



Largo Medical Center

A Teaching Hospital

**Medical Staff
Bylaws
Review / Revised 04/24/2012**

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1. ARTICLE ONE: DEFINITIONS/CONSTRUCTION OF TERMS AND HEADINGS

1.1. DEFINITIONS

The following terms shall have the meanings as set forth below, unless the context clearly indicates otherwise. Some of the terms defined below are not capitalized when used throughout these Bylaws.

Active Staff: Active staff category shall consist of Practitioners (including those practitioners who are in the first year provisional status) who actively support the Medical Staff and the Hospital by contributing to efforts to fulfill Medical Staff functions. The Active Staff category shall consist of Practitioners who regularly admit, or personally provide services to patients in the Hospital and who are located (primary or satellite office and permanent or temporary residence) within a reasonable distance and/or travel time, (“reasonable” to be determined by the Board based on the Practitioner’s specialty and scope of care at the Hospital) to provide continuous care to their patients. Active staff will provide patient service to at least twelve (12) patients per year to include admissions, surgeries, procedures and consults. Hospital-based Practitioners who do not admit patients may be members of the active Medical Staff if otherwise qualified. The Active Staff category of Practitioners shall be responsible for oversight of care, treatment and services provided by the Medical Staff, and members in the Active Staff category shall have the requisite skills for providing such oversight.

Administration: The executive members of the Hospital staff, including the Chief Executive Officer (CEO), Chief Operating Officer (COO), Chief Financial Officer (CFO), Chief Nursing Officer (CNO), and Chief Medical Officer (CMO).

Administrator: The individual appointed by Corporate Management to act on behalf of the Hospital in the overall management of the Hospital. The administrator holds the title of Chief Executive Officer (CEO) of the Hospital. In the event of his/her absence, the CEO may select a designee to temporarily serve in the role of administrator.

Adverse Action: An action that adversely affects an individual’s Medical Staff membership or clinical privileges. An adverse action shall entitle the individual to the procedural rights afforded by the Fair Hearing Plan, except as provided in these Bylaws. An adverse action shall include a denial or termination of Medical Staff membership, or a denial, reduction, or termination of clinical privileges.

Advanced Practice Professional (APP): An individual, other than those defined under “Practitioner,” who provides direct patient care services in the Hospital under a defined degree of supervision, exercising judgment within the areas of documented professional competence and consistent with applicable law. APPs are designated by the Board to be credentialed through the Medical Staff system and are granted clinical privileges as either a dependent or independent healthcare professional as defined in these Bylaws. APPs are not eligible for Medical Staff membership. The Board has determined the categories of individuals eligible for clinical privileges as an APP are physician assistants (PA), certified registered nurse anesthetists (CRNA), clinical psychologists (Ph.D.) and advanced registered nurse practitioners (ARNP).¹

Affiliate Staff: The Affiliate Staff category shall consist of Practitioners who are not actively involved in Medical Staff affairs and are not major contributors to fulfillment of Medical Staff functions, due to practicing primarily at another hospital or in an office-based specialty, or other reasons, but who wish to remain affiliated with the Hospital for consultation, call coverage, referral of patients, or other patient care purposes.

Applicant: An individual who has submitted a Complete Application for appointment, reappointment or clinical privileges.

AOA: American Osteopathic Association. The AOA serves as the primary certifying body for doctors of Osteopathic Medicine (D.O.), and is the accrediting agency for all osteopathic medical colleges and health care facilities.

¹ 42 C.F.R. §482.12(a)(1)

Approved School: (a) a medical school in the United States or Canada, accredited by the Liaison Committee on Medical Education of the American Medical Association, or (b) a medical school approved by the American Osteopathic Association, or (c) a medical school approved by the Educational Council for Foreign Medical Graduates, or (d) a dental school approved by the American Dental Association.

Board Certification or Board Certified: A designation for a physician or other practitioner who has completed an approved educational training program and an evaluation process including an examination designed to assess the knowledge, skills and experience necessary to provide quality patient care in that specialty and has maintained certification through retesting and completion of other maintenance of certification requirements. Board certification shall be from an American Board of Medical Specialties (ABMS) Member Board or from a Member Board of Certification of the Bureau of Osteopathic Specialists or from the American Board of Podiatric Surgery (ABPS) if the applicant is a podiatrist, or from the American Board of Oral/Maxillofacial Surgeons (ABOMS) if the applicant is an oral surgeon. ABMS is the umbrella organization for the 24 approved medical specialty boards in the United States. Member Boards determine whether candidates have received appropriate preparation in approved residency training programs in accordance with established educational standards, evaluate candidates with comprehensive examinations, and certify those candidates who have satisfied the board requirements. The Bureau of Osteopathic Specialists was organized in 1939 as the Advisory Board for Osteopathic Specialists to meet the needs resulting from the growth of specialization in the osteopathic profession. There are currently 18 AOA certifying boards. Each is titled, "American Osteopathic Board of (Specialty)." Podiatrists are certified through the American Board of Podiatric Surgery (ABPS) and oral surgeons are certified through the American Board of Oral/Maxillofacial Surgeons (ABOMS).

Board Certification Candidate: A Practitioner who has successfully completed a residency or fellowship program for the Practitioner's specialty within the last five years and who is able to provide proof that he/she has applied for and been accepted to take the exam for certification, or has successfully completed the written portion of the exam and is a current candidate to take an oral portion of the testing, or submit cases for review, or otherwise complete the certification requirements. A Practitioner shall no longer be deemed a Board Certification Candidate if the five year time limit has been exceeded without successful completion of Board Certification, or the Practitioner has exhausted the permitted number of attempts at the exam without success. Acceptable certification boards are defined under "Board Certification" in this section of the Bylaws.

Board of Directors: The individuals elected by the shareholders for the Corporation (or selected or appointed by the Partnership) to hold ultimate responsibility for the Hospital² and are the governing body of the Corporation (or Partnership), sometimes herein referred to as the "Directors."

Board of Trustees: As used herein, the Board of Trustees is the local governing body of the Hospital, delegated specific authority and responsibility, and appointed by the Board of Directors. It is the "governing body" as described in the standards of The Joint Commission (TJC) and the Medicare Conditions of Participation. The Board of Trustees may also be referred to as the "Trustees" or the "Board" unless otherwise specifically stated.

Bylaws: The Bylaws of the Medical Staff, unless otherwise specifically stated.

Certification: The procedure and action by which a duly authorized body evaluates and recognizes (certifies) an individual as meeting predetermined requirements.³

² 42 C.F.R. §482.12

³ HCA, Ethics & Compliance Policy QM.002

Chief of Staff: A Member of the active Medical Staff who is elected in accordance with these Bylaws to serve as chief officer of the Medical Staff of this Hospital. The Chief of Staff shall be a doctor of medicine or osteopathic medicine.

Chief Executive Officer (CEO): Person to whom the Board of Trustees delegates the full-time authority and responsibility for the operation of the Hospital. When used in these Bylaws, Chief Executive Officer shall mean Chief Executive Officer or his designee.

Clinical Privilege/Privilege: The permission granted by the Board to appropriately licensed individuals to render specifically delineated professional, diagnostic, therapeutic, medical, surgical, dental, or podiatry services with the approval of the Board.

Complete Application: An application for either initial appointment or reappointment to the Medical Staff, or an application for clinical privileges, that has been determined by the applicable Medical Staff Department Chairperson, the Credentials Committee, the Medical Executive Committee and/or the Board to meet the requirements of these Bylaws. Specifically, to be complete the application must be submitted in writing on a form approved by the Medical Executive Committee and the Board, and include all required supporting documentation and verifications of information, and any additional information needed to perform the required review of qualifications and competence of the applicant.⁴ Specific to applications or requests for clinical privileges, it shall not be complete unless it includes supporting evidence of competence for each of the privileges requested and proof that the applicant meets the criteria for each of the privileges requested.

Conflict Management: The identification and use of techniques to effectively manage interpersonal, intra- and inter-group, and organizational conflicts. It requires impartiality, and use of negotiating and listening skills.

Contract Practitioner: A Practitioner providing care or services to Hospital patients through a contract or other arrangement with the Hospital.

Core Privileges: Those clinical activities within a specialty or subspecialty that any appropriately trained physician with good references would be competent to perform.

Corporation : Largo Medical Center, Inc.

CPCS: The Clinical Patient Care System, used to electronically document patient care.

Criminal Action: Conviction, or a plea of guilty or no contest pertaining to any felony, or to any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; or (iv) violence against another.

Data Bank: The National Practitioner Data Bank (NPDB) implemented pursuant to the HCQIA.

Days: Calendar days, unless otherwise noted.

Dentist: An individual, who has received a doctor of dental surgery or a doctor of dental medicine degree from a dentistry program accredited by the Commission on Dental Accreditation (CODA) and has a current, unrestricted license to practice dentistry.

Dependent Healthcare Professional: An individual who is permitted both by law and by the Hospital to provide patient care services under the direction or supervision of an independent practitioner, within the scope of the individual's license, and in accordance with individually granted clinical privileges if the dependent practitioner is an APP.⁵

Department: A clinical grouping of members of the Medical Staff in accordance with their specialty or major practice interest, as specified in these Bylaws.

⁴ MS.4.10, MS.4.20, MS.4.40

⁵ HCA, Ethics & Compliance Policy QM.002; 42 C.F.R. §482.12(c)(2)

Director of Medical Education: An osteopathic physician at an institution that has the authority and responsibility for oversight and administration of internship and residency programs.

Educational Commission for Foreign Medical Graduates (ECFMG): The ECFMG, through a series of exams, assesses whether physicians graduating from Medical schools outside the United States and Canada are ready to enter U.S. residency and fellowship programs that are accredited by the Accreditation Council for Graduates Medical Education (ACGME).

Ex Officio: Serves as a member of a body by virtue of an office or position held, and unless otherwise expressly provided, means without voting rights.

Fair Hearing Plan: The fair hearing plan as approved by the MEC and Board and incorporated into these Bylaws.

