate education, training, and experience supportive of the request and will be subject to focused professional practice evaluation if granted.

4.14.2. Procedure. A request for modification of Medical Staff appointment and/or Privileges shall be processed in the same manner as a request for reappointment/regrant of Privileges.

SECTION 4.15. LEAVE OF ABSENCE

4.15.1. Request for Leave. An Appointee may, for good cause shown such as for medical reasons, educational reasons, or military service, obtain a voluntary leave of absence from the Medical Staff by submitting written notice to the MEC 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. An Appointee on a leave of absence shall not be entitled to admit, attend, or treat patients or otherwise exercise any Privileges or Prerogatives of appointment in the Hospital during the period of the leave. The Appointee shall also be excused from all Medical Staff and committee meetings and responsibilities during the leave. Prior to a leave of absence being granted, the Appointee shall have made arrangements for the care of his or her patients during the leave of absence that are acceptable to the MEC and Board.

4.15.2. Request for Reinstatement

a. In order to qualify for reinstatement after 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 at the Hospital. The Appointee shall provide information to demonstrate satisfaction of continuing Professional Liability Insurance coverage or tail coverage as required by this provision upon request for reinstatement.

b. If reinstatement is requested, the Appointee must submit such information as reasonably requested by the MEC to confirm that the Appointee is qualified for reinstatement of Medical Staff appointment and/or Privileges.

i. If the leave of absence is for educational or military reasons, the Appointee shall provide a statement summarizing the educational activities undertaken during the leave of absence or documentation of military status.

ii. If the Appointee is returning from a medical leave of absence, the Appointee may be asked to submit to a physical examination and/or mental evaluation addressing the Practitioner's capability to resume practice.

4.15.3. Extension of Leave. 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 specified period not to exceed the final date of the Appointee's current appointment/Privilege term.

4.15.4. Process. Once the Appointee's request for reinstatement is deemed complete, the same process as is followed for reappointments/regrant of Privileges shall apply.

4.15.5. Failure to Request Reinstatement. 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 Article 8 of these Bylaws.

SECTION 4.16. RESIGNATIONS & TERMINATIONS

4.16.1. Request. Resignation of Medical Staff appointment and/or Privileges shall be submitted in writing to the Medical Staff Office who shall notify the CEO, Chief of Staff, and appropriate Hospital personnel. A Practitioner must provide the Hospital with not less than thirty (30) days advance notice of his or her resignation date. Regardless of the date when the notice is received, a resignation will become effective on the later of either thirty (30) days from the date received or the date set forth in the Practitioner's written notice. During this thirty (30) day period, the Practitioner shall continue to be obligated to participate in the Emergency Room Call schedule, if this is a responsibility of the Practitioner's Medical Staff category of appointment, to provide consultation services if requested to do so, and to complete his/her patients' medical record(s).

4.16.2. Departure From Area Without Forwarding Address. In those cases when a Practitioner moves away from the area without submitting a forwarding address, the Practitioner shall be deemed to have resigned and his/her Medical Staff appointment and Privileges shall be terminated upon recommendation by the Medical Executive Committee and approval of the Board.

4.16.3. Departure from Area With Forwarding Address. If a forwarding address is known, the Practitioner will be asked his/her intentions with regard to the Medical Staff appointment and/or Privileges. If the Practitioner does not respond within thirty (30) days, the Practitioner shall be deemed to have resigned and his/her Medical Staff appointment and Privileges shall be terminated upon recommendation of the Medical Executive Committee and approval of the Board.

4.16.4. Failure to Comply. Consideration may be given to contacting the applicable State licensing board regarding the Practitioner's actions for failure to comply with the requirements of §4.16 in the absence of good cause shown.

4.16.5. Procedural Rights. Provided a resignation or termination pursuant to this §4.16 is determined by the Board to be voluntary, such resignation or termination shall not give rise to any procedural rights set forth in Article 8 of these Bylaws.

ARTICLE 5
OFFICERS

SECTION 5.1. OFFICERS OF THE MEDICAL STAFF

5.1.1. The officers of the Medical Staff shall be:

a. Chief of Staff
b. Vice Chief of Staff
c. Secretary

5.1.2. The individuals elected to serve as the Medical Staff Chief of Staff, Vice Chief of Staff, and Secretary at the Hospital shall be the same individuals elected to serve as the Chief of Staff, Vice Chief of Staff, and Secretary at the Affiliate Hospital.

SECTION 5.2. QUALIFICATIONS OF OFFICERS

5.2.1. Only those Appointees to the active or affiliate Medical Staff who satisfy the following criteria initially and continuously shall be eligible to serve as an officer of the Medical Staff. They must:

a. Be appointed in Good Standing to the active or affiliate Medical Staff.

b. Have no pending Adverse recommendations concerning Medical Staff appointment or Privileges.

c. With the exception of an Affiliate Hospital, not be presently serving as a Medical Staff officer, Board member, or department chair/director/chief at any other hospital and shall agree to not so serve during their term of office.

d. Be willing to faithfully discharge the duties and responsibilities of the position.

e. Be knowledgeable about the duties of the office.

f. Attend regionally available continuing education relating to Medical Staff leadership and/or credentialing functions during the term of the office as requested and/or arranged by Hospital administration.

g. Not have a financial relationship (*i.e.*, an ownership or investment interest in or compensation arrangement by the Practitioner or any of the Practitioner's immediate family members) with an entity that competes with the Hospital or any affiliate of the Hospital that the Board determines constitutes an unacceptable conflict of interest with the Hospital.

SECTION 5.3. ELECTION OF OFFICERS

5.3.1. Election. Officers shall be elected every three (3) years at the December meeting of the Medical Staff. Only active and affiliate Medical Staff Appointees shall be eligible to vote. Such Appointees may vote by absentee ballot prior to the election. Candidates receiving a majority of the votes cast for the specified office shall be elected. If no candidate receives a simple majority vote on the first ballot, a run-off election shall be held promptly between the two (2) candidates receiving the highest number of votes.

5.3.2. Nominations. A nominating committee shall be convened and shall consist of individuals appointed by the Medical Executive Committee. This committee shall offer one (1) or more nominees for each office. Nominations must be announced, and the names of the nominees distributed, to all active and affiliate Medical Staff Appointees at least five (5) days prior to the meeting at which an election will be held. Nominations may also be made by any active or affiliate Appointee provided they are made in writing to the Medical Executive Committee not less than fourteen (14) days prior to the election. All nominations will be screened by the MEC to determine that each candidate meets the qualifications for holding the designated office. Any nominee that does not meet the qualifications shall be notified and shall be required to withdraw from the candidate list.

SECTION 5.4. TERM OF OFFICE

All officers serve a term of three (3) years or until a successor is elected, unless he/she sooner resigns or is removed from office. Officers shall take office on the fifteenth day of January following the election.

SECTION 5.5. VACANCIES IN OFFICE

If there is a vacancy in any office, such vacancy shall be filled by election by the Medical Staff at the next general Medical Staff meeting. The newly elected officer shall serve only for the remaining unexpired term of the office.

SECTION 5.6. RESIGNATION AND REMOVAL FROM OFFICE

5.6.1. Resignation. A Medical Staff officer may resign at any time by giving written notice to the MEC. Such resignation takes effect on the date of receipt or at any later time specified in the written notice.

5.6.2. Removal

a. Removal of an elected officer may be effectuated by (1) a petition signed by twenty-five percent (25%) of the active and affiliate Medical Staff that is presented to the Medical Executive Committee which, in turn, approves the petition by a two-third (2/3) vote; or (2) by majority vote of the Board for:

   i. Failure to comply with the Medical Staff Bylaws, Rules & Regulations or applicable Hospital/Medical Staff policies.

ii. Failure to perform the duties of the position held.

iii. Exhibiting conduct detrimental to the interests of the Hospital and/or its Medical Staff.

iv. Suffering from an infirmity that renders the individual incapable of fulfilling the duties of that office.

v. Failure to meet the qualifications of §5.2.

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

b. Prior to the initiation of any removal action, the Medical Staff officer shall be given written notice, by Special Notice, of the date of the meeting at which such action shall be taken at least ten (10) days prior to the date of the meeting. The Medical Staff officer shall be afforded an opportunity to speak to the Medical Executive Committee or the Board, as applicable, prior to such a removal vote being taken.

5.6.3. Grounds for Automatic Removal. Imposition of an automatic termination of Medical Staff appointment and Privileges shall result in an automatic removal of the Medical Staff officer from his/her office.

SECTION 5.7. DUTIES OF OFFICERS

5.7.1. Chief of Staff. The Chief of Staff shall serve as the chief medico-administrative officer of the Medical Staff and will perform the following duties:

a. Account to the Board and to the Medical Staff for the overall quality and efficiency of patient care at the Hospital.

b. Call, preside at, and ensure an appropriate agenda for all meetings of the Medical Staff and MEC; and, be a member of all other Medical Staff committees, *Ex Officio* (*e.g.*, without vote unless otherwise provided). The Chief of Staff shall serve as chair of the MEC with vote.

c. Take reasonable steps to promote professional ethical conduct and competent clinical performance on the part of Practitioners and APPs.

d. Promote adherence to the Bylaws, Rules & Regulations, and to the applicable policies and procedures of the Medical Staff and Hospital.

e. Make recommendations on medico-administrative and Hospital management matters.

f. Inform the Medical Staff of the accreditation program requirements and the accreditation status of the Hospital.

g. Provide leadership for the Medical Staff's quality/performance improvement activities with those of other health care disciplines.

h. Review and report to the MEC on a continuous basis and enforce or coordinate compliance with established policies and protocols relating to clinical practice in the Hospital.

i. Periodically review the Bylaws, Rules & Regulations, and related policies of the Medical Staff/Hospital; and, together with the Medical Executive Committee, recommend appropriate revisions to such documents.

j. Appoint, in consultation with the MEC, all Practitioner committee chairs and Practitioner committee members to standing and special Medical Staff committees other than the MEC.

k. Serve as a liaison for quality review issues with the Medical Staff, the Hospital staff, and the committee(s) responsible for accreditation.

l. Implement and follow-up on the actions of the Medical Executive Committee.

m. Assist in the evaluation of the Hospital's overall quality review program for its comprehensiveness, integration, and effectiveness.

n. Assist in the evaluation of existing programs, services, and facilities of the Hospital and Medical Staff and recommend continuation, expansion, abridgment, or closure of each.

o. Through membership in the Hospital's Board, assist in the evaluation of the Hospital's financial, personnel, and other resource needs for beginning a new program or service, for constructing new facilities, or for acquiring new or replacement capital equipment, and assess the relative priorities of services and needs and allocation of present and future resources.

p. Assist in the development of an annual strategic plan, in coordination with the Director of Quality and Risk Management Services, for the Hospital's Performance Improvement activities and review the effectiveness of the Hospital's performance improvement activities.