Federal Health Care Program: Any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government or a State health care program (with the exception of the Federal Employees Health Benefits Program).⁶ The most significant Federal health care programs are Medicare, Medicaid, Blue Cross Federal Employee Program (FEP)/Tricare/Champus and the Veterans programs.⁷

Fellow: A physician in an AOA approved subspecialty residency program that is beyond the requirements for eligibility for first board certification in the discipline and who are either registered with or licensed by the State of Florida.

Fifth Pathway: The Fifth Pathway permits qualifying students who have completed four years of medical training at the Universidad Autonoma de Guadalajara (UAG) to return to the United States and enter a year of supervised clinical training at a U.S. Medical School with an approved Fifth Pathway Program. This is offered as an alternative to ECFMG certification.

Good Standing: The term “good standing” means a Member who, during the current term of appointment, has maintained all qualifications for Medical Staff membership (provided, however that such Member shall be permitted to complete medical records within a reasonable time frame following treatment), the assigned staff category, and been granted clinical privileges granted to the individual, and has met meeting attendance, on-call and other participation requirements, is not in arrears in dues payment or the completion of medical records, and has not received a limitation, suspension, or restriction of Medical Staff membership or privileges.

Governing Body: The Board of Trustees of the Hospital, which has been delegated specific authority and responsibility, and appointed by the Board of Directors.

Graduate Medical Education (GME): The second phase of medical education which prepares physicians practice in a medical specialty. GME focuses on the development of clinical skills and professional competencies and on the acquisition of detailed factual knowledge in a medical specialty.

GSA List: The General Service Administration’s List of Parties Excluded from Federal Programs.⁸

HCQIA: The Health Care Quality Improvement Act of 1986, 42 U.S.C.S. §11101 et seq.

HIPPA: The Health Insurance Portability and Accountability Act of 1996, is a Federal Law at 45 C.F.R 160, 162, 164 which includes The Standards for Privacy of Individually Identifiable Health Information (“Privacy Standards”) developed to provide Federal Standards for the protection of health information that is used and disclosed by Hospitals, Healthcare Providers, Health Plans, Healthcare Clearing Houses (“Covered Entities”) and their “Business Associates”. The Privacy Standards provide certain rights to patients for the control of access to and disclosure of their personal protected health information. At the same time, the Privacy Standards establish obligations of Covered Entities for the protection of their patient’s health information. For purposes of meeting these obligations, the

⁶ Section 1128B(f) of the Social Security Act

⁷ HCA, Ethics & Compliance Policy QM.002

⁸ HCA, Ethics & Compliance Policy QM.002

Hospital has established an Organized Health Care Arrangement with its Medical Staff and Allied Health Professional Staff. Under this Arrangement, Medical Staff members and Allied Health Professionals who have not opted out of the Arrangement, in writing, have agreed to abide by Hospital policies and procedures related to the Hospital's legal responsibilities under the Privacy Standards.

Healthcare Professional: An individual licensed, certified, or registered by the State, or otherwise permitted, through virtue of completion of a course of study and possession of skills in a field of health, to provide health care to patients.

Hospital: Largo Medical Center Inc. d/b/a Largo Medical Center 201 14th Street Southwest, Largo Florida 33770. As the term is used in these Bylaws, it shall mean all of the facilities, services, and locations licensed or accredited as part of the Hospital, which is an organization inclusive of the Medical Staff.

House Staff: Includes Interns and Residents who are in a graduate training program that is approved by a nationally recognized accrediting body, approved by the U.S. Department of Education; and who are permitted to participate in patient care under the direction of an appointee of the Medical Staff and who are either registered with or licensed by the State of Florida. This definition excludes Externs or Clinical Clerks who are medical students.

Independent Healthcare Professional: An individual who is permitted by both the applicable state law(s) and by the Hospital to provide patient care services without direction or supervision, within the scope of the individual's license and in accordance with individually granted clinical privileges.⁹

Ineligible Person: Any individual who: (1) is currently excluded, suspended, debarred, or otherwise ineligible to participate in Federal health care programs; or (2) has been convicted of a criminal offense related to the provision of health care items or services but has not yet been excluded, debarred, or otherwise declared ineligible; or (3) is currently excluded on a state exclusion list.¹⁰

Intern: An intern is a graduate of a school of Osteopathic Medicine who is in the first year of postdoctoral training at an AOA accredited internship program.

License: An official or a legal permission, granted by a competent authority, usually public, to an individual to engage in a practice, an occupation or an activity otherwise unlawful.¹¹

License Status: Indicates the status of the practitioner's license, which is issued by the State licensure board. The most common status categories are:¹²

- active—full and unrestricted license to practice
- inactive—practitioner is not practicing, but reserves the right to activate their license in the future
- expired—no longer valid for use
- revoked—disciplinary action prohibits practice
- restricted—board imposed limitation on practice

Licensure: A legal right that is granted by a governmental agency in compliance with a statute governing the activities of a profession.¹³

Licensed Independent Practitioner (LIP): An individual who is permitted by both the applicable state law(s) and by the Hospital to provide patient care services without direction or supervision, within the scope of the individual's license and in accordance with individually granted clinical privileges. These are individuals who are designated by the State and by the Hospital to provide patient care independently. The Board has determined that the categories of individuals eligible for clinical

⁹ HCA, Ethics & Compliance Policy QM.002; 42 C.F.R. §482.12(c)(1); 42 C.F.R. §482.12(c)(4)

¹⁰ HCA, Ethics & Compliance Policy QM.002

¹¹ HCA, Ethics & Compliance Policy QM.002

¹² Federation of State Medical Boards, Consumer Guide to Using Physician Profiles, <http://www.fsmb.org/>

¹³ HCA, Ethics & Compliance Policy QM.002

privileges as a LIP are physicians (MD or DO), maxillofacial/oral surgeons (DMD), dentists (DDS), clinical psychologists (CP) and podiatrists (DPM).¹⁴

Medical Executive Committee (MEC): The Medical Executive Committee of the Medical Staff, unless otherwise specifically stated.

Medical Staff: The Medical Staff is the term referring to the Practitioners designated by the Board to be eligible for Medical Staff membership and who are credentialed and privileged to provide professional healthcare services. The Board has determined that the categories of Practitioners eligible for Medical Staff membership are physicians (MD or DO), maxillofacial/oral surgeons (DMD), dentists (DDS), clinical psychologists (CP) and podiatrists (DPM).

Medical Staff Office: The Hospital employee(s) or contractor assigned the responsibility for processing applications for Medical Staff appointments, reappointments, and requests for clinical privileges, and for maintaining documents related to the credentialing process. Medical Staff Office responsibilities are assigned by Administration and the Hospital employee(s)/contractor who works in the Medical Staff Office is accountable to Administration. The Medical Staff Office has the authority to delegate functions and to perform other duties if requested by the Administration or the Hospital. The term “Medical Staff Office” shall refer to the Medical Staff Office’s designee when the Medical Staff Office has delegated a particular task or function to the designee. The documents maintained by the Medical Staff Office are the property of the Hospital.

Medical Staff, Organized: The Organized Medical Staff is the body of those individuals who, as a group, are responsible for establishing the bylaws and rules and regulations, and policies for the Medical Staff at large and for overseeing the quality of care provided by all Medical Staff members. The Organized Medical Staff is limited to Practitioners who are Medical Staff Members in the Active category of membership and have therefore been granted the rights to vote, to be a member of a Medical Staff committee, and to hold office in the Organized Medical Staff.

Medical Staff Year: The period from May 1 to April 30 of each year.

Medical Student: An individual who is completing his/her third and fourth year of medical education.

Medico-Administrative Practitioner: A Practitioner who is under contract, employed by, or otherwise engaged by the Hospital on a full time or part time basis, whose responsibilities may be both administrative and, if permitted by State law, clinical in nature. Clinical duties may relate to direct medical care of patients and/or supervision of the professional activities of individuals under such Practitioner’s direction.

Member: A Practitioner who has been granted and maintains Medical Staff membership and whose membership is in good standing pursuant to these Bylaws.

Membership: The approval granted by the Board to a qualified Practitioner to be a member of the Medical Staff of the Hospital.

Non-Privileged Practitioner: Those individuals who are licensed to order specific tests and services but who are not medical staff members or practitioners with clinical privileges for practice within this Hospital.¹⁵

OIG Sanction Report: The HHS/OIG List of Excluded Individuals/Entities.¹⁶

Oromaxillofacial Surgeon Qualified: An individual who has successfully completed a postgraduate program in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation (CODA).¹⁷

Peer: An individual from the same discipline (for example, physician and physician, dentist and dentist) and with essentially equal qualifications.¹⁸

¹⁴ 42 C.F.R. §482.12(a)(1); 42 C.F.R. §482.12(c)(1)

¹⁵ HCA, Ethics & Compliance Policy QM.002

¹⁶ HCA, Ethics & Compliance Policy QM.002

¹⁷ Joint Commission Comprehensive Accreditation Manual for Hospitals (CAMH), Glossary

Peer Review: The concurrent or retrospective review of an individual's performance of clinical professional activities by peer(s) through formally adopted written procedures that provide for adequate notice and an opportunity for a hearing of the Healthcare Professional under review. With reference to Practitioners and Allied Health Professionals, written procedures for peer review are part of these Bylaws.

Physician: A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which the practitioner performs such function or action.

Podiatrist: A doctor of podiatric medicine legally authorized to practice podiatry by the State in which the practitioner performs such function or action.

Privileges: Authorization granted by the Board to an individual to provide specific patient care services in the Hospital within defined limits, based on the individual's license, education, training, experience, competence, health status, judgment, individual character, and performance.¹⁹

Qualified Medical Person or Personnel: In addition to a physician, Qualified Medical Persons may perform a Medical Screening Examination. Individuals who have demonstrated current competence in the performance of Medical Screening Examinations, and who are functioning within the scope of his or her license and policies of the Hospital, have been approved by the Board as Qualified Medical Personnel: Physician Assistants in the Emergency Room, Advanced Registered Nurse Practitioners (ARNP), Psychiatric Social Worker or Registered Nurse in Psychiatric Services.²⁰

Proctor/Proctoring: Clinical proctoring is an objective evaluation of a Practitioner's actual clinical competence by a monitor or proctor who represents the Medical Staff and is responsible to the Medical Staff.

Provisional Status: A physician's first year of Active Staff Category.

Registration: The process in which a person licensed to practice by a federal or state authority has such a license recorded or registered.²¹

Residency Program: The unit of specialty education, comprising a series of graduated learning experiences in GME, designed to conform to the program requirements of a particular specialty.

Resident: A physician at any level of GME in a program accredited by the American Osteopathic Association.

Rules and Regulations: The Rules and Regulations of the Medical Staff including those of its Departments as approved by the MEC and Board of Trustees.

Sponsoring Institution: The institution that assumes the ultimate responsibility for a program of GME.

Staff: Unless otherwise specifically stated, the Medical Staff of this Hospital.

State: The State in which the Hospital operates and is licensed to provide patient care services, which is Florida.

Supervising Physician: The teaching staff member who is responsible for supervising all clinical activities of a resident and/or medical student.

Supervision, Direct: By a supervising physician of a resident physician means to be physically present at the same general area with the ability to observe all or part of the procedure and to communicate with the resident.

¹⁸ MS.4.70

¹⁹ 42 C.F.R. §482.12(a)(6); MS.06.01.07

²⁰ Social Security Act, Section 1867, 42 U.S.C. 1395dd, Examination and Treatment for Emergency Medical Conditions and Women in Labor; HCA, Ethics & Compliance Policy, EMTALA – Medical Screening Examinations, LL.EM.001

²¹ HCA, Ethics & Compliance Policy QM.002

Supervision, Indirect: By a supervising physician of a resident physician means to be generally aware of the resident's activities or of the medical procedure, to be available to the resident physically or by telecommunication and to provide follow-up review of the resident's activities or of the medical procedure.

Teaching Faculty: Consists of Board Certified or Board eligible licensed physicians (DO or MD) who have been appointed by the Medical Education Committee of Largo Medical Center to teach, supervise and direct medical students (MS-3 and MS-4), Interns (PGY-1), Residents (PGY I-V) and Fellows.

Telemedicine: Medical practice is defined as any contact that results in a written or documented medical opinion and affects the medical diagnosis or medical treatment of a patient.²² Telemedicine is the practice of medicine through the use of electronic communication or other communication technologies to provide or support clinical care at a distance.²³ The Joint Commission and the American Telemedicine Association define telemedicine as the use of medical information exchanged from one site to another via electronic communications for the health and education of the patient or healthcare provider and for the purpose of improving patient care, treatment and services.²⁴

Unprofessional or Inappropriate Conduct: Conduct which adversely impacts the operation of the Hospital, affects the ability of others to get their jobs done, creates a "hostile work environment" for hospital employees or other individuals working in the Hospital, or begins to interfere with the individual's own ability to practice competently. Such conduct may include disruptive, rude or abusive behavior or comments to staff members or patients, negative comments to patients about other physicians, nurses or other staff or about their treatment in the Hospital, threats or physical assaults, sexual harassment, refusal to accept medical staff assignments, disruption of committee or departmental affairs, or inappropriate comments written in patient medical records or other official documents.

1.2. CONSTRUCTION OF TERMS AND HEADINGS

All pronouns and any variations thereof in these Bylaws and Rules and Regulations shall be deemed to refer to the masculine, feminine, or neuter, singular or plural, as the identity of the person or persons may require, unless the context clearly indicates otherwise.

²² Definition of the Federation of State Medical Boards

²³ MS.4.120– MS.4.130

²⁴ The Joint Commission Comprehensive Accreditation Manual for Hospitals, January 2005, page MS-29

2 ARTICLE TWO: NAME, PURPOSES & RESPONSIBILITIES

2.1 NAME

The name of the Medical Staff shall be the “Medical Staff of Largo Medical Center.

2.2 PURPOSES AND RESPONSIBILITIES

The purposes and responsibilities of the Medical Staff are:

- 2.2.1 To provide a formal organizational structure through which the Medical Staff shall carry out their responsibilities and govern the professional activities of its members and other individuals with clinical privileges, and to provide mechanisms for accountability of the Medical Staff to the Board. These Bylaws shall reflect the current organization and functions of the Medical Staff.²⁵
- 2.2.2 To provide patients with the quality of care that is commensurate with acceptable standards and available community resources;
- 2.2.3 To collaborate with the Hospital in providing for the uniform performance of patient care processes throughout the Hospital.²⁶
- 2.2.4 To serve as a primary means for accountability to the Board concerning professional performance of Practitioners and others with clinical privileges authorized to practice at the Hospital with regard to the quality and appropriateness of health care. This shall be provided through leadership and participation in the quality assessment, performance improvement, risk management, case management, utilization review and resource management, and other Hospital initiatives to measure and improve performance.²⁷
- 2.2.5 To provide mechanisms for recommending to the Board the appointment and reappointment of qualified Practitioners, and making recommendations regarding clinical privileges for qualified and competent Healthcare Professionals.
- 2.2.6 To provide education that will assist in maintaining patient care standards and encourage continuous advancement in professional knowledge and skills;
- 2.2.7 To adopt Rules and Regulations for the proper functioning of the Staff, and the integration and coordination of the Staff with the functions of the Hospital;
- 2.2.8 To provide a means for communication and conflict resolution with regard to issues of mutual concern to the Staff, Administration, and Board;²⁸
- 2.2.9 To participate in identifying community health needs and establishing appropriate institutional goals;²⁹
- 2.2.10 To assist the Board by serving as a professional review body in conducting professional review activities, which include, without limitation, quality assessment, performance improvement, and peer review.³⁰
- 2.2.11 To pursue corrective actions with respect to members of the Medical Staff or those individuals granted clinical privileges, when warranted.
- 2.2.12 To monitor and enforce compliance with these Bylaws, Rules and Regulations, and Hospital policies.
- 2.2.13 To maintain compliance of the Medical Staff with regard to applicable accreditation requirements and applicable Federal, State, and local laws and regulations.³¹

²⁵ MS.1.10, MS.1.20, 42 C.F.R. §482.22(b)(1), 42 C.F.R. §482.22(c)(3), 42 C.F.R. §482.12(a)(3)

²⁶ LD.3.20

²⁷ MS.1.10, MS.1.20, 42 C.F.R. §482.22(b)(1), 42 C.F.R. §482.22(c)(3)

²⁸ MS.1.20, MS.2.20, MS.2.30, LD.3.60

²⁹ LD.3.10, LD.3.30

³⁰ 42 C.F.R. §482.12(a)(5), MS.3.10, MS.4.90

2.3 Organized Health Care Arrangement; HIPAA Compliance.

2.3.1 The Hospital and all members of the Medical Staff shall be considered members of, and shall participate in, the Hospital's Organized Health Care Arrangement ("OHCA") formed for the purpose of implementing and complying with the Standards for Privacy of Individually Identifiable Health Information promulgated by the U.S. Department of Health and Human Services pursuant to the Administrative Simplification provisions of HIPAA. An OHCA is a clinically integrated care setting in which individuals typically receive health care from more than one healthcare provider. An OHCA allows the Hospital to share information with the Physicians and the Physicians' offices for purposes of payment and practice operations. The patient will receive one Notice of Privacy Practices during the Hospital's registration or admissions process, which shall include information about the Organized Health Care Arrangement with the Medical Staff, Physicians, Advanced Practice Professionals with clinical privileges or practice prerogatives and Dependent Healthcare Professionals. Each Medical Staff member, each Physician with temporary privileges, Advanced Practice Professional with clinical privileges or practice prerogatives and Dependent Healthcare Professional agrees to comply with the Hospital's policies as adopted from time to time regarding the use and disclosure of individually identifiable health information ("IIHI") and protected health information ("PHI"), as those terms are defined by HIPAA or as any similar terms are defined by more stringent state law (collectively, "IIHI/PHI").³²

³¹LD.1.30, 42 C.F.R. §482.11(a)

³²45 C.F.R. §164.501

3. ARTICLE THREE: APPOINTMENT/REAPPOINTMENT

3.1 NATURE OF MEMBERSHIP AND GENERAL QUALIFICATIONS

The Medical Staff includes fully licensed Physicians and other Practitioners permitted by law and by the Hospital to provide patient care independently within the Hospital, and whom the Board appoints.³³ Staff membership is a privilege extended by the Hospital, and not a right of any Physician, Practitioner or other person. Membership and/or the permission to exercise clinical privileges shall be extended only to individuals who continuously meet the requirements of these Bylaws.