5.7.2. Vice Chief of Staff. The Vice Chief of Staff shall perform the following duties:

a. Assume all of the duties and have the authority of the Chief of Staff in the Chief of Staff's absence.

b. Perform such further duties to assist the Chief of Staff as the Chief of Staff may from time to time request.

5.7.3. Secretary. The Secretary shall perform the following duties:

a. Ensure that accurate records are created and retained for the proceedings of all meetings of the Medical Staff.

b. Serve as custodian of all Medical Staff records.

c. Issue all duly authorized notices of meetings.

d. Maintain an attendance record for all general Medical Staff meetings.

ARTICLE 6
MEDICAL STAFF COMMITTEES

SECTION 6.1. DESIGNATION

6.1.1. General. There shall be a Medical Executive Committee and other standing Medical Staff committees as listed in these Bylaws, and such special committees as may from time to time be necessary and desirable to perform the Medical Staff functions listed in these Bylaws. All Medical Staff committees shall report and be responsible to the Medical Executive Committee unless otherwise provided in these Bylaws. Those functions requiring participation of, rather than direct oversight by, the Medical Staff may be discharged by Medical Staff representatives on Hospital committees established to perform such functions.

6.1.2. Appointment. Unless otherwise provided in these Bylaws, appointments of qualified Practitioners to standing and special Medical Staff committees and Medical Staff representatives to Hospital committees shall be made by the Chief of Staff with the approval of the Medical Executive Committee. Appointees to the active, courtesy, affiliate, and honorary Medical Staff categories are eligible to serve as a voting member of a Medical Staff committee. Non-Practitioner representatives to Medical Staff committees shall be recommended for appointment by the Chief Executive Officer.

6.1.3. CEO. The CEO shall be an *Ex Officio* member of all Medical Staff committees without vote unless the committee specifically provides otherwise.

6.1.4. Chair. Unless otherwise provided in these Bylaws, all Medical Staff committees shall have a Physician as chair appointed by the Chief of Staff with approval of the Medical Executive Committee. Physician Appointees to the active and affiliate Medical Staff are eligible to serve as the chair of a Medical Staff committee.

6.1.5. Removal. The Chief of Staff, with approval of the Medical Executive Committee, may remove Practitioner members and chairs of Medical Staff committees unless otherwise provided in these Bylaws.

6.1.6. Joint Meetings. Hospital and Affiliate Hospital Medical Staff committees may meet jointly.

SECTION 6.2. MEDICAL EXECUTIVE COMMITTEE

6.2.1. Composition. The Medical Executive Committee shall be chaired by the Chief of Staff. The Medical Executive Committee shall consist of the officers of the Medical Staff, the Chief Executive Officer, and the chairs of the following committees:

a. Credentials/Medical Staff Bylaws

b. Quality Improvement

c. Pharmacy and Therapeutics

d. Medical Records

e. Surgical Services

All active and affiliate Appointees of any discipline or specialty are eligible for membership on the MEC.

MEC members who are Medical Staff officers serve on the MEC as long as they hold such Medical Staff office. Resignation and removal of Medical Staff officers is addressed in §5.6. MEC members who are committee chairs serve on the MEC as long they hold the designated committee chair position. Resignation and removal of committee chairs is addressed in §6.1.5.

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

a. Represent and act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws.

b. Receive and/or act upon committee reports and recommendations.

c. Recommend to the Board or other Hospital committees specific programs and systems.

d. Assist in coordinating the activities of and policies adopted by the Board regarding the Medical Staff.

e. Submit recommendations to the Board concerning all matters relating to appointment category, Privileges, and corrective action.

f. Account to the Board and to the Medical Staff for the overall quality and efficiency of patient care in the Hospital and the participation of the Medical Staff in organization performance improvement activities.

g. Take reasonable steps to encourage professionally ethical conduct and competent clinical performance on the part of Practitioners and APPs, including initiating investigations and pursuing corrective action, when warranted.

h. Make recommendations to the Board on medico-administrative and Hospital management matters.

i. Keep the Medical Staff current concerning the accreditation status of the Hospital and supervise overall Medical Staff compliance with accreditation and other regulatory requirements applicable to the Medical Staff.

j. Formulate Medical Staff rules, regulations, policies and procedures.

k. Make recommendations to the Medical Staff concerning Bylaws amendments.

l. Assess and recommend to the Hospital relevant off-site sources for needed patient care services not provided by the Hospital.

m. Develop and adopt Medical Staff Rules & Regulations and Policies including, but not limited to, a Practitioner Effectiveness Policy and Disruptive Practitioner Policy.

n. Advise the Board, at the Board's request, as to the MEC's opinion as to whether to execute an exclusive contract in a previously open clinical service; to renew or modify an exclusive contract in a particular clinical service; or to terminate an exclusive contract in a particular service.

o. Conduct or oversee those functions outlined in these Bylaws.

p. Request evaluation of Practitioners and APPs in instances where there is doubt about the Practitioner's or APP's ability to perform the requested Privileges.

q. Such other duties as may be recommended by the Medical Staff and approved by the Board from time to time.

6.2.3. Meetings. The Medical Executive Committee shall meet at least ten (10) times per year and whenever called by the Chief of Staff. Permanent records of its proceedings and actions shall be maintained.

SECTION 6.3. CREDENTIALS / MEDICAL STAFF BYLAWS COMMITTEE

6.3.1. Composition. The Credentials/Medical Staff Bylaws Committee shall consist of at least two (2) eligible and qualified Appointees to the Medical Staff.

6.3.2. Duties. The Credentials/Medical Staff Bylaws Committee shall:

a. Investigate the qualifications of applicants for appointment and/or Privileges and present its report to the Medical Executive Committee.

b. Ensure that the Medical Staff carries out its appropriate functions with respect to credentialing, appointment/reappointment, privileging, and Medical Staff document matters.

c. Evaluate current Practitioners and APPs with, as applicable, Medical Staff appointment and/or Privileges and make recommendations regarding reappointment/regrant of Privileges.

6.3.3. Meetings. The Credentials/Medical Staff Bylaws Committee shall meet as needed at the call of the committee chair. The committee shall maintain a record of its proceedings and actions and shall report to the Medical Executive Committee.

SECTION 6.4. PHARMACY AND THERAPEUTICS ("P&T") COMMITTEE

6.4.1. Composition. The Pharmacy and Therapeutics Committee shall consist of at least two (2) Practitioners from the active or affiliate Medical Staff, a nursing representative, and an administrative representative.

6.4.2. Duties. The P&T Committee shall:

a. Ensure surveillance of drug utilization within the Hospital.

b. Review all unexpected drug reactions.

c. Assist in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures and all other matters relating to drugs in the Hospital.

d. Review and revise the Hospital Formulary and make any recommendations on drug usage to the Hospital and Medical Staff as necessary.

e. Make recommendations concerning drugs to be stocked on the nursing units, floors, and by other services.

f. Advise the Medical Staff and the Hospital's Pharmacy on matters pertaining to the choice of available drugs.

g. Submit written reports at least annually to the Medical Executive Committee concerning drug utilization policies and practices in the Hospital.

h. Report to the Medical Staff regarding drug usage and drug control within the Hospital, with specific emphasis on antibiotic use.

6.4.3. Meetings. The P&T Committee shall meet at least quarterly and as otherwise needed at the call of the chair. The committee shall maintain a record of its proceedings and actions and shall report to the Medical Executive Committee.

SECTION 6.5. QUALITY IMPROVEMENT COMMITTEE

6.5.1. Composition. The Medical Staff Quality Improvement Committee consists of three (3) eligible and qualified Practitioners appointed by the Chief of Staff and five (5) non-Practitioner members appointed by the Chief Executive Officer who shall represent Nursing Service and Quality Improvement.

6.5.2. Duties. The Medical Staff Quality Improvement Committee shall:

a. Operate to strengthen the responsibility and authority of existing Medical Staff and administrative structures regarding performance improvement activities by making practical recommendations to the appropriate body for consideration and action.

b. Provide direction and prioritization of performance improvement activities incorporating the organization's strategic plan, mission, and values.

c. Review the performance improvement activities conducted in the organization.

d. Develop or assist in developing performance improvement teams.

e. Act as a resource for performance improvement activities.

f. Formulate and carry out a Quality Improvement Plan and a Utilization Review Plan which shall be approved by the Medical Staff and the Board.

g. Coordinate monitoring activities for the continuing assessment, maintenance and improvement of the quality of patient care, consistent with accreditation and Medical Executive Committee guidelines.

h. Review collected data to determine the level of performance and stability of existing processes, and priorities for possible improvement of existing processes.

i. Coordinate and track trends and patterns of performance improvement monitoring activities, including their impact on improving patient care, maintaining the safety of patients, and pro-active risk assessment.

j. Review reports from Hospital-based Practitioner groups on quality assurance monitoring and performance improvement projects undertaken during the previous year.

k. Report aberrations to the Medical Executive Committee as appropriate.

6.5.3. Meetings. The Medical Staff Quality Improvement Committee shall meet at least quarterly and as otherwise needed at the call of the chair. The committee shall maintain a record of its proceedings and actions and shall report at least quarterly to the Medical Executive Committee and the Board.

SECTION 6.6. PATIENT CARE COMMITTEE

6.6.1. Composition. The Patient Care Committee shall consist of four (4) qualified and eligible Practitioners, the Director of Quality Improvement, and the Director of Nursing Services.

6.6.2. Duties. The Patient Care Committee shall monitor patient care including, but not limited to, blood usage reviews.

6.6.3. Meetings. The Patient Care Committee shall meet at least twice per year and as otherwise needed at the call of the chair. The committee shall maintain a record of its proceedings and actions and shall report to the Quality Improvement Committee.

SECTION 6.7. ETHICS COMMITTEE

6.7.1. Composition. The Ethics Committee shall consist of at least two (2) qualified and eligible Practitioners and representatives from Social Work, Risk Management, and Nursing.

6.7.2. Duties. The Ethics Committee shall:

a. Participate in the development of guidelines for consideration of cases having ethical implications.

b. Develop and/or review institutional policies regarding care and treatment of such cases.

c. Facilitate communication and aid conflict resolution.

d. Educate the Hospital/Medical staff on ethical matters.

6.7.3. Meetings. The Ethics Committee shall meet as often as necessary at the call of the chair. The committee shall be convened at the request of the Hospital, a patient, a patient's family, or Medical Staff. The committee shall maintain a record of its proceedings and actions and shall report to the Medical Executive Committee.

SECTION 6.8. MEDICAL RECORDS COMMITTEE

6.8.1. Composition. The Medical Records Committee consists of at least two (2) Appointees to the active or affiliate Medical Staff, a nursing representative, a representative from Administration, and the Medical Records Director.

6.8.2. Duties. The Medical Records Committee shall:

a. Ensure maintenance of proper records for all patients in the Hospital.

b. Maintain continuous supervision over the quality of the Medical Records.

c. Send warnings to any Practitioner or APP who is derelict in medical records duties.

d. Report to the Medical Executive Committee any Practitioner or APP who has not shown adequate improvement within one (1) month after a warning was issued.

6.8.3. Meetings. The Medical Records Committee shall meet at least quarterly and as otherwise needed at the call of the chair. The committee shall maintain a record of its proceedings and actions and shall report to the Medical Executive Committee.

SECTION 6.9. INFECTION CONTROL

6.9.1. Composition. The Infection Control Committee shall consist of at least three (3) Practitioners from the active or affiliate Medical Staff, a representative from Nursing, the Infection Control Surveillance Officer, the Pharmacist, the Director of Quality Improvement, and a Laboratory representative. Representation from other services shall be requested on a consultative basis, as needed.

6.9.2. Duties. The Infection Control Committee shall:

a. Define isolation procedures and techniques in the Hospital.

b. Monitor infectious disease control measures in the Hospital.

6.9.3. Meetings. The Infection Control Committee shall meet at least twice per year and as otherwise needed at call of the chair. The committee shall maintain a record of its proceedings and actions and shall report to the Medical Executive Committee.

SECTION 6.10. INTERNAL CONFLICTS OF INTEREST

6.10.1. 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 or a Medical Staff committee, the Practitioner is expected to disclose the conflict to the individual in charge of the meeting. The Practitioner may be asked and is expected to answer any questions concerning the conflict. The committee (or, in the absence of a committee, the individual in charge of the meeting) is responsible for determining whether a conflict exists and, if so, whether the conflict rises to the level of precluding the Practitioner from participating in the pending matter.

6.10.2. The Chief of Staff or committee chair may routinely inquire, prior to initiating discussion, as to whether any Practitioner has any bias or conflict of interest regarding the matter(s) to be addressed. The existence of a bias or potential conflict of interest on the part of any Practitioner may be called to the attention of the Chief of Staff or committee chair by any Practitioner with knowledge of the conflict.

6.10.3. For purposes of this Section 6.12, the fact that Practitioners are competitors, partners, or employed in the same group shall not, in and of itself, automatically disqualify such Practitioners from participating in Medical Staff matters with respect to their colleagues.

SECTION 6.11. PEER REVIEW COMMITTEES

6.11.1. 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 in Ohio Revised Code §2305.25 *et seq*. The Medical Staff, through its committees, shall be responsible for evaluating, maintaining, and/or monitoring the quality and utilization of the Hospital's health care services.

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

6.11.3. Such peer review committees and its designated agents may, from time to time and/or as specifically provided herein, appoint Hospital administrative personnel as their agent in carrying out such peer review duties.

ARTICLE 7
COLLEGIAL INTERVENTION/INFORMAL REMEDIATION, CORRECTIVE ACTION, SUMMARY SUSPENSION, GROUNDS FOR AUTOMATIC SUSPENSION AND AUTOMATIC TERMINATION

SECTION 7.1. COLLEGIAL INTERVENTION & INFORMAL REMEDIATION

7.1.1. Prior to initiating corrective action against an Appointee for professional conduct or competency concerns, a Medical Staff officer or the Board (through the Chief Executive Officer as its administrative agent) may elect, but is not obligated, to attempt to resolve the concern(s) informally.

7.1.2. An appropriately designated Medical Staff peer review committee may enter into a voluntary remedial agreement with an Appointee, consistent with the Medical Staff's peer review/professional practice evaluation policies, to resolve potential clinical competency or conduct issues. If the affected Appointee fails to abide by the terms of an agreed-to remedial agreement, the affected Appointee will be subject to the formal corrective action procedure set forth in Section 7.2.

7.1.3. Any such collegial intervention/informal remediation attempts shall be documented and retained in the Appointee's quality file.

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

SECTION 7.2. CORRECTIVE ACTION

7.2.1. Criteria for Initiation. Any person may provide information to the Medical Executive Committee about the conduct, performance, or competence of an Appointee. When reliable information indicates an Appointee may have exhibited acts, demeanor, or conduct reasonably likely to be (1) detrimental to patient safety or to the delivery of quality patient care within the Hospital; (2) unethical or damaging to the Hospital's or Medical Staff's reputation; (3) contrary to the Medical Staff Bylaws or related documents; (4) disruptive to Hospital operations; or (5) below applicable professional standards, a request for corrective action against such Appointee may be initiated by the Medical Executive Committee (or chair thereof), the CEO, or the Board (or chair thereof).

7.2.2. Initiation

a. A request for corrective action must be in writing (which writing may be evidenced by minutes), submitted to the Medical Executive Committee, and supported by reference to specific activities or conduct alleged. If the Medical Executive Committee initiates the request, it shall make an appropriate record of the reasons through its minutes. The Chief of Staff shall promptly notify the CEO in writing of all requests for corrective action received by the MEC and shall keep the CEO fully informed of all action taken in connection with such requests.

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

i. Determine that no corrective action is warranted and close the matter.

ii. Determine that no corrective action is warranted and remand the matter for collegial intervention or informal remediation consistent with the applicable Medical Staff governing documents.

iii. Initiate a formal corrective action investigation in accordance with the requirements set forth in this Section 7.2.

7.2.3. Commencement of Formal Investigation

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

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

ii. The start of a MEC meeting at which a request for corrective action is being presented.

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

c. The affected Appointee shall be provided with written notice of a determination by the MEC to go forward with a corrective action investigation.

7.2.4. Investigation

a. If the Medical Executive Committee concludes an investigation is warranted, it shall direct an investigation to be undertaken. The Medical Executive Committee may conduct the investigation itself; assign the task to a Medical Staff officer, or to a standing or *ad hoc* committee of the Medical Staff (that may consist of one (1) or more members); or, may refer the matter to the Board for investigation and resolution. If the task is assigned to an *ad hoc* committee, members of the *ad hoc* committee cannot be in direct economic competition with the Appointee to be investigated. The Medical Executive Committee, at its discretion, may appoint

Practitioners or other individuals who are not Appointees as members of an *ad hoc* committee.

b. This investigative process is not a "hearing" as that term is used in Article 8 and shall not entitle the Appointee to the procedural rights provided in Article 8.

c. The investigating individual or group will proceed with its investigation in a prompt manner. The investigative process may include, without limitation, a meeting with the Appointee involved who may be given an opportunity to provide information in a manner and upon such terms as the investigating individual/group deems appropriate; with the individual or group who made the request for corrective action; and/or with other individuals who may have knowledge of or information relevant to the events involved. The investigating individual or group may utilize the expertise of outside consultants so long as such use is approved by the Hospital CEO.

d. If the investigation is conducted by a group or individual other than the MEC or the Board, that group or individual shall submit a written report of the investigation, which may be reflected by minutes, to the MEC as soon as is practical after its receipt of the assignment to investigate. The report should contain such detail as is necessary for the MEC to rely upon it including recommendations for appropriate corrective action or no action at all (and the basis for such recommendations).

e. Despite the status of any investigation, at all times the Medical Executive Committee shall retain authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension, termination of the investigative process, or other action.

f. 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.

7.2.5. Action. As soon as practical following completion of its report (which may be reflected by minutes), or receipt of a report from the investigating individual or group, the MEC shall act upon the request for corrective action. Its action may include, without limitation, the following:

a. Determine that no corrective action be taken.

b. Defer action for a reasonable time where circumstances warrant.

c. Issue a letter of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude the Chief of Staff or Vice Chief of Staff from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letter is issued, the affected Practitioner may make a written response that shall be placed in the Practitioner's file.

d. Imposition of a focused professional practice evaluation period with retrospective review of cases or other review of professional behavior but without requirement of prior or concurrent consultation or direct supervision.

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

f. Imposition of a suspension of all, or any part, of the Medical Staff Appointee's Privileges for a period up to fourteen (14) days.

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

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

i. Recommendation of a suspension of all, or any part, of the Appointee's Privileges for a period in excess of fourteen (14) days.

j. Recommendation of revocation of all, or any part, of the Appointee's Privileges.

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

7.2.6. Notification

a. The MEC shall notify the Appointee in writing, by Special Notice, of its determination or recommendation.

b. If the recommendation of the MEC entitles the Appointee to request a hearing, the Chief of Staff shall promptly notify the affected Appointee, in writing, by Special Notice. The Chief of Staff shall then hold the recommendation until the Appointee has exercised or has waived the right to a hearing and appeal, after which the Chief of Staff shall forward the final MEC recommendation, together with all accompanying information, to the Board.

c. 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.

i. If the Board's decision 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.

ii. 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 Article 8.

d. The commencement of corrective action procedures against an Appointee shall not preclude the summary suspension or automatic suspension or termination of the Medical Staff appointment and/or all, or any portion of, the Appointee's Privileges in accordance with the procedures set forth in Sections 7.3, 7.4, or 7.5 of this Article.