3.1.1 Patients may be admitted to the Hospital only on the orders of a physician (MD/DO) or categories of licensed independent practitioners as noted in section 3.1.1.1. All Hospital patients must be under the care of a member of the Medical Staff or under the care of a practitioner who shall be directly under the supervision of a member of the Medical Staff. All patient care shall be provided by or in accordance with the orders of a practitioner who meets the Medical Staff criteria and procedures for the privileges granted, who shall have been granted privileges in accordance with those criteria by the Board of Trustees, and who shall be working within the scope of those granted privileges.³⁴

3.1.1.1 Patients admitted by licensed independent practitioners who are not physicians but are one of the following; a maxillofacial/oral surgeon (DMD), a dentist (DDS), a podiatrist (DPM) or a clinical psychologist who can admit only to a separate and distinct psychiatric unit, shall be under the care of a physician with respect to any medical or psychiatric problem that is present on admission or develops during hospitalization that is outside the scope of practice of the admitting practitioner.³⁵

Appointment to the Staff or granting of clinical privileges shall confer on the individual only such prerogatives of membership that are granted by the Board based on their approval of the individual's Staff category or as are afforded to APPs when clinical privileges are granted to an individual in this category. For purposes of these Bylaws, "membership in" is used synonymously with "appointment to" the Staff. The granting of membership or approval of appointment does not automatically confer clinical privileges. The Board has determined the categories of healthcare professionals eligible for Staff membership and/or clinical privileges, as defined in these Bylaws.³⁶ The Hospital-specific mechanism for appointment, reappointment, and for granting, renewing, or revising clinical privileges is fully documented in these Bylaws,³⁷ and has been approved and implemented by the Medical Staff and the Board.³⁸ All Medical Staff members and individuals with clinical privileges are subject to these Bylaws and Rules and Regulations.³⁹ Only those individuals possessing all of the following qualifications shall be eligible for appointment to the Staff or clinical privileges, and these professional criteria shall apply uniformly to all applicants:⁴⁰

3.1.2 LICENSURE

The applicant must possess a current, active (as defined in these Bylaws) license in the State of Florida for the practice of medicine, dentistry, podiatry or an allied health practice. The applicant shall also be required to provide information related to any current or past licensure as a healthcare professional in any other States.⁴¹

3.1.3 CONTROLLED SUBSTANCE REGISTRATION

³³ MS.1.10, 42 C.F.R. §482.22(a)

³⁴ 42 C.F.R. §482.12(a)(5), Interpretive Guidelines

³⁵ 42 C.F.R. §482.12(c)(4)

³⁶ 42 C.F.R. §482.12(a)(1)

³⁷ MS.1.20

³⁸ MS.1.20

³⁹ MS.1.20, MS.1.30, MS.4.20, MS.4.40

⁴⁰ MS.4.10, MS.4.20, MS.4.40

⁴¹ MS.4.20, 42 C.F.R. §482.11(c), 42 C.F.R. §482.22(c)(4)

To have prescribing privileges for controlled substances, the applicant must possess a current Federal Drug Enforcement Administration (DEA) registration. Prescribing privileges shall be limited to the classes of drugs granted to the applicant by the DEA and may be further limited by the Medical Staff through the delineation of medication prescribing privileges based on the scope of practice and current competence of the applicant.⁴²

3.1.4 PROFESSIONAL EDUCATION AND TRAINING

The applicant must have graduated from an accredited School of Medicine, Dentistry, Podiatry, or school appropriate to their profession. If the applicant is a physician who is a foreign medical graduate, he/she must have successfully completed the Education Commission for Foreign Medical Graduate (ECFMG) verification of graduation from a foreign medical school, and/or Fifth Pathway. An applicant Practitioner must also have successfully completed a residency and or fellowship program in the field of specialty for which the Practitioner requests clinical privileges and shall be board certified, or actively pursuing board certification for his/her specialty, or comparably qualified as determined by the Medical Executive Committee.⁴³ Unless the applicant is found to be comparably qualified under this section, Board certification must be accomplished within a three year period upon appointment of medical staff membership. If the applicant for appointment or the appointee fails to accomplish board certification within a three year period, the applicant/appointee's appointment to the Medical Staff and clinical privileges shall automatically terminate without any procedural rights afforded under Article VII. The Medical Executive Committee and the Board may grant a waiver to criteria as defined in 3.1.4.1. At the time of reappointment to the Medical Staff or renewal or revision of clinical privileges, the applicant shall document his/her participation in continuing education as related to the clinical privileges requested. Participation in continuing education shall be considered when making decisions about clinical privileges.⁴⁴ An applicant Practitioner shall demonstrate current Board Certification by a Hospital accepted specialty Board or provide proof of active pursuit of board certification. Physician specialty board certification programs accepted by the Hospital are those of the approved Member Boards of American Board of Medical Specialties (ABMS), or the certifying boards of the American Osteopathic Association (AOA). For podiatrists, the board certification program accepted by the Hospital is the American Board of Podiatric Surgery (ABPS) and for dentists the board certification program accepted by the Hospital is the American Board of Oral/Maxillofacial Surgeons (ABOMS)

3.1.4.1 WAIVER OF CRITERIA

(a) Any individual who does not satisfy one or more of the criteria outlined above may request that it be waived. The individual requesting the waiver bears the burden of demonstrating exceptional circumstances, and that his or her qualifications are equivalent to, or exceed, the criterion in question.

(b) A request for a waiver will be submitted to the relevant Credentials Committee for consideration. In reviewing the request for a waiver, the Credentials Committee may consider the specific qualifications of the individual in question, input from the relevant Department Chairman, and the best interests of the Hospital and the communities it serves. Additionally, the Credentials Committee may, in its discretion, consider the application form and other information supplied by the applicant. The Hospital Credentials Committee recommendation will be forwarded to the Medical Executive Committee and the Board of Trustees. Any recommendation to grant a waiver must include the basis for such.

⁴² MS.4.20

⁴³ MS.4.10, 42 C.F.R. §482.12(a)(6), 42 C.F.R. §482.22(c)(4)

⁴⁴ MS.5.10,

(c) The Board of Trustees will review the recommendation of the MEC and determine whether to grant a waiver.

(d) No individual is entitled to a waiver or to a hearing solely because the Board of Trustees determines not to grant a waiver. A determination that an individual is not entitled to a waiver is not a "denial" of membership or clinical privileges.

(e) The granting of a waiver in a particular case is not intended to set a precedent for any other individual or group of individuals.

(f) An application for membership that does not satisfy an eligibility criterion will not be processed until the Board of Trustees has determined that a waiver should be granted following this procedure.

3.1.5 CURRENT COMPETENCE, EXPERIENCE AND JUDGMENT

The applicant must document his/her current clinical competence, experience and judgment with sufficient adequacy, as determined at the discretion of the Medical Executive Committee and the Board, to demonstrate that patients receiving healthcare services from him/her will receive care of the generally recognized professional level of quality and efficiency established by the Hospital.⁴⁵ Evidence of current competence and experience shall include, but shall not be limited to, continuing medical education, responses to related questions provided in information from training programs, peers, and other facility affiliations. In the case of an applicant for reappointment, evidence of current competence and experience shall also include, but not be limited to, documentation of continuing medical education, the results of performance improvement and peer review, and recommendation(s) provided by Department Chairperson(s).⁴⁶

3.1.6 CONDUCT/BEHAVIOR

The applicant must be able to demonstrate the ability to work cooperatively with others and to treat others within the Hospital with respect. Evidence of ability to display appropriate conduct and behavior shall include, but shall not be limited to, responses to related questions provided in information from training programs, peers, and other facility affiliations. In the case of an applicant for reappointment, evidence of ability to display appropriate conduct and behavior shall also include, but not be limited to, a review of conduct during the previous term(s) of appointment and recommendation(s) provided by Department Chairperson(s).

3.1.7 PROFESSIONAL ETHICS AND CHARACTER

By virtue of applying for medical staff membership or clinical privileges, and agreeing to abide by the medical staff bylaws, the applicant shall be bound to adherence to the code of ethics of his/her professional discipline (e.g., the Principles of Medical Ethics of the American Medical Association, the American Osteopathic Association, the Code of Ethics of the American Dental Association, the Code of Ethics of the American Podiatry Association, or the ethical standards governing the applicant's practice if it is not listed). The applicant shall also agree to abide by applicable provisions of the Code of Conduct of HCA, and the code of ethical business and professional behavior of this Hospital unless in conflict with general community standards.

3.1.8 HEALTH STATUS/ABILITY TO PERFORM

The applicant shall possess the ability to perform the clinical privileges requested. In the event that the applicant has a physical or mental health issue that adversely affects his/her ability to practice within the clinical privileges requested, the applicant shall notify the Chief of Staff.

⁴⁵ MS.4.10, MS.4.20, MS.4.40, 42 C.F.R. §482.12(a)(6), 42 C.F.R. §482.22(c)(4)

⁴⁶ MS.4.10, MS.4.20, 42 C.F.R. §482.12(a)(6)

Upon receipt of such notification, the Chief of Staff will meet with the applicant to determine the extent of the health issue. If it is determined that the health issue does not adversely affect the applicant's ability to perform the essential functions of the clinical privileges requested, the Chief of Staff and applicant will discuss whether there is a reasonable accommodation that would enable the applicant to perform such functions. If reasonable accommodation is necessary, the Hospital will provide such accommodation to the extent required by law, or if not so required, as determined to be appropriate within the sole discretion of the Hospital unless in conflict with general community standards.

3.1.9 COMMUNICATION SKILLS

The applicant shall possess an ability to communicate in English in an understandable manner sufficient for the safe delivery of patient care (as determined in the sole discretion of the Hospital), both verbally and in writing. Hospital records, including patients' medical records, shall be recorded in a legible fashion, in English.

3.1.10 PROFESSIONAL LIABILITY INSURANCE

The applicant shall maintain professional liability insurance coverage as outlined by the state of Florida.

3.1.11 ELIGIBILITY TO PARTICIPATE IN FEDERAL PROGRAMS

The individual shall not currently be an Ineligible Person and shall not become an Ineligible Person in any state or federal program.

3.2 HOSPITAL NEED AND ABILITY TO ACCOMMODATE

No person shall be appointed to the Staff or shall be granted clinical privileges if the Hospital is unable to provide adequate facilities and support services for the applicant or his/her patients. The Board may decline to accept, or have the Staff review requests for Staff membership and/or particular clinical privileges in connection with appointment, reappointment or otherwise on the basis of the following:

3.2.1 AVAILABILITY OF FACILITIES/SUPPORT SERVICES

Clinical privileges shall be granted only for the provision of care that is within the scope of services, capacity, capabilities, and business plan of the Hospital.

3.2.3 EXCLUSIVE CONTRACTS

The Board may determine after consultation with the Medical Executive Committee, in the interests of quality of patient care and as a matter of policy, that certain Hospital clinical facilities may be used only on an exclusive basis in accordance with written contracts between the Hospital and qualified Practitioners.

3.2.4 MEDICAL STAFF DEVELOPMENT PLAN

The Board may decline to accept new applications based on the requirements or limitations in the Hospital's Medical Staff development plan which shall be based on identification by the Hospital of the patient care needs within the population served.⁴⁷ This shall be applied consistently in like specialties from that point forward. If the Board after consultation with the Medical Executive Committee determines that it is in the best interest of patient care to open the specialty for new applicants, prior applicants will be given first option to apply.