SECTION 7.3. SUMMARY RESTRICTION OR SUSPENSION

7.3.1. Criteria for Initiation. Whenever a Practitioner's conduct appears to require that immediate action be taken to protect, or to reduce the substantial likelihood of imminent danger to, the life, health, or safety of any person present at the Hospital (to include if a Practitioner's conduct so materially/significantly disrupts the operation of the Hospital such as to create an imminent danger or the potential therefore), the Chief of Staff, the Chief Executive Officer, the Medical Executive Committee, or the chair of the Board shall each have the authority to summarily restrict or suspend the Medical Staff appointment and/or all, or any portion, of the Privileges of such Practitioner.

7.3.2. Effect. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition, and the person or body responsible for imposing the summary restriction or suspension shall promptly give written notice to the Medical Executive Committee and the Chief Executive Officer (assuming the summary restriction or suspension was not imposed by the CEO or MEC). The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary restriction or suspension, the affected Practitioner's patients shall be promptly assigned to another Appointee with appropriate Privileges by the Chief of Staff considering where feasible, the wishes of the patient in the choice of a substitute Practitioner.

7.3.3. Written Notice of Summary Suspension. As soon as possible following the imposition of a summary suspension, the affected Practitioner shall be provided with written notice of such suspension from the CEO or Chief of Staff, by Special Notice. This notice shall include a statement of facts setting forth the basis for the action.

7.3.4. Medical Executive Committee Action. Unless the summary suspension was imposed by action of the MEC, in which case no further action on the part of the MEC shall be required, within seventy-two (72) hours after a summary suspension, the MEC shall convene to

review and consider the action taken and the need, if any, for corrective action. At such meeting, the MEC may recommend modification, continuation, or lifting of the terms of the summary restriction or suspension provided that the summary restriction or suspension was not imposed by the Board or the CEO. At the discretion of the MEC, the affected Appointee may be invited to attend such meeting. In the case of a summary suspension imposed by the Board or CEO, 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.

7.3.5. Length of Summary Suspension. Not later than fourteen (14) days following the original imposition of the summary restriction or suspension, the Practitioner shall be advised, by Special Notice, of the MEC's determination; or, in the case of a summary restriction or suspension imposed by the Board or CEO of the MEC's recommendation as to whether such restriction or suspension should be terminated, modified, or sustained, and of the Practitioner's rights, if any, pursuant to Article 8. Lifting of a summary restriction or suspension within fourteen (14) days of its imposition on the ground that such restriction or suspension was not required shall not be deemed to have been Adverse, and a statement to such effect shall be placed in the Practitioner's file.

SECTION 7.4. AUTOMATIC SUSPENSION OR LIMITATION

7.4.1. Imposition of Automatic Suspension or Limitation and Subsequent Process. The following events shall result in an automatic suspension or limitation of appointment and/or Privileges, as applicable, without recourse to the procedural rights set forth in Article 8:

a. Licensure. Action by any federal or state authority suspending or limiting a Practitioner's professional license shall result in an automatic comparable suspension/limitation on the Practitioner's Medical Staff appointment and Privileges. Whenever a Practitioner's licensure is made subject to probation, the Practitioner's right to practice shall automatically become subject to the same terms of the probation.

b. Controlled Substance Authorization

i. Whenever a Practitioner's DEA registration or state controlled substance authorization is suspended, his/her Medical Staff appointment and Privileges shall be automatically suspended.

ii. Whenever a Practitioner's DEA registration or state controlled substance authorization is restricted/limited, his/her right to prescribe medications covered by the registration/number shall automatically become subject to the terms and conditions of such restriction or limitation.

iii. Whenever a Practitioner's DEA registration or state controlled substance authorization is subject to probation, the Practitioner's right to prescribe such medications shall automatically become subject to the same terms of the probation.

c. Insurance Coverage. If a Practitioner's Professional Liability Insurance coverage lapses, falls below the required minimum, is terminated, or otherwise ceases to be in effect, in whole or in part, the Practitioner's Medical Staff appointment and Privileges shall be automatically suspended until adequate Professional Liability Insurance coverage is restored or the matter is otherwise resolved pursuant to §7.5.1 (c) below. The Medical Staff Office shall be provided with a certified copy of the insurance certificate from the insurance company and a written statement explaining the circumstances of the previous insurance being canceled or not renewed, any limitations on the new policy, and a summary of relevant activities during the period of no 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.

d. Federal Health Program. Whenever a Practitioner is suspended from participating in a Federal Health Program, the Practitioner's appointment and Privileges shall be automatically suspended.

e. Failure to Complete Medical Records. Whenever a Practitioner fails to complete medical records as provided for in the Medical Staff Rules & Regulations or applicable Medical Staff/Hospital policy, the Practitioner's Privileges shall be automatically suspended.

7.4.2. Impact of Automatic Suspension/Limitation

a. During such period of time when a Practitioner's Privileges are suspended or limited pursuant to §7.4.1 (a) – (d) above, he or she may not, as applicable, exercise any Prerogatives of appointment or exercise any Privileges at the Hospital, participate in Emergency Room Call, or otherwise provide professional services within the Hospital for patients.

b. A Practitioner whose Privileges are automatically suspended pursuant to §7.4.1 (e) is subject to the same limitations except that such Practitioner may:

i. Conclude the management of any patient under his or her care in the Hospital at the time of the effective date of the automatic suspension of Privileges.

ii. Attend to the management of any patient under his or her care whose admission was scheduled prior to the effective date of the automatic suspension.

iii. Attend to the management of any patient requiring emergency care and intervention.

7.4.3. Action Following Imposition. As soon as practicable after the imposition of an automatic suspension, 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 on Privileges shall result in the automatic reinstatement of the Practitioner's appointment and/or Privileges, as applicable; provided, however, that to the extent the automatic 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 the Medical Staff Office shall reasonably request to assure that all information in the Practitioner's credentials file is current.

SECTION 7.5. AUTOMATIC TERMINATION

7.5.1. Imposition of Automatic Termination. The following events shall result in an automatic termination of appointment and Privileges without recourse to the procedural rights set forth in Article 8. Reapplication shall be subject to the provisions of §4.5.

a. Licensure. Action by any federal or state authority terminating a Practitioner's professional license shall result in an automatic termination of the Practitioner's appointment and Privileges.

b. Controlled Substances. Whenever a Practitioner's DEA registration or state controlled substances authorization is revoked, the Practitioner's Medical Staff appointment and Privileges shall automatically terminate,

c. Insurance. If a Practitioner's Professional Liability Insurance coverage lapses, falls below the required minimum, is terminated, or otherwise ceases to be in effect for a period greater than thirty (30) days, the Practitioner's appointment and Privileges shall automatically terminate as of the thirty-first (31st) day. 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.

d. Federal Health Program. Whenever a Practitioner is ineligible to participate or excluded from participating in a Federal Health Program, the Practitioner's appointment and Privileges shall be automatically terminated.

e. Plea of Guilty to Certain Offenses. If a Practitioner pleads guilty 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 appointment and Privileges shall be immediately and automatically terminated.

ARTICLE 8
HEARING PROCEDURES

SECTION 8.1. GENERAL PROVISIONS

8.1.1. Exhaustion of Remedies. If an Adverse recommendation or action as described herein is taken or recommended, the applicant or Appointee must exhaust the remedies afforded by these Bylaws before resorting to legal action. Adverse recommendations or actions shall become final only after the hearing and appellate rights set forth in these Bylaws have either been exhausted or waived, and only upon being adopted as final actions by the Board.

8.1.2. Application of Article. The purpose of this Article is to provide a mechanism for resolution of matters Adverse to Practitioners who have, or who have requested, appointment and Privileges at the Hospital.

8.1.3. Effect of Adverse Recommendation or Action

a. By the Medical Executive Committee. Unless otherwise provided in these Bylaws, when a Practitioner receives notice of an Adverse recommendation of the MEC, the Practitioner shall be entitled to a hearing and appellate review, if applicable, in accordance with the procedures set forth in this Article.

b. By the Board of Directors. Unless otherwise provided in these Bylaws, when a Practitioner receives notice of an Adverse recommendation or action of the Board, and such decision is not based upon a prior Adverse recommendation of the MEC with respect to which the Practitioner was entitled to a hearing, the Practitioner shall be entitled to a hearing and appellate review, if applicable, in accordance with the procedures set forth in this Article.

SECTION 8.2. GROUNDS FOR HEARING

8.2.1. Actions Giving Rise to a Hearing. Except as otherwise specified in these Bylaws, any one or more of the following actions, provided that it has been recommended by the MEC or taken by the Board under circumstances where no prior right to request a hearing existed, shall be deemed Adverse (as such term is defined in these Bylaws) and entitle a Practitioner to request a hearing:

a. Denial or termination of requested Privileges.

b. Involuntary reduction of existing Privileges.

c. Suspension of Privileges for a period in excess of fourteen (14) days as part of a formal corrective action process.

d. Reduction or restriction of Privileges (including imposition of an individual mandatory prior or concurrent consultation requirement, direct supervision, or other form of focused professional practice evaluation that limits the Practitioner's ability to exercise previously exercised Privileges) for a period in excess of fourteen (14) days as part of a formal corrective action process.

e. Other Adverse recommendations or actions of the MEC or Board as so designated by the MEC or Board.

8.2.2. Actions Which Do Not Give Right to a Hearing. Notwithstanding the above provision, no action described in this §8.2.2 shall constitute grounds for or entitle the Practitioner to request a hearing.

a. An oral or written reprimand or warning.

b. The denial, termination, or suspension of temporary, disaster, emergency, telemedicine, or moonlighting Privileges.

c. Imposition of professional practice evaluation or ongoing professional practice evaluation as part of the routine peer review process.

d. Any action recommended/taken by the MEC or the Board against a Practitioner where the action was recommended/taken solely for administrative or technical failings of the Practitioner (*e.g.* failure of a Practitioner to satisfy the basic qualifications for Medical Staff appointment and/or Privileges, or to provide requested information, *etc.*).

e. Ineligibility for Medical Staff appointment or reappointment or the Privileges requested, in whole or in part, because a service has been closed or there exists an exclusive contract limiting the granting of Privileges requested by the Practitioner.

f. Termination of or the inability to exercise Privileges, either in whole or in part, because the Hospital has determined to close a service or grant an exclusive contract limiting the ability of current Practitioners to exercise such Privileges.

g. Termination of the Practitioner's employment or other contract for services with the Hospital or through a group contract.

h. Ineligibility for Medical Staff appointment or requested Privileges because of lack of facilities, equipment, or because the Hospital has elected not to perform, or does not provide, the service which the Practitioner intends to provide or the procedure for which Privileges are sought.

i. Automatic suspension, or automatic termination of Medical Staff appointment or Privileges as provided in §7.4, and §7.5.

j. Voluntary suspension or resignation of Privileges or Medical Staff appointment when clinical competence or conduct is not at issue.

k. Voluntary suspension or resignation of Privileges or Medical Staff appointment that is not in return for the MEC or Board refraining from conducting an investigation based upon clinical competence or conduct.

l. Any other recommendation or action by the MEC or Board that does not relate to the clinical competence or professional conduct of a Practitioner unless the Bylaws otherwise provide.

SECTION 8.3. NOTICE OF ADVERSE RECOMMENDATION OR ACTION

8.3.1. In all cases in which an Adverse recommendation or Adverse action has been initiated that gives rise to the right to a hearing under this Article, the Chief of Staff (or CEO, if initiated by the Board) shall promptly notify the affected Practitioner of the Adverse action or recommendation and of the right to request a hearing pursuant to this Article. Such notice shall be in writing and shall be delivered by Special Notice. Such notice shall set forth the following:

a. A description of the Adverse action or Adverse recommendation.

b. The reasons for the Adverse action or Adverse recommendation including a concise statement of the acts or omissions upon which the decision was based and identifying, where applicable, the medical records of patients affected by such acts or omissions, or the other reasons or subject matter forming the basis for the Adverse action or recommendation.

c. That the Practitioner has a period of thirty (30) days from the date of receiving the notice within which to request a hearing and the manner in which to do so.

d. A summary of the rights of the Practitioner for hearing and appellate review as hereinafter set forth.

e. A statement that if the Practitioner fails to request a hearing, in the manner and within the time period prescribed, such failure shall constitute a waiver of his/her right to a hearing and to an appellate review on the issue that is the subject of the notice.

SECTION 8.4. REQUEST FOR HEARING

A Practitioner shall have thirty (30**)** days following receipt of notice pursuant to §8.3 to request a hearing. The request shall be in writing addressed to the Chief Executive Officer and delivered by Special Notice. In the event the Practitioner does not request a hearing within the time and in the manner described, the Practitioner shall be deemed to have waived any right to a hearing and to any appellate review to which he/she might otherwise have been entitled. The Adverse recommendation and/or action shall thereafter be presented to the Board for final decision. The action shall become effective immediately upon final Board action. The Practitioner shall be informed of the Board's final decision by Special Notice.

SECTION 8.5. NOTICE OF HEARING AND STATEMENT OF REASONS

8.5.1. Within a reasonable period of time after receiving a timely request for a hearing, the MEC or the Board, as appropriate, shall schedule the hearing and the Chief Executive Officer shall give Special Notice to the Practitioner who requested the hearing. The notice shall include:

a. The time, place, and date of the hearing.

b. A proposed list of witnesses, as known at that time, who will give testimony or present evidence at the hearing regarding the Adverse recommendation or action.

c. The name of the hearing officer or names of the hearing panel members and presiding officer, if known.

8.5.2. The hearing shall begin as soon as practicable, but no sooner than thirty (30) days after the date of the notice of hearing unless an earlier hearing date has been specifically agreed to in writing by the parties.

8.5.3. A hearing for a Practitioner who is under summary suspension shall, at the request of the Practitioner, be held as soon as the arrangements may be reasonably made and provided that the Practitioner agrees to a waiver of the thirty (30) day advance notice time requirement.

SECTION 8.6. WITNESS LIST AND EXHIBITS

8.6.1. List of Witnesses. Within ten (10) days after receiving notice of the hearing, the Practitioner requesting the hearing shall provide a written list of the names and addresses of the individuals expected to offer testimony or evidence on the Practitioner's behalf including a brief summary of the nature of the anticipated testimony. The witness list of either party may, in the discretion of the presiding officer, be supplemented or amended at any time during the course of the hearing, provided that notice of the change is given to the other party. The presiding officer shall have the authority to limit the number of witnesses, especially character witnesses or witnesses whose testimony is merely cumulative.

8.6.2. Hospital Employees. Neither the Practitioner, nor his or her attorney, nor any other person on behalf of the Practitioner, shall contact a Hospital employee while the employee is working at the Hospital. The Practitioner (or his or her attorney or other agent) may contact the CEO (or legal counsel to the MEC or Board, as applicable, if representation has been obtained) to request assistance in talking with Hospital employees. Although Hospital employees will be encouraged to participate in the peer review process, all such participation shall be voluntary, and the Hospital shall not have the authority to demand participation unless such participation is a part of the employee's job description. At his or her request, a Hospital employee may be accompanied by legal counsel (who may be the counsel who represents the MEC or Board, as applicable) when meeting with the Practitioner or his or her attorney or other agent.

8.6.3. Exhibits. The parties shall cooperate in the exchange of exhibits reasonably in advance of the hearing date. Prior to any exchange of exhibits, the parties must agree that all such

documents will be maintained as confidential peer review documents and will not be disclosed or used for any purpose other than the hearing and any appeal related thereto.

8.6.4. Objections. All objections to witnesses or exhibits, to the extent then reasonably known, shall be submitted to the presiding officer in writing in advance of the hearing.

8.6.5. Continuing Obligation. Each party remains under a continuing obligation to provide to the other party any documents or witnesses identified after the initial exchange which the party intends to introduce at the hearing. The introduction of any documents not provided prior to the hearing, or the admissibility of testimony to be presented by a witness not so listed, shall be at the discretion of the presiding officer.

SECTION 8.7. HEARING OFFICER/HEARING PANEL AND PRESIDING OFFICER

8.7.1. Hearing Officer. The Chief Executive Officer, after consulting with the Chief of Staff (or chair of the Board if the hearing was occasioned by a Board determination), shall appoint a hearing officer to perform the functions of both hearing officer and presiding officer. 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. The hearing officer may not be in direct economic competition with the Practitioner requesting the hearing nor, if the hearing officer is an attorney, may the hearing officer represent clients who are in direct economic competition with the Practitioner requesting the hearing. The hearing officer may not be professionally associated with or related to the Practitioner requesting the hearing. Knowledge of the matter involved shall not preclude any individual from serving as a hearing officer provided such individual did not actively participate in the consideration of the matter involved at any previous level.

8.7.2. Hearing Panel. As an alternative to a hearing officer, the Chief Executive Officer, after consulting with the Chief of Staff (or chair of the Board if the hearing is occasioned by a Board determination), shall appoint a hearing panel which shall be composed of not less than three (3) individuals who did not actively participate in the consideration of the matter involved at any previous level. The individuals may be Appointees, Practitioners, or lay persons not connected with the Hospital, or any combination of such persons. The CEO shall designate one (1) of the panel members to act as presiding officer (with the right to vote); or, alternatively, the CEO may appoint a presiding officer to assist the hearing panel (who may assist the panel in its private deliberations but who shall not have the right to vote). Knowledge of the matter involved shall not preclude any individual from serving as a member of the hearing panel. The hearing panel shall not include any individual who is in direct economic competition with, or any individual who is professionally associated with or related to, the Practitioner requesting the hearing.

8.7.3. Presiding Officer. The presiding officer must not act as a prosecuting officer or as an advocate for either side at the hearing. The presiding officer may be advised by legal counsel to the Hospital with regard to the hearing procedure provided that such counsel shall not be the same individual as is representing the MEC or Board (as applicable) during the hearing process. The presiding officer shall:

a. Allow the participants in the hearing to have a reasonable opportunity to be heard and to present oral and documentary evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process.

b. Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, or abusive, or that causes undue delay.

c. Maintain decorum throughout the hearing.

d. Determine the order of procedure throughout the hearing.

e. Have the authority and discretion to make rulings on all questions that pertain to matters of procedure and to the admissibility of evidence.

f. If a hearing panel is appointed, conduct argument by counsel on procedural points outside the presence of the hearing panel unless the panel wishes to be present.

SECTION 8.8. HEARING PROCEDURE

8.8.1. Pre-Hearing Conference. The presiding officer may require counsel or other representative for the Practitioner and for the Medical Executive Committee (or the Board, as applicable) to participate in a pre-hearing conference for purposes of resolving all procedural questions in advance of the hearing.

8.8.2. Failure to Appear. Failure, without good cause, of the Practitioner requesting the hearing to appear and proceed at such a hearing shall constitute a waiver of the Practitioner's hearing rights unless the presiding officer determines that good cause exists for such lack of attendance. The matter shall then be forwarded to the Board for final action.

8.8.3. Record of Hearing. A record of the hearing shall be made by a stenographic reporter present at the hearing. The cost of such report shall be borne by the Hospital, but copies of the transcript shall be provided to the Practitioner requesting the hearing at that Practitioner's expense. Oral evidence shall be taken only on oath or affirmation administered by any person entitled to notarize documents in the State of Ohio.

SECTION 8.9. RIGHTS AT THE HEARING

8.9.1. Rights of Parties. At a hearing, both sides shall have the following rights, subject to reasonable limits determined by the presiding officer:

a. To be represented by an attorney or other person of the party's choice
b. To call and to examine witnesses, to the extent they are available and willing to testify.

c. To cross-examine any witness on any matter relevant to the issues.

d. To impeach (challenge the credibility of) witnesses

e. To introduce exhibits.

f. To present, and/or rebut, evidence determined relevant by the Hearing Officer or Hearing Panel regardless of the admissibility of the evidence in a court of law.

g. To submit a written statement at the close of the hearing.

h. To have a record made of the proceedings, copies of which may be obtained by the Practitioner upon payment of any reasonable charges associated with the preparation thereof.

i. Upon completion of the hearing, to receive a copy of the written recommendation of the Hearing Officer or Hearing Panel (including a statement of the basis for the Hearing Officer's or Hearing Panel's recommendation(s)) and to receive a copy of the written decision of the Board (including a statement of the basis for the Board's decision.).

8.9.2. Right to Call Appointee. A Practitioner requesting a hearing who does not testify in his or her own behalf may be called and questioned as if under cross-examination.