3.2.4 EFFECTS OF DECLINATION

Refusal to accept or review requests for Staff membership or clinical privileges based upon Hospital need and ability to accommodate, as described in this section, shall not constitute a denial of Staff membership or clinical privileges and shall not entitle the individual to any procedural rights of hearing or appeal. Any portion of the application which is accepted (e.g.,

⁴⁷ MS.4.10, MS.4.20, MS.4.40

requests for clinical privileges that are not subject to a limitation) shall be processed in accord with these Bylaws.

3.3 EFFECTS OF OTHER AFFILIATIONS

No person shall be automatically entitled to Staff membership or to the exercise of clinical privileges merely because he/she is licensed to practice within his/her healthcare profession, is a member of any professional organization, is certified by any board, or has/had staff membership or clinical privileges in another hospital or health care organization.⁴⁸

3.4 NONDISCRIMINATION

No person shall be denied appointment or clinical privileges on the basis of race, creed, color, religion, gender, sexual orientation, gender identity/expression, disability, age, veteran status, political belief or affiliation, ancestry, or national or ethnic origin.⁴⁹

3.5 BASIC OBLIGATIONS ACCOMPANYING STAFF APPOINTMENT AND/OR THE GRANTING OF CLINICAL PRIVILEGES

By submitting an application for Staff membership and/or a request for clinical privileges, the applicant signifies agreement to fulfill the following obligations of holding Staff membership and/or clinical privileges. The applicant shall agree to:

- 3.5.1 Appear for any requested interviews regarding his/her application, or subsequent to appointment or the granting of clinical privileges, to appear for any requested interviews related to questions regarding the applicant's performance;
- 3.5.2 Provide continuous care to his/her patients⁵⁰ at the generally recognized professional level of quality and efficiency established by the Hospital; delegate in his/her absence, the responsibility for diagnosis and/or care of his/her patients only to a Practitioner who is a member in good standing of the Medical Staff and who is qualified and approved by the Hospital to undertake this responsibility by the granting of appropriate clinical privileges; and seek consultation whenever necessary, and in accordance with the consultation policies of the Medical Staff;
- 3.5.3 Abide by these Bylaws, the Rules and Regulations, and all other rules, policies and procedures, guidelines, and other requirements of the Medical Staff and the Hospital;
- 3.5.4 Abide by all local, State and Federal laws and regulations, The Joint Commission standards, and State licensure and professional review regulations and standards, as applicable to the applicant's professional practice;
- 3.5.5 Regularly attend meetings of the Medical Staff unless excused.
- 3.5.6 Discharge such Medical Staff, Department, Committee, and Hospital functions for which he/she is responsible based upon appointment, election, or otherwise, including as appropriate, providing on-call coverage for emergency care services within his/her clinical specialty, as required by the Medical Staff;
- 3.5.7 Participate in necessary training and utilize the electronic record systems or other technology in use by the Hospital to prepare a patient record for each patient, and prepare and complete in a timely, legible manner the medical and other required records for all patients for whom he/she provides care in the Hospital;
- 3.5.8 Cooperate with the Hospital in matters involving its fiscal responsibilities and policies, including those relating to payment or reimbursement by governmental and third party payers;

⁴⁸ 42 C.F.R. §482.12(a)(7)

⁴⁹ LD.1.30

⁵⁰ MS.2.10

- 3.5.9 Participate in peer review, quality assessment, performance improvement, risk management, case management/resource management, and other review and improvement activities as requested;
- 3.5.10 Participate in continuing education to maintain clinical skills and current competence.⁵¹
- 3.5.11 Notify and update the Medical Staff and Hospital immediately [“immediately” defined as within two business days of being notified of a change] upon a change in any qualifications for membership or clinical privileges, as listed in Article Three of these Bylaws or in any Rules and Regulations outlining criteria for clinical privileges (including but not limited to becoming an Ineligible Person, if become an ineligible Person must notify the Hospital within one business day);
- 3.5.12 Agree that the Hospital may obtain an evaluation of the applicant’s performance by a consultant selected by the Hospital if the Hospital considers it appropriate; and,
- 3.5.13 Perform such other responsibilities as the Hospital or the Medical Staff may require.

3.6 TERMS OF APPOINTMENT

Initial appointments and initial granting of clinical privileges shall be for a period of one year (12 months), and subject to extension for a total period not to exceed two years (24 months).⁵² Reappointments shall be for a period not to exceed two years (24 months).⁵³ In the event that reappointment has not occurred due to lack of submission of a complete application prior to the expiration of the current term of appointment, the membership and clinical privileges of the individual will be considered to have been voluntarily surrendered. In such case the individual shall be notified of the expiration of the term of membership and/or clinical privileges and the need to submit a new application if continued membership or clinical privileges are desired. Voluntary surrender of membership and/or clinical privileges shall not entitle the individual to a fair hearing and appeal.

3.7 CREDENTIALS VERIFICATION

3.7.1 APPLICATION

A separate credentials record shall be maintained for each potential applicant for Staff membership or clinical privileges.⁵⁴ Each Request for Consideration (RFC) or Recredentialing Request for Consideration (R-RFC) for Staff appointment, reappointment, and/or clinical privileges shall be in a prescribed format, and signed by the applicant. When an individual seeks to apply for initial appointment or is initially requesting clinical privileges, he/she shall be asked to complete a RFC. When a completed RFC is received, the information shall be verified by a HCA Credentials Processing Center (CPC) to determine whether the individual is eligible to apply.⁵⁵ Prior to expiration of the current term of membership or clinical privileges for an individual who is a Member of the Medical Staff or who currently holds clinical privileges, the individual should be notified of the impending expiration and asked to complete a R-RFC. When a completed R-RFC is received, the information shall be verified by a HCA Credentials Processing Center (CPC) to determine whether the individual is eligible to reapply.

3.7.2 BURDEN ON APPLICANT TO PROVIDE A COMPLETE APPLICATION

The potential applicant or applicant for appointment, reappointment, and/or clinical privileges shall have the burden of producing adequate information for a proper evaluation of his/her qualifications for membership or clinical privileges. It shall be the responsibility of the applicant to ensure that any required information from his/her training programs, peer references, or other

⁵¹ MS.5.10

⁵² MS.4.20

⁵³ MS.4.20

⁵⁴ 42 C.F.R. §482.22(a)(2), Guidance to Surveyors

⁵⁵ LD.03.04.01

facilities is submitted directly to the HCA Credentials Processing Center by such sources. The HCA Credentials Processing Center (CPC) shall not have any obligation to process any RFC or R-RFC unless it is complete, after a seventy-five day time limit, determine that there has been failure to comply and end efforts to process the RFC or R-RFC. Only after a completed RFC or R-RFC has been received and all information verified, and the individual has been deemed eligible to apply, shall the CPC submit the information to the Hospital as an application. The Hospital shall analyze the information and determine whether additional information or investigation is needed to resolve any doubts, concerns, or gaps in the information. The applicant shall provide accurate, up-to-date information, and shall be responsible for ensuring that all supporting information and verifications are provided, as requested. The applicant shall be responsible for resolving any doubts regarding the application. If during the processing of the application the Hospital or the Medical Staff or any committee or representative thereof, determines that additional information or verification, or an interview with the applicant is needed, further processing of the application may be stayed and the application may not be considered complete until such additional information or verification is received, or the interview is conducted. Any Medical Staff committee or the Board may request that the applicant appear for an interview with regard to the application. Should the Medical Staff Services determine that an application is incomplete, the Medical Staff Services shall notify the applicant in writing by special notice of the specific missing information being requested, the time frame within which a response is required, and the effect on the application if the information is not received timely. Neither the Medical Staff nor the Board shall have any obligation to review or consider any application until it is complete, as defined in these Bylaws. Failure to provide a complete application, or failure to appear for any requested interview, shall be deemed a voluntary withdrawal from the application process. Voluntary withdrawal from the application process shall not be considered an adverse action, and shall not entitle the applicant to exercise procedural rights outlined in these Bylaws in the event of such withdrawal. The Medical Staff Services shall provide special notice to an individual regarding his/her withdrawal from the application process due to lack of requested information or failure to appear for an interview. The completed application shall include, without limitation:

- 3.7.2.1 Identifying information, including full name, social security number, date of birth, any aliases, and addresses of office & residence, and any other information required to verify identification or background. Verification of identity may be performed by a current/licensed notary public and documented with a notarized statement, or verification may be performed by the staff of the Medical Staff Services Office provided that the applicant physically presents himself/herself for the verification process before the application may be considered complete;
- 3.7.2.2 For new applicants, evidence of citizenship in the United States of America (e.g., birth certificate showing place of birth in this country, naturalization papers, or USA passport), or evidence that the applicant is in the USA legally and has the required permission(s) to work in this country. For applicants who are not USA citizens who are requesting reappointment or renewal of privileges, evidence of a current visa and current work permit shall be required. The requirements of this section do not apply to an applicant who is residing and working from a foreign country (i.e., a foreign-based telemedicine practitioner) because the immigration laws of the USA do not check;
- 3.7.2.3 For a new applicant, written permission for background check, and submission of any fees associated with processing a background check;
- 3.7.2.4 Evidence of current licensure in the State of Florida and information from the applicant regarding any current or past licensure in any healthcare profession or in any other state or other jurisdiction;⁵⁶

⁵⁶ MS.4.10, MS.4.20, MS.4.40, 42 C.F.R. §482.22(a)(2), Guidance to Surveyors, HCA Requirement