8.9.3. Right of Hearing Officer or Panel. The Hearing Officer or Panel may question the witnesses, call additional witnesses, or request additional documentary evidence.

8.9.4. Admissibility of Evidence. The hearing shall not be conducted according to the rules of evidence. Hearsay evidence shall not be excluded merely because it is hearsay. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.

8.9.5. Official Note. The Hearing Officer or Panel may take official note at any time for evidentiary purposes of any generally accepted technical or scientific principles relating to the matter at hand and of any facts that may be judicially noticed by Ohio courts. The parties to the hearing shall be informed of the principles or facts to be noticed, and the same shall be noted in the hearing record. Any party shall be given the opportunity to request that a principle or fact be officially noticed or to refute any officially noticed principle or fact by evidence or by written or oral presentation of authority in such manner as determined by the Hearing Officer or Panel.

8.9.6. Post-Hearing Statement. Each party shall have the right to submit a written statement, and the Hearing Officer or Panel may request such a statement to be filed, following the close of the hearing.

8.9.7. Observers. The hearing shall be restricted to those individuals involved in the proceeding. Appropriate administrative personnel may be present as requested by the Chief Executive Officer and the Chief of Staff.

SECTION 8.10. HEARING PROCESS

8.10.1. Order of Presentation. The MEC (or the Board, as applicable), shall first present evidence in support of its recommendation. Thereafter, the Practitioner shall present his or her case. The MEC (or the Board, as applicable) shall then have the right to present rebuttal evidence.

8.10.2. Basis of Recommendation. The Hearing Officer or Panel shall recommend in favor of the Medical Executive Committee (or the Board, as applicable) unless it finds that the Practitioner has proved by clear and convincing evidence that the Adverse recommendation/action that prompted the hearing was arbitrary, capricious, or not supported by substantial, credible evidence. The report and recommendation of the Hearing Officer or Panel shall be based on the evidence produced at the hearing.

8.10.3. Adjournment and Conclusion. The presiding officer may adjourn the hearing and reconvene it. Upon conclusion of the presentation of evidence by the parties and questions by the Hearing Officer or Panel, the hearing shall be ended.

8.10.4. Deliberations and Recommendation of the Hearing Officer or Panel. Within thirty (30) days after final adjournment of the hearing (which may be designated as the time the Hearing Officer or Panel receives the hearing transcript and any post-hearing statements, whichever is later), the Hearing Officer or Panel shall conduct deliberations outside the presence of any other person (except the presiding officer), and shall render a recommendation, accompanied by a report, that shall contain a concise statement of the reasons for the recommendation.

8.10.5. Disposition of Hearing Officer or Panel Report. The Hearing Officer or Panel shall deliver the hearing report and recommendation (including a statement of the basis for such recommendation) to the Chief Executive Officer who shall forward it, along with all accompanying documentation, to the body whose recommendation/action triggered the hearing. Within fifteen (15) days of receiving the hearing report and recommendation, the initiating body shall make its final recommendation.

a. Favorable Recommendation or Action.

i. When the MEC's recommendation is favorable to the Practitioner, such recommendation will be forwarded to the Board. The Board may thereafter adopt or reject any portion of the MEC's recommendation that was favorable to the Practitioner or refer the matter back to the MEC for additional consideration. Any such referral shall state the reason(s) for the requested reconsideration, set a time limit within which a subsequent recommendation must be made to the Board, and may include a directive that an additional hearing be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation, and any new evidence in the matter, the Board shall take action.

ii. A favorable determination by the Board (whether as the triggering body or in affirmance of a favorable recommendation by the MEC) shall be effective as the Board's final decision and the matter shall be considered closed.

b. Adverse Recommendation/Action. If the recommendation of the MEC or action of the Board is Adverse to the affected Practitioner after exhaustion of his/her hearing rights, the Practitioner shall be entitled, upon timely and proper request, to an appellate review before a final decision is rendered on the matter by the Board.

8.10.6. Notice of Result. Such recommendation or action of the MEC and/or Board shall be transmitted, together with the hearing record, the report of the Hearing Officer or Panel, and all other documentation introduced at the hearing and considered by the Hearing Officer/Panel to the Chief Executive Officer. The Chief Executive Officer shall promptly send a copy of the Hearing Officer's or Panel's report, together with a copy of the decision of the body whose Adverse recommendation or action triggered the hearing, to the affected Practitioner by Special Notice. In the event of an Adverse result, the notice shall inform the Practitioner of his/her right to request an appellate review by the Board before a final decision regarding the matter is rendered

SECTION 8.11. APPEAL PROCEDURE

8.11.1. Request for Appeal

a. Within ten (10) days after receiving notice of the initiating body's final recommendation and his/her right to request an appellate review, the affected Practitioner may request an appeal. The request shall be made in writing to the Board in care of the CEO, by Special Notice, and must include a statement of the reasons for appeal, and the specific facts or circumstances that justify further review. If the Practitioner wishes an attorney to represent him/her at any appellate review appearance permitted, his/her request for appellate review shall so state. The request shall also state whether the Practitioner wishes to present oral arguments to the Review Panel.

b. If an appeal is not requested in writing within ten (10) days, the opportunity to appeal shall be deemed to be waived, and the initiating body's recommendation shall be ripe for review by the Board for final action.

c. If a timely request is made, the initiating body shall be so notified and shall have the right to participate in the appeal.

8.11.2. Grounds for Appeal. The grounds for appeal shall be limited to the following:

a. There was substantial failure to comply with the Medical Staff Bylaws during or prior to the hearing so as to deny a fair hearing.

b. The final recommendation was made arbitrarily, capriciously, or with prejudice.

c. The final recommendation was not supported by substantial, credible evidence.

8.11.3. Time, Place and Notice. Whenever an appeal is requested as set forth in the preceding sections, the chair of the Board shall, within ten (10) days, taking into account the schedules of all participants, schedule and arrange for an appeal. The Practitioner shall be informed, by Special Notice, of the time, place, and date of the appeal, and whether oral arguments will be permitted. The appeal shall be not less than fourteen (14) nor more than twenty-one (21) days after receipt of the notice of request for appellate review provided, however, that when the Practitioner requesting the review is under a summary suspension which is then in effect such review shall be scheduled as soon as arrangements for it may reasonably be made provided that the Practitioner agrees to waive the time requirements set forth in this section.

8.11.4. Nature of Appellate Review. The chair of the Board shall appoint a review panel comprised of not less than three (3) persons, either members of the Board or the Board may hear the appeal as a whole body. ("Review Panel"). The proceedings by the Review Panel shall be in the nature of an appellate review based upon the record of the hearing before the Hearing Officer or Panel, the Hearing Officer's or Panel's report, and all subsequent results and actions thereon for the purpose of determining whether the Practitioner was denied a fair hearing and/or whether the Adverse recommendation or action against the affected Practitioner was justified, as supported by substantial, credible evidence presented at the hearing, and not arbitrary, capricious or with prejudice. The affected Practitioner shall have access to the report and record of the Hearing Officer or Panel and the MEC and/or the Board, as applicable, and all other material, favorable or unfavorable, that was introduced at the hearing and considered in making the Adverse recommendation or taking the Adverse action against the Practitioner

8.11.5. Written Statements. Each party shall have the right to present a written statement in support of its position on appeal. The written statement is due four (4) days prior to the appeal date.

8.11.6. Oral Arguments. In its sole discretion, the Review Panel may allow each party or its representative to appear personally and make oral arguments not to exceed thirty (30) minutes each or such other period of time as the Review Panel, in its sole discretion, deems appropriate. The Review Panel shall further decide whether oral arguments, if any, will be presented separately or with representatives of both parties in the room. Parties or their representatives appearing before the Review Panel must be willing to answer questions posed to them by the Review Panel.

8.11.7. Presiding Officer. The chair of the Review Panel shall preside over the appellate review, including determining the order of procedure, making all required rulings, and maintaining decorum during all proceedings.

8.11.8. Consideration of New/Additional Evidence

a. If a party wishes to introduce new/additional evidence not raised or presented during the original hearing and not otherwise reflected in the record, the party must make such request in writing at the time he/she submits a request for appellate review pursuant to §8.11.1.

b. The party may introduce such evidence at the appellate review only if expressly permitted by the Review Panel, in its sole discretion, and only upon a clear showing by the party requesting consideration of the evidence that it is new, relevant evidence not previously available at the time of the hearing or that a request to admit relevant evidence was previously erroneously denied.

c. In the exceptional circumstance where the Review Panel determines to hear such evidence, the Review Panel shall further have the ability to recess appellate review and remand the matter back to the Hearing Officer or Panel.

d. In such event, the hearing shall be reopened as to this evidence only and the evidence shall be subject to submission and cross-examination and/or counter-evidence.

e. The Hearing Officer or Panel shall then prepare a supplemental report and submit it to the triggering body. The triggering body will then notify the Review Panel, in writing, through the CEO as to whether the triggering body will or will not be amending its recommendation or action; and, if so, the nature of the amendment or reason for non-amendment.

f. The CEO shall then provide a copy of the Hearing Officer's or Panel's supplemental report and the triggering body's recommendation/action to the Practitioner and the appellate review process shall recommence.

8.11.9. Recesses and Adjournments. The Review Panel may recess the review proceeding and reconvene the same without additional notice if it deems such recess necessary for the convenience of the participants, to obtain new or additional evidence, or if consultation is required for resolution of the matter. Upon conclusion of oral statements, if allowed, the appellate review shall be closed. The Review Panel shall then deliberate outside the presence of the parties at such time and in such location as is convenient to the review body. The appellate review shall be adjourned at the conclusion of the Review Panel's deliberations.

8.11.10. Action Following Conclusion of Appellate Review

a. If the appellate review is conducted by the Board as a whole, it may affirm, modify or reverse its prior decision; accept or reject the recommendation of the MEC; or refer the matter back to the MEC for further review and recommendation. Such referral may include a request that the MEC arrange for a further hearing to resolve specified disputed issues and a specified time period in which to do so and report back to the Board.

b. If the appellate review is conducted by a Board appointed *ad hoc* committee, such committee shall, within fifteen (15) days after adjournment of the appellate review, issue a written report recommending that the Board affirm, modify, or reverse its prior decision; accept or reject the recommendation of the MEC; or refer the matter

back to the MEC for further review and recommendation. Such referral may include a request that the MEC arrange for a further hearing to resolve disputed issues and a specified time period in which to do so and report back to the Board.

8.11.11. Final Decision of the Board

a. Within thirty (30) days after adjournment of the appellate review the Board shall reach a decision.

i. If this decision is in accordance with the MEC's last recommendation, or the Board's last action in the matter, it shall be immediately effective and final and shall not be subject to further hearing or appellate review.

ii. If this decision is contrary to the MEC's last recommendation, or the Board's last action, the Board of Directors shall refer the matter to the Joint Advisory Committee prior to issuing notice of its final decision. This committee shall make its written recommendation to the Board within fifteen (15) days of receipt of the Board's request. The Board of Directors shall then make its final decision. The Board's final decision shall be immediately effective, and the matter shall not be subject to any further referral or review.

b. The Chief Executive Officer will promptly send a copy of the Board's written decision, with a statement of the basis for the decision, to the affected Practitioner by Special Notice, and to the Chief of Staff.

SECTION 8.12. WAIVER

If at any time after receipt of notice of an Adverse recommendation, action or result, the affected Practitioner fails to satisfy a request, make a required appearance or otherwise fails to comply with this Article, he/she shall be deemed to have voluntarily waived all rights to which he/she might otherwise have been entitled with respect to the matter involved.

SECTION 8.13. EXHAUSTION OF REMEDIES

A Practitioner must exhaust the remedies afforded by this Article before resorting to any form of legal action. By requesting a hearing or appellate review under these Bylaws, the Practitioner agrees to be bound by the provisions set forth in Article 10 regarding confidentiality, reporting immunity and release of liability.

SECTION 8.14. RIGHT TO ONE HEARING AND ONE APPEAL ONLY

No applicant or Appointee shall be entitled to more than one (1) hearing and one (1) appeal on any matter that may be the subject of an appeal.

SECTION 8.15. REPRESENTATION BY COUNSEL

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

SECTION 8.16. FEDERAL & STATE REPORTING OBLIGATIONS

The Chief Executive Officer, in consultation with the MEC and/or the Board, as applicable, shall be responsible for assuring that any reports required to be filed with the National Practitioner Data Bank and/or Ohio State Medical Board (or other applicable licensing entity) are filed accurately and in a timely manner.

ARTICLE 9
MEETINGS AND RELATED MATTERS

SECTION 9.1. CALL OF MEETINGS

9.1.1. General Medical Staff Meetings. Not less than nine (9) general Medical Staff meetings shall be held on the second Monday of the month at 6:30 p.m.

9.1.2. Special Medical Staff Meetings. The Chief of Staff may call a special meeting of the Medical Staff at any time. The Chief of Staff shall call a special meeting within twenty-one (21) days after receipt of a written request therefore signed by not less than five (5) Appointees to the active and affiliate Medical Staff. Such request shall state the purpose of the meeting, and the agenda at such meeting shall not move beyond the stated purpose. The Chief of Staff shall designate the time and place of any special meeting.

9.1.3. Regular Medical Staff Committee Meetings. Regular meetings of each Medical Staff committee shall be held as scheduled or as otherwise called by the applicable committee chair.

9.1.4. Special Medical Staff Committee Meetings. A special meeting of any Medical Staff committee shall be called at the request of the presiding officer, the Board, the Chief of Staff, or one-third (1/3) of the current voting members of the committee.

9.1.5. Notice of Meetings. Written or printed notice stating the place, day, and hour of any Medical Staff or Medical Staff committee meeting not otherwise held as specified in these Bylaws or by resolution shall be delivered personally, by U.S. mail, or by electronic transmission (facsimile or email) to each person entitled to be present at such meeting not less than three (3) days nor more than twenty-one (21) days before the date of such meeting, unless otherwise specified within these Bylaws. Notice of committee meetings may be given orally. If delivered by U.S. mail, the notice of the meeting shall be deemed delivered seventy-two (72) hours after being placed with the postal service. If delivered by electronic transmission, the notice of the meeting shall be deemed delivered twenty-four (24) hours after being transmitted provided the notice clearly states the Practitioner's name. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

SECTION 9.2. QUORUM

The following constitute a quorum:

a. Medical Staff meeting. Those voting members who are present but not less than five (5) Appointees to the active or affiliate Medical Staff.

b. Medical Executive Committee meetings.

   i. Adoption/amendment of Medical Staff document: Not less than half (1/2) of the voting members must be present.

ii. Action on requests for appointment/reappointments and grant/regrant of Privileges: Not less than two (2) voting members must be present.

iii. All other regular business items: Not less than two (2) voting members must be present.

c. Other Medical Staff committee meetings. Those voting members who are present but not less than two (2).

SECTION 9.3. ATTENDANCE REQUIREMENTS

9.3.1. Appointee Attendance. Appointees are encouraged to attend Medical Staff meetings, and Medical Staff committee meetings; however, attendance will not be used in evaluating Practitioners at the time of reappointment/regrant of Privileges.

9.3.2. Committee Attendance. Members of the Medical Executive Committee are expected to attend at least fifty percent (50%) of the meetings held within any year. Individuals who do not meet this requirement may be removed from the committee. All MEC members are expected to be actively involved in committee activities.

SECTION 9.4. MEETING OBLIGATIONS—QUALITY OF CARE ISSUE

Whenever a pattern of suspected deviation from standard clinical or professional practice is identified, the Chief of Staff may require the Practitioner to confer with him/her or with a standing or *ad hoc* committee that is considering the matter. The Practitioner will be given written notice, by Special Notice, of the conference at least seven (7) days prior to the conference, including: (a) the date, time and place; (b) a statement of the issue involved; and (c) a statement that the Practitioner's appearance is mandatory. A failure of the Practitioner to appear at any such conference, unless excused by the party or entity requiring the meeting upon a showing of good cause, may result in the initiation of corrective action based upon a failure to participate in the peer review process.

SECTION 9.5. CONDUCT OF MEETINGS

Common sense, as determined by the Chief of Staff or chair of a Medical Staff committee 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.

SECTION 9.6. VOTING RIGHTS

Any individual who, by virtue of his or her position, attends a meeting in more than one (1) capacity, shall be entitled to only one vote.

SECTION 9.7. MANNER OF ACTION

Except as otherwise specified in these Bylaws, the action of a majority of the individuals entitled to vote shall be the action of the group. Voting may occur in any of the following ways as

determined by the chair of the respective Medical Staff committee; or for voting by the Medical Staff, as determined by the Chief of Staff:

a. Vote by voice at a meeting at which a quorum is present.

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

c. Vote by written ballot at a meeting at which a quorum is present.

d. 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.

e. Absentee written or electronic ballots may also be accepted provided the ballot(s) are received prior to the deadline date set forth in the notice advising of the purpose for which a vote is to be taken.

SECTION 9.8. RIGHTS OF EX OFFICIO MEMBERS

Except as otherwise provided in these Bylaws, persons serving as *Ex Officio* members of a Medical Staff committee shall have all rights and privileges of regular members thereof, except that they shall not vote or be counted in determining the existence of a quorum.

SECTION 9.9. PARTICIPATION BY CHIEF EXECUTIVE OFFICER

The Chief Executive Officer may attend any meeting of the Medical Staff, and any committee meeting, without vote, unless these Bylaws provide otherwise.

SECTION 9.10. MEETING PROCEDURES

9.10.1. Order of Business at General Medical Staff Meetings. The order of business at a general Medical Staff meeting shall be:

a. Call to order.

b. Review of minutes from the last general Medical Staff meeting and all special meetings.

c. Unfinished business.

d. Administrative reports from the Chief of Staff and from the CEO.

e. Reports of standing and special Medical Staff committees.

f. New Business

9.10.2. Order of Business at Special Medical Staff Meetings. The order of business at a special Medical Staff meeting shall be:

a. Reading of the notice calling the special meeting.

b. Business for which the special meeting was called.

SECTION 9.11. MINUTES

Minutes shall be prepared for any meeting held by the Medical Staff or a Medical Staff committee. Minutes shall include a record of attendance and the vote(s) taken on each matter. Copies of such minutes shall be signed by the presiding officer, forwarded to the Medical Executive Committee; and, when appropriate, made available to the Medical Staff. A permanent file of the minutes of all meetings shall be maintained in the Medical Staff Office or in other designated secure, confidential area(s).

ARTICLE 10
CONFIDENTIALITY, IMMUNITY AND RELEASES

SECTION 10.1. SPECIAL DEFINITIONS

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

INFORMATION means records of proceedings, minutes, interviews, records, reports, forms, memoranda, statements, investigations, examinations, 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 §10.5.

REPRESENTATIVE means the Board of Directors of the Hospital and any director or committee thereof; the Hospital and its CEO, or the CEO's designee; the Medical Staff, Medical Staff officers, and Medical Staff committees; and any individual(s) (*e.g.*, other Hospital employees, Practitioners, *etc.*) authorized by any of the foregoing to perform specific information gathering, analysis, use or disseminating functions.

THIRD PARTIES means any individual or organization providing information to any Representative.

SECTION 10.2. AUTHORIZATIONS AND CONDITIONS

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

a. Authorizes, as needed, Representatives to solicit, provide and act upon Information bearing on his or her professional ability and other qualifications.

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

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

SECTION 10.3. CONFIDENTIALITY OF INFORMATION

Information with respect to any Practitioner submitted, collected or prepared by any Representative of this Hospital or by any other health care facility or organization of health professionals or medical staff for the purpose of: evaluating, monitoring or improving the quality, appropriateness and efficiency of patient care; reducing morbidity and mortality; contributing to teaching or clinical research; determining that health care services were 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. Said Information shall not be disseminated to anyone other than

a Representative or other health care facility or organization of health professionals or medical staff engaged in an official, authorized activity for which the information is needed, nor be used in any way except as provided herein or except as otherwise required by law. Such confidentiality shall also extend to Information of like kind that may be provided by Third Parties. This Information shall not become part of any particular patient's record. It is expressly acknowledged by each Practitioner that violation of the confidentiality provided herein is grounds for corrective action.

SECTION 10.4. IMMUNITY FROM LIABILITY

10.4.1. For Action Taken. No Representative shall be liable to a Practitioner for damages or other relief for any decision, opinion, action, statement or recommendation made within the scope of his or her duties as a Representative provided that such Representative does not act on the basis of false Information knowing such Information to be false.