- 3.7.2.5 For applicants requesting medication prescribing privileges, evidence of a Federal DEA listing an in-state address, and evidence of a state controlled substance registration, if applicable;
- 3.7.2.6 For a new appointment, the names and addresses of educational institutions, and dates of attendance, for undergraduate and postgraduate education, including professional degrees earned, or in the case of a foreign graduate, ECFMG certificate and/or Fifth Pathway;⁵⁷
- 3.7.2.7 For applicants for appointment who are not newly graduated from residency or fellowship program within the last year, and for applicants for reappointments or renewal of clinical privileges, the applicant's participation in continuing education, specifically as related to the clinical privileges requested;
- 3.7.2.8 The names of at least two peers who will provide a written evaluation of the applicants' medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, professionalism, and ability to perform the clinical privileges requested. The peer shall be someone with current knowledge of the applicant who can provide an unbiased appraisal;
- 3.7.2.9 Information regarding specialty board certification, if any, including the name of the specialty board(s), and dates of certification;
- 3.7.2.10 Information regarding all current and all past healthcare facility affiliations, including the name and address of the facility(s) and dates of affiliation;⁵⁸
- 3.7.2.11 Evidence of current professional liability insurance, including the name of the carrier, amount and dates of coverage, and professional practice covered;
- 3.7.2.12 National Provider Identifier (NPI) for the individual provider (e.g. not a NPI for a group practice);
- 3.7.2.13 Information as to any current, or pending sanctions affecting participation in any Federal Health Care Program, or any actions which might cause the applicant to become an Ineligible Person, as well as any sanctions from a professional review organization;⁵⁹
- 3.7.2.14 Accurate and complete disclosure with regard to the following queries:
 - 3.7.2.14.1 Whether the applicant's professional license or controlled substance registration (DEA, state or local), in any jurisdiction, has ever been disciplined, restricted, revoked, suspended, or surrendered, or whether such action is currently pending, or whether the applicant has voluntarily or involuntarily relinquished such licensure or registration in any jurisdiction;⁶⁰
 - 3.7.2.14.2 Whether the applicant has had any voluntary or involuntary termination of Medical Staff membership, or voluntary or involuntary limitation, reduction, loss, or denial of clinical privileges at another Hospital or other healthcare facility in which you have applied and have been granted privileges;⁶¹

⁵⁷ MS.4.10, MS.4.20, MS.4.40, Intent, 42 C.F.R. §482.22(a)(2)

⁵⁸ MS.4.10

⁵⁹ HCA, Ethics & Compliance Policy QM.002

⁶⁰ MS.4.20

⁶¹ MS.4.20

- 3.7.2.14.3 Whether the applicant has had any notification of, or any involvement in a professional liability action, including any final judgments or settlements involving the applicant; and,⁶²
- 3.7.2.14.4 Whether the applicant has ever been subject to criminal action, as defined in these Bylaws, or whether any such action is pending.
- 3.7.2.15 A statement from the applicant that he/she agrees to abide by the ethical code and standards governing his/her profession;
- 3.7.2.16 A statement from the applicant that his/her health status is such that he/she has the ability to perform the clinical privileges that he/she is requesting, pursuant to Article Three, Section 3.1.8;⁶³
- 3.7.2.17 Evidence that the applicant has complied with hospital health screening requirements.
- 3.7.2.18 A statement from the applicant that he/she has received and read the current Staff Bylaws, Rules and Regulations, and policies and agrees to be bound by them, including any future Bylaws, Rules and Regulations and policies which may be duly adopted;⁶⁴
- 3.7.2.19 A pledge from the applicant to provide continuous care to his/her patients, as defined in these Bylaws;
- 3.7.2.20 A statement from the applicant consenting to the release and inspection of all records or other documents that may be material to an evaluation of his/her professional qualifications, including all health information and medical records necessary to verify the applicant's health status as required by Section 3.1.8, and for a new applicant a permission to conduct a background check, and a statement providing immunity and release from civil liability for all individuals requesting or providing information relative to the applicant's professional qualifications or background, or evaluating and making judgments regarding such qualifications or background.⁶⁵
- 3.7.2.21 A statement from the applicant agreeing that in the event of an adverse action concerning his/her Staff membership or clinical privileges, he/she will exhaust all remedies afforded by these Bylaws before resorting to formal legal action or commencing legal proceedings.
- 3.7.2.22 In the case of applicants for initial appointment to the Medical Staff, a signed Medicare Acknowledgement Statement.
- 3.7.2.23 All physicians and other practitioners shall submit a signed Physician Acknowledgement Statement. The physician or other practitioner must complete the acknowledgement at the time he or she is granted admitting privileges at the hospital or before or at the time the physician admits his or her first patient to the hospital (i.e., when temporary privileges have been granted). Existing acknowledgements signed by physicians already on staff remain in effect as long as the physician has admitting privilege at the hospital. Physicians, other Practitioners, and Advanced Practice Professionals will also sign a confidentiality and Security Agreement at the time of application for initial appointment and periodically as such Agreement may be revised, and shall agree that as a condition of membership or holding clinical privileges, the individual

⁶² MS.4.20

⁶³ MS.4.10, 42 C.F.R. §482.22(c)(4)

⁶⁴ LD.3.60

⁶⁵ MS.5.10.1

shall abide by the privacy and confidentiality policies of the Hospital. Completed Agreements will be maintained in the individuals credentials file.

3.7.2.24 Unless the applicant is applying for medical staff membership only, all applications must include a specific written request for clinical privileges using prescribed forms.⁶⁶ Requests for clinical privileges shall not be complete unless the request includes supporting evidence of competence for each of the privileges requested outside of Core and proof that the applicant meets the criteria for each of the privileges requested.

3.7.2.25 As a condition of consideration for initial appointment to the Medical Staff, every applicant shall specifically agree to immediately provide (within two business day of being officially notified of a change in status) to the Medical Staff and the Hospital, with or without request, any new or updated information that is pertinent to the individual's professional qualifications or any question on the application form, including but not limited to any change in Federal Health Care Program Ineligible Person status, any exclusion from a State Program, any change in licensure in any state, any change in DEA status or status with a State controlled substance regulatory agency, or any exclusion or other sanctions imposed or recommended by the Federal Department of Health and Human Services or any state, the receipt of a QIO citation, any change in legal status to reside and/or work in the USA, any investigation by an ABMS or AOA specialty board, any change in health status, any change in location of office or residence, any criminal investigation, and/or a quality denial letter concerning alleged quality problems in patient care.

3.7.3 VERIFICATION PROCESS

Upon the receipt of a completed application form from a Physician or Allied Health Professional, the Medical Staff Office in conjunction with the Central Processing Center shall arrange to verify the qualifications and obtain supporting information relative to the application. The Medical Staff Office shall consult primary sources of information about the applicant's credentials, where feasible.⁶⁷ Verifications of licensure, controlled substance registration, the query of the NPDB, and queries of the OIG and GSA lists shall be done within 120 days prior to the Board receiving the application; if there are delays in completing the application that are caused by the Physician or Allied Health Professional, any of these verifications that were done more than 120 days before the Board receives the application shall be repeated. Verification may be made by a letter or computer printout obtained from the primary source or it may be verbally or electronically transmitted (e.g., telephone, facsimile, email, Internet) information when the means of transmittal is directly from the primary source to the Hospital and the verification is documented. If the primary source has designated another organization as its agent in providing information to verify credentials, the Hospital may use this other organization as the designated equivalent source.⁶⁸ The Medical Staff Office shall promptly notify the applicant of any problems in obtaining required information. Any action on an application shall be withheld until the application is completed; meaning that all information has been provided and verified, as defined in these Bylaws.⁶⁹ The following information shall be verified for all applicants for appointment, and\ or clinical privileges, except as specified:

3.7.3.1 Current licensure shall be verified in all states in which the applicant currently holds a license, including the State of Florida through the applicable state licensure boards for all applicants. For new applicants, current and past licensure

⁶⁶ 42 C.F.R. §482.22(a)(2)

⁶⁷ MS.4.10

⁶⁸ MS.4.10

⁶⁹ MS.4.10, MS.4.20, MS.4.40

- in other states shall also be verified through those applicable state licensure boards.⁷⁰
- 3.7.3.2 For individuals requesting prescribing privileges, federal DEA registration shall be verified through the US Department of Commerce, National Technical Information Service's electronic verification mechanism.
- 3.7.3.3 For new applicants, completion of medical school or other post-graduate programs appropriate to the applicant's healthcare profession shall be verified through the school's registrar's office, or the National Student Clearinghouse if designated by the school to provide degree verification, and/or through the ECFMG in the case of a foreign medical school graduate.⁷¹ The American Medical Association (AMA) profile, the American Osteopathic Association (AOA) profile and/or the Federation Credentials Verification Service (FCVS) profile may be used as a secondary source of information only when it is not possible to obtain information from primary source.
- 3.7.3.4 For new applicants, their internship, residency, or other applicable postgraduate training shall be verified through the program's registrar's office or program director's office or via AMA, AOA, as secondary source.⁷²
- 3.7.3.5 For new applicants, a background check shall be obtained. The background check shall be used in part to verify that the individual requesting approval is the same individual identified in the credentialing documents.⁷³
- 3.7.3.6 Information reported pursuant to the HCQIA shall be obtained from the National Practitioner Data Bank.⁷⁴
- 3.7.3.7 The OIG Sanction Report, the GSA List, and the State Exclusion List, if any, shall be checked to ensure that the applicant is not listed.⁷⁵
- 3.7.3.8 Professional liability insurance shall be verified through the insurance carrier.
- 3.7.3.9 Data and information regarding professional performance shall be requested from available sources:
- 3.7.3.9.1 Relevant applicant-specific data as compared to aggregate data;
- 3.7.3.9.2 Morbidity and mortality data.⁷⁶
- 3.7.3.10 The applicant's health status as applicable to their ability to perform the clinical privileges requested shall be verified in accordance with Article Three, Section 3.1.8, and as part of information requested from the applicant's peers.⁷⁷
- 3.7.3.11 Letters from the applicant's peers shall be obtained. Two peer letters of reference shall be required for initial applicants.⁷⁸ Peer recommendations shall include written information regarding the applicant's current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism.
- 3.7.3.12 Specialty board certification shall be verified through consultation with the American Board Medical Specialties (ABMS), the American Osteopathic