10.4.2. For Providing Such Information. No Representative and no Third Party shall be liable to a Practitioner for damages or other relief by reason of providing Information, including otherwise privileged or confidential Information, to a Representative or to any other health care facility or organization of health professionals or medical staff concerning a Practitioner who is or has been an applicant to or Appointee of the Medical Staff or who did or does exercise Clinical Privileges at this Hospital, provided that such Representative or Third Party does not act on the basis of false Information knowing such Information to be false.

SECTION 10.5. ACTIVITIES AND INFORMATION COVERED

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

a. Applications for appointment or Clinical Privileges.

b. Periodic reappraisals for reappointment or regrant of Clinical Privileges.

c. Corrective actions recommended or taken.

d. Hearings and appellate reviews.

e. Performance improvement/quality assessment activities.

f. Utilization review activities.

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

10.5.2. Information. The Information referred to in this Article may relate to a Practitioner's qualifications (including, but not limited to professional licensure or certification, education, training, clinical competency, judgment, utilization practices, character, ability to fully

and competently carry out the Clinical Privileges requested, professional ethics, *etc.*) or any other matter that might directly or indirectly affect the quality, efficiency, or appropriateness of patient care provided in the Hospital.

SECTION 10.6. RELEASES

10.6.1. Execution. Each Practitioner shall, upon request of the Hospital, execute general and specific releases in accordance with the tenor and import of this Article, subject to such requirements as may be applicable under the State of Ohio and federal law. Execution of such releases is not a prerequisite to the effectiveness of this Article.

10.6.2. Failure to Execute

a. Failure to execute such releases in connection with a corrective action shall be grounds for automatic suspension of Medical Staff appointment and Clinical Privileges.

b. Failure to execute such releases in connection with a corrective action shall result in the facts or circumstances that are the subject matter of the particular releases being construed in the most negative manner possible in relation to the Practitioner involved.

SECTION 10.7. CUMULATIVE EFFECT

Provisions in these Medical Staff Bylaws and in application forms relating to authorization, confidentiality of Information, and release of/immunity from liability are in addition to other protections provided by State of Ohio and federal law and not in limitation thereof.

ARTICLE 11
REVIEW, REVISION, ADOPTION AND AMENDMENT OF MEDICAL STAFF DOCUMENTS

SECTION 11.1. MEDICAL STAFF BYLAWS

11.1.1. Medical Staff Authority and Responsibility. The Medical Staff shall have the initial responsibility to formulate, adopt, and recommend to the Board Medical Staff Bylaws, and amendments thereto, which shall be effective when approved by the Board. Such responsibility shall be exercised in good faith and in a reasonable, timely, and responsible manner. Neither the Medical Staff nor the Board may unilaterally amend the Medical Staff Bylaws. All actions of the Medical Staff are subject to the ultimate authority of the Board.

11.1.2. Medical Staff Action

a. Adoption of Medical Staff Bylaws, or amendments thereto, may be initiated upon recommendation of the Board, the MEC, the Credentials/Bylaws Committee, or by the submission of written recommendations by any active or affiliate Appointee to the Credentials/Bylaws Committee.

b. Recommendations for adoption or amendment of the Medical Staff Bylaws will be reviewed by the Credentials/Bylaws Committee and conveyed to the MEC.

c. Following review and recommendation by the MEC, the Medical Staff Bylaws may be adopted or amended by either of the following methods:

   i. At a Medical Staff meeting. Notice will be provided to all voting Medical Staff Appointees in advance of the meeting at which the vote will be taken. The notice will cite the exact wording of the applicable provision(s) in the existing Bylaws, if any, and the proposed change(s). Adoption or amendment of the Bylaws requires the affirmative vote of a majority of the active and affiliate Appointees in Good Standing entitled to vote thereon who may vote either in person at a designated Medical Staff meeting at which a quorum is present, or by absentee ballot.

   ii. By ballot without a Medical Staff meeting. Ballots will be provided to all voting Medical Staff Appointees in such manner as determined by the MEC (*e.g.,* by mail, electronic distribution, *etc.*) and will include the exact wording of the applicable provision(s) in the existing Bylaws, if any, and the proposed change(s). Adoption or amendment of the Bylaws requires the affirmative vote of a majority of the active and affiliate Appointees in Good Standing entitled to vote thereon.

d. Adoption or amendment of the Medical Staff Bylaws shall be effective when approved by the Board of Directors which approval shall not be unreasonably withheld.

11.1.3. Technical Amendments to Medical Staff Bylaws. The Medical Executive Committee shall have the power to adopt such amendments to the Bylaws or Rules & Regulations as are, in the committee's judgment:

a. Technical or legal modifications or clarifications, reorganization, or renumbering; or

b. Amendments needed because of punctuation, spelling, or other errors of grammar or expression.

SECTION 11.2. ADOPTION AND AMENDMENT OF MEDICAL STAFF POLICIES AND RULES & REGULATIONS

11.2.1. Subject to subsections (a) – (d) below, the Medical Staff delegates to the MEC the responsibility to adopt and amend such Medical Staff Policies and Rules & Regulations as may be necessary to implement the general principles set forth in these Bylaws and for the proper conduct of the Medical Staff. Such Policies and Rules and Regulations may be adopted or amended by a majority vote of the MEC members, in Good Standing, entitled to vote thereon.

a. If the MEC proposes to adopt a Rule or Regulation, or an amendment thereto, the MEC shall first communicate the proposal to the Medical Staff.

b. When the MEC adopts a Medical Staff Policy, or an amendment thereto, the MEC shall communicate such Policy, or amendment, to the Medical Staff.

c. In the event that at least ten percent (10%) of the voting members of the active or affiliate Medical Staff propose, as reflected by a signed petition, to adopt a Rule, Regulation, or Policy, or an amendment thereto, the Medical Staff shall first communicate its proposal to the MEC.

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

11.2.2. Adoption or amendment of Medical Staff Policies and Rules & Regulations shall become effective when approved by the Board.

SECTION 11.3. BOARD ACTION REGARDING MEDICAL STAFF BYLAWS, POLICIES AND RULES & REGULATIONS

11.3.1. When Favorable to Medical Staff or MEC Recommendation

a. Medical Staff recommendations regarding adoption or amendment of the Medical Staff Bylaws are effective upon the affirmative vote of a majority of the members of the Board or as otherwise provided in the Hospital's Code of Regulations.

b. MEC recommendations regarding adoption or amendment of Medical Staff Policies and Rules & Regulations are effective upon the affirmative vote of a majority of the members of the Board or as otherwise provided in the Hospital's Code of Regulations.

11.3.2. Conflict with MEC/Medical Staff Recommendation. If the Board has determined not to accept a recommendation submitted to it by the Medical Executive Committee (with respect to adoption or amendment of Medical Staff Policies or Rules & Regulations) or the Medical Staff (with respect to adoption or amendment of Medical Staff Bylaws), the Medical Executive Committee may request a meeting of the Joint Advisory Committee. The Chief Executive Officer will schedule such conference within fourteen (14) days after receipt of a request for such meeting from the Chief of Staff. The Board may then take final action.

11.3.3. Board-Initiated Action. In the event the Medical Staff or MEC, as applicable, fails to exercise its responsibility in good faith and in a reasonable and timely manner, the Board may adopt or amend Medical Staff Bylaws, Policies, or Rules & Regulations provided that the Board has first proposed its recommended changes to the Medical Staff and/or MEC, as applicable, and the Medical Staff/MEC has declined to adopt such recommendations. In such event, the Board shall then present the recommended changes to the Joint Advisory Committee for its recommendation prior to adopting any such changes.

SECTION 11.4. DOCUMENT CONFLICTS

In the event of a conflict between the Hospital's Code of Regulations or a Hospital policy and the Medical Staff Bylaws, then the Hospital's Code of Regulations or Hospital policy, as applicable, shall control; provided, however, that such conflict shall then be referred to the Joint Advisory Committee for recommendation to the Board as to how such conflict can be resolved. In the event of a conflict between the Medical Staff Bylaws and a Medical Staff Policy or the Rules & Regulations, the Medical Staff Bylaws shall control; provided, however, that such conflict shall then be reviewed by the MEC to determine how such conflict can be resolved.

SECTION 11.5. APPOINTEE ACTION

Any active or affiliate Appointee may raise a challenge to the Rules & Regulations or any Medical Staff Policy established by the MEC and approved by the Board. In order to raise such challenge, the active or affiliate Appointee must submit to the MEC a petition signed by not less than ten percent (10%) of the active or affiliate Appointees. Upon receipt of the petition, the MEC shall either (a) provide the petitioner(s) with information clarifying the intent of such Policy, Rule or

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 petitioner(s), the matter shall be brought before the Medical Staff for vote subject to final review and action by the Board.

SECTION 11.6. MEDICAL STAFF/MEC CONFLICT RESOLUTION

In the event of a conflict between the Medical Staff and the MEC, a special meeting of the Medical Staff and MEC shall be convened to discuss issues of concern and resolution therefore. In the event that the issue cannot be resolved to the mutual satisfaction of both parties, the matter shall be brought before the Medical Staff for vote subject to final review and action by the Board.

SECTION 11.7. DISTRIBUTION

Approved Medical Staff documents, as such documents may be amended from time to time, are made available to Practitioners with Medical Staff appointment and/or Privileges at the Hospital.

SECTION 11.8. REVIEW

The Bylaws shall be reviewed as needed to maintain compliance with current changes in the law or accreditation requirements.

SECTION 11.9. EXCLUSIVITY

The mechanisms described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff Bylaws, Policies, and Rules & Regulations..

ARTICLE 12
CERTIFICATION OF ADOPTION AND APPROVAL

These Bylaws are adopted by the Medical Staff and made effective upon approval of the Board, superseding and replacing any and all other Medical Staff Bylaws, Policies, and Rules & Regulations pertaining to the subject matter contained herein.

Adopted by the Medical Staff:

Signed Original on File in the Medical Staff Office
Chief of Staff Signature
Date: May 11, 2020

Approved by the Board:
Signed Original on File in the Medical Staff Office
President of the Board of Directors Signature
Date: May 20, 2020