⁷⁰ MS.4.10, MS.4.20, MS.4.40, 42 C.F.R. §482.22(a)(2)

⁷¹ MS.4.10, MS.4.20, MS.4.40, 42 C.F.R. §482.22(a)(2)

⁷² MS.4.10, MS.4.20, MS.4.40, 42 C.F.R. §482.22(a)(2)

⁷³ MS.4.10 (3)

⁷⁴ 42 U.S.C §11135, 45 C.F.R §60.10

⁷⁵ HCA, Ethics & Compliance Policy QM.002

⁷⁶ MS.4.20; MS.4.40

⁷⁷ MS.4.10, MS.4.20, MS.4.40

⁷⁸ MS.4.10, MS.4.20, MS.4.40, MS.4.70, 42 C.F.R. §482.22(a)(2)

Association (AOA), the American Board of Podiatric Surgery (ABPS) and the American Board of Oral/Maxillofacial Surgeons (ABOMS),

- 3.7.3.13 With regard to new applicants for Staff membership or clinical privileges, evidence of qualifications and competence shall be verified through correspondence with the Medical Staff offices of other facilities where the applicant is affiliated.⁷⁹

3.7.4 APPLICATION PROCESSING

After verification is accomplished and the application is fully complete it shall be reviewed and processed as follows:⁸⁰

- 3.7.4.1 Department Report: The Medical Staff Services Office shall make available the application and all supporting materials to the Chairperson of each Department in which the applicant seeks privileges, and request the documented evaluation and recommendations as to the staff category, in the case of applicants for Staff membership, the Department to be assigned and the clinical privileges to be granted, and any concerns regarding the clinical privileges requested.⁸¹ In the event that the applicant is the Department Chairperson, the Chief of Staff or the Department Vice-chairperson shall make the evaluation and recommendations. Following the Department and/or Vice-Department Chairperson(s)' evaluation and recommendations, the report shall then be transmitted to the Credentials Committee. The time frame for completion of the Department report(s) shall be within 30 days of receipt of a complete application.⁸²

- 3.7.4.1.1 Credentials Committee Report: The Credentials Committee shall receive from the Department Chairperson and review the application, supporting materials, the report of the Department Chairperson, and any such other available information as may be relevant to the applicant's qualifications. The Credentials Committee shall prepare a written report and recommendations for the Medical Executive Committee as to Staff appointment and staff category in the case of applicants for Staff membership, the Department/Division to be assigned, the clinical privileges to be granted, and any special conditions to be placed on the clinical privileges to be granted. In the event there are any adverse recommendations, the reasons shall be stated. The time frame for completion of the Credentials Committee action shall be at the next regular meeting of the committee following receipt of the Department report, to be within 30 days. In the event there is no Credentials Committee quorum then the review is performed by the Medical Executive Committee.

- 3.7.4.2 Criteria for Additional Inquiry: Additional inquiry shall be conducted by the Department Chairperson, Credentials Committee, or Medical Executive Committee for any of the reasons listed below. Additional inquiry may include a personal interview with the applicant, a request for a letter of explanation from the applicant, further contact with sources of information, or any other means appropriate to resolving questions about the application. The application shall be deemed incomplete until additional inquiry is completed, and questions about the following matters are explained to the satisfaction of the Department Chairperson, Credentials Committee, Medical Executive Committee or Board of Trustees.:

⁷⁹ MS.4.10, MS.4.20, MS.4.40, MS.4.70, 42 C.F.R. §482.22(a)(2)

⁸⁰ MS.1.20, MS.4.20, MS.4.40

⁸¹ MS.1.20, MS.4.20, MS.4.40, LD.2.20

⁸² MS.1.20, MS.4.20, MS.4.40, LD.2.20

- 3.7.4.2.1 Inability to verify any of the information or credentials represented in the application;
 - 3.7.4.2.2 Any unexplained gaps in medical staff membership, clinical privileges and/or work history;
 - 3.7.4.2.3 More than three concurrent licenses to practice (e.g., license to practice in two or more other states in addition to this State);
 - 3.7.4.2.4 Any evidence of an unusual pattern or excessive number of professional liability actions, to include two or more professional liability claims, settlements or judgments;⁸³
 - 3.7.4.2.5 Inability to confirm identity;
 - 3.7.4.2.6 Any other inconsistent or less than favorable information about the applicant's professional qualifications, competence or character, as judged by the Department Chairperson Credentials Committee, Medical Executive Committee or Board of Trustees.
- 3.7.4.3 Medical Executive Committee Recommendation: The Medical Executive Committee shall receive from the Credentials Committee and review the application, supporting materials; the reports of the Department Chairperson and the Credentials Committee, and any such other available information as may be relevant to the applicant's qualifications. The Medical Executive Committee shall prepare a written report and recommendations for the Board as to Staff appointment and Staff category in the case of applicants for Staff membership, the Department to be assigned, the clinical privileges to be granted, and any special conditions to be placed on the clinical privileges to be granted.⁸⁴ In the event there are any adverse recommendations, the reasons shall be stated. The time frame for the Medical Executive Committee to decide on a recommendation to the Board shall be at the next regular meeting of the committee following receipt of the Credentials Committee report.
- 3.7.4.4 Effect of MEC Recommendation
- 3.7.4.4.1 Deferral: The Medical Executive Committee may defer making a recommendation where the deferral is not solely for the purpose of causing delay. A decision by the Medical Executive Committee to defer the application for further consideration shall state the reasons for deferral; provide direction for further investigation, and state time limits for such further investigation. As soon as practical after the deferral, such decision to defer the application shall be followed with a subsequent favorable or adverse recommendation. The Medical Executive Committee may delegate the responsibility for further consideration to the Credentials Committee or Department Chairperson as deemed appropriate.
 - 3.7.4.4.2 Favorable Recommendation: When the recommendation is completely favorable, the application shall be forwarded promptly to the Board for action at the Board's next regular meeting.
 - 3.7.4.4.3 Adverse Recommendation: If the recommendation of the MEC is adverse under Article Seven of these Bylaws, the Chief of Staff shall promptly notify the applicant. Such notice shall contain the information prescribed in Article Seven of these Bylaws. In such case, the applicant shall be entitled to procedural rights provided in

⁸³ MS.4.20, MS.4.40

⁸⁴ 42 C.F.R. §482.22(a)(2), MS.1.40

Article Seven of these Bylaws, and the recommendation need not be transmitted to the Board until after the applicant has exercised or waived such rights.

- 3.7.4.5 **Board Action:** Unless subject to the provisions of the fair hearing and appeal provisions in these Bylaws, the Board shall act on the application at its next regular meeting following receipt of the recommendation from the Medical Executive Committee.⁸⁵ The action of the Board shall be taken within 30 days after receiving a recommendation from the Medical Executive Committee.
- 3.7.4.5.1 If the Board adopts the recommendation of the Medical Executive Committee, it shall become the final action of the Hospital.
- 3.7.4.5.2 If the Board does not adopt the recommendation of the Medical Executive Committee, the Board may either refer the matter back to the Medical Executive Committee with instructions for further review and recommendation and a time frame for responding to the Board, or the Board may take unilateral action. If the matter is referred back to the Medical Executive Committee, the Medical Executive Committee shall review the matter and shall forward its recommendation to the Board. If the Board adopts the recommendation of the Medical Executive Committee, it shall become the final action of the Hospital.
- 3.7.4.5.3 If the action of the Board is adverse to the applicant, the Secretary of the Board shall promptly send written notice to the applicant. Such notice shall contain the information prescribed in the Article Seven of these Bylaws. In such case, the applicant shall be entitled to procedural rights provided in the Article Seven of these Bylaws, and the adverse decision of the Board shall not become final until after the applicant has exercised or waived such rights. At its next regular meeting, after all of the applicant's hearing and appeal rights under these Bylaws have been exhausted or waived, the Board shall take final action.
- 3.7.4.5.4 All decisions to appoint shall include a delineation of clinical privileges, the assignment of a staff category and Department affiliation, and any applicable conditions placed on the appointment or clinical privileges. The applicant shall be so notified.
- 3.7.4.5.5 Subject to any applicable provisions of Article Seven, notice of the Board's final decision shall be given in writing through the Secretary of the Board to the applicant within five (5) working days of the final decision. In the event a hearing and/or appeal was held, Article Seven shall govern notice of the Board's final decision.

3.8 CREDENTIALS SUBJECT TO ONGOING VERIFICATION

In addition to being verified at the time of initial appointment and initial granting of privileges, and at reappointment or renewal or revision of clinical privileges, the following credentials shall be subject to primary source verification, at the time of expiration and renewal or as specified, and any failure to continuously maintain the following credentials during the entire term of appointment shall result in automatic suspension actions as provided in these Bylaws and shall be reported to the Credentials Committee:

⁸⁵ 42 C.F.R. §482.12(a)(2), 42 C.F.R. §482.22(a)(2), MS.1.20, MS.4.10, MS.4.20

- 3.8.1 Current licensure
- 3.8.2 Drug Enforcement Administration registration;
- 3.8.3 Professional liability insurance; as outlined by the state of Florida
- 3.8.4 Specialty board certification, if required for membership or any of the clinical privileges granted;
- 3.8.5 Privilege-specific requirements for current certifications as applicable to the clinical privileges granted; and,
- 3.8.6 Eligible to participate in the Federal Health Care Program. (The OIG Sanction Report, the GSA List and the State Exclusion List [shall be checked according to the frequencies defined by hospital policy].)⁸⁶

3.9 ELIGIBILITY FOR REAPPOINTMENT

To be eligible to apply for reappointment and renewal of clinical privileges, an individual must have, during the previous appointment term:

- 3.9.1 Shall have no delinquent medical records as specified in Section 3 of the Hospital's applicable Rules and Regulations;
- 3.9.2 Completed all continuing medical education requirements;
- 3.9.3 Satisfied all Medical Staff responsibilities, including payment of dues, fines, and assessments;
- 3.9.4 Continued to meet all qualifications and eligibility criteria for appointment and the clinical privileges requested; and,
- 3.9.5 For individuals requesting clinical privileges, the individual had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. Any individual seeking reappointment who has minimal activity at the Hospital must submit such information as may be requested (such as a copy of his/her confidential quality profile from his/her primary hospital, clinical information from the individual's private office practice, and/or a quality profile from a managed care organization) before the application shall be considered complete and processed further.

3.10 EXPIRATION OF CURRENT APPOINTMENT

- 3.10.1 If an application is not submitted timely, the individual's appointment and clinical privileges shall expire at the end of the then current term of appointment. Only after a complete application is received shall an individual be considered for reappointment or renewal of clinical privileges.
- 3.10.2 If an application for reappointment is submitted timely, but the Board has not acted on it prior to the end of the current term, the individual's appointment and clinical privileges shall expire at the end of the then current term of appointment. The Board may subsequently grant reappointment and renewal of clinical privileges.

3.11 CREDENTIALS VERIFICATION AND REAPPLICATION PROCESSING PROCEDURES

3.11.1 REAPPLICATION

Each application for reappointment from a Physician or Allied Health Professional, and/or clinical privileges shall be in writing, submitted on the prescribed form, and signed by the applicant. At least six months prior to expiration of the current term of membership or clinical privileges for an individual who is a member of the Medical Staff or who currently holds clinical privileges, the individual should be sent a notice of the impending expiration and an application for reappointment and/or renewal of privileges.

⁸⁶ HCA Ethics & Compliance Policy QM.002

3.11.2 BURDEN ON APPLICANT

The applicant for reappointment, and/or clinical privileges shall have the burden of producing adequate information for a proper evaluation of his/her qualifications for membership or clinical privileges. Neither the Medical Staff nor the Board shall have any obligation to review or consider any reapplication until it is complete, as defined in these Bylaws. The applicant shall provide accurate, up-to-date information on the application form, and shall be responsible for ensuring that all supporting information and verifications are provided, as requested. It shall be the responsibility of the applicant to ensure that any required information from peer references, or other facilities are submitted directly to the Medical Staff Office by such sources. The applicant shall be responsible for resolving any doubts regarding the reapplication. If during the processing of the reapplication the Hospital or the Medical Staff or any committee or representative thereof, determines that additional information or verification, or an interview with the applicant is needed, further processing of the reapplication may be stayed and the reapplication may not be considered complete until such additional information or verification is received, or the interview is conducted. Any Medical Staff committee or the Board may request that the applicant appear for an interview with regard to the reapplication. The Medical Staff Office shall notify the applicant by special notice of the specific information being requested, the time frame within which a response is required, and the effect on the reapplication if the information is not received timely. Failure to provide a complete reapplication, as defined in these Bylaws, within six months after being provided with an application form for reappointment or clinical privileges, or failure to appear for any requested interview, shall be deemed a voluntary withdrawal from the reapplication process. Voluntary withdrawal from the reapplication process shall not be considered an adverse action, and shall not entitle the applicant to exercise procedural rights outlined in these Bylaws in the event of such withdrawal. The Medical Staff Office shall provide special notice to an individual regarding his/her withdrawal from the reapplication process due to lack of requested information or failure to appear for an interview. The completed reapplication form shall include, without limitation:

- 3.11.2.1 Identifying information, including name, social security number, date of birth, any aliases, and addresses of office & residence.
- 3.11.2.2 Evidence of current licensure in the State of Florida and information regarding any current or past licensure in any healthcare profession or in any other state;⁸⁷
- 3.11.2.3 Evidence of current controlled substance registration(s), both federal DEA, and state, if applicable;
- 3.11.2.4 The applicant's participation in continuing education, specifically as related to the clinical privileges requested;⁸⁸
- 3.11.2.5 The name of one peer who will provide information as to the applicant's experience, current competence, judgment, conduct, ethics and character, and ability to perform the clinical privileges requested. The peer shall be someone with current knowledge of the applicant who can provide an unbiased appraisal (and therefore not a current partner in medical practice, spouse or other family member). For an applicant for reappointment, the applicant's Department Chairperson may serve as one of the peers, if he/she is a peer of the applicant;⁸⁹
- 3.11.2.6 Updated information regarding specialty board certification, if any, including the name of the specialty board(s), and dates of certification;

⁸⁷ MS.4.10, MS.4.20, MS.4.40, 42 C.F.R. §482.22(a)(2), Guidance to Surveyors, HCA Requirement

⁸⁸ MS.5.10

⁸⁹ MS.4.10, MS.4.20, MS.4.40, MS.4.70, 42 C.F.R. §482.22(a)(2)

- 3.11.2.7 Information regarding all current and all past healthcare facility affiliations, including the name and address of the facility(s) and dates of affiliation;⁹⁰
- 3.11.2.8 Evidence of current professional liability insurance, including the name of the carrier, amount and dates of coverage, and professional practice covered;
- 3.11.2.9 National Provider Identifier (NPI);
- 3.11.2.10 Information as to any current, possible, or pending sanctions affecting participation in any Federal Health Care Program, or any actions which might cause the applicant to become an Ineligible Person, as well as any sanctions from a professional review organization;⁹¹
- 3.11.2.11 Accurate and complete disclosure with regard to the following queries:
 - 3.11.2.11.1 Whether the applicant's professional license or controlled substance registration (DEA, state or local), in any jurisdiction, has ever been disciplined, restricted, revoked, suspended, or surrendered, or whether such action is currently pending, or whether the applicant has voluntarily or involuntarily relinquished such licensure or registration in any jurisdiction;⁹²
 - 3.11.2.11.2 Whether the applicant has had any voluntary or involuntary termination of Medical Staff membership, or voluntary or involuntary limitation, reduction, loss, or denial of clinical privileges at another Hospital;⁹³
 - 3.11.2.11.3 Whether the applicant has had any notification of, or any involvement in a professional liability action, including any final judgments or settlements involving the applicant; and,⁹⁴
 - 3.11.2.11.4 Whether the applicant has ever been subject to a criminal conviction, as defined in these Bylaws, or whether any such action is pending.
- 3.11.2.12 A statement from the applicant that his/her health status is such that he/she has the ability to perform the clinical privileges that he/she is requesting, pursuant to Article Three, Section 3.1.8;⁹⁵
- 3.11.2.13 Evidence that the applicant has complied with hospital health screening requirements.
- 3.11.2.14 A pledge from the applicant to provide continuous care to his/her patients, as defined in these Bylaws;
- 3.11.2.15 A statement from the applicant consenting to the release and inspection of all records or other documents that may be material to an evaluation of his/her professional qualifications, including all health information and medical records necessary to verify the applicant's health status as required by Section 3.1.8.
- 3.11.2.16 A statement from the applicant agreeing that in the event of an adverse action concerning his/her Staff membership or clinical privileges, he/she will exhaust all remedies afforded by these Bylaws before resorting to formal legal action or commencing legal proceedings.

⁹⁰ MS.4.10

⁹¹ HCA, Ethics & Compliance Policy QM.002

⁹² MS.4.20

⁹³ MS.4.20

⁹⁴ MS.4.20

⁹⁵ MS.4.10, 42 C.F.R. §482.22(c)(4)

- 3.11.2.17 Physicians, other Practitioners, and Allied Health Professionals will sign an Information Security Agreement and shall agree that as a condition of membership or holding clinical privileges, the individual shall abide by the privacy policies of the Hospital. Completed Agreements will be maintained in the individual's credentials file.⁹⁶
- 3.11.2.18 All applications must include a specific written request for clinical privileges using prescribed forms.⁹⁷ Requests for clinical privileges shall not be complete unless it includes supporting evidence of competence for each of the privileges requested outside Core and proof that the applicant meets the criteria for each of the privileges requested.
- 3.11.2.19 As a condition of consideration for continued appointment to the Medical Staff, every applicant shall specifically agree to immediately provide (within two business day of being officially notified of a change in status) to the Medical Staff and the Hospital, with or without request, any new or updated information that is pertinent to the individual's professional qualifications or any question on the application form, including but not limited to any change in Federal Health Care Program Ineligible Person status, any exclusion from a State Program, any change in licensure in any state, any change in DEA status or status with a State controlled substance regulatory agency, or any exclusion or other sanctions imposed or recommended by the Federal Department of Health and Human Services or any state, the receipt of a QIO citation, any change in legal status to reside and/or work in the USA, any investigation by an ABMS or AOA specialty board, any change in health status, any change in location of office or residence, any criminal investigation, and/or a quality denial letter concerning alleged quality problems in patient care.

3.11.3 VERIFICATION PROCESS

Upon the receipt of a completed reapplication form, the Medical Staff Office shall arrange to verify the qualifications and obtain supporting information relative to the reapplication. The Medical Staff Office shall promptly notify the applicant of any problems in obtaining required information. Any action on a reapplication shall be withheld until the reapplication is completed; meaning that all information has been provided and verified, as defined in these Bylaws.⁹⁸ The following information shall be verified for all applicants for reappointment, or renewal of clinical privileges, except as specified:

- 3.11.3.1 Current licensure shall be verified in all states in which the applicant currently holds a license, including the State of Florida through the applicable state licensure boards for all applicants.
- 3.11.3.2 For individuals requesting prescribing privileges, federal DEA registration shall be verified through the US Department of Commerce, National Technical Information Service's electronic verification mechanism.
- 3.11.3.3 For applicants for reappointment or renewal of privileges, information about the topics and content of the applicant's continuing education shall be documented and considered as related to the privileges requested.⁹⁹
- 3.11.3.4 Information reported pursuant to the HCQIA shall be obtained from the National Practitioner Data Bank.¹⁰⁰

⁹⁶ HCA Ethics & Compliance Policy IS.SEC.005

⁹⁷ 42 C.F.R. §482.22(a)(2)

⁹⁸ MS.4.10, MS.4.20, MS.4.40

⁹⁹ MS.5.10

¹⁰⁰ 42 U.S.C §11135, 45 C.F.R §60.10

- 3.11.3.5 The OIG Sanction Report, the GSA List, and the State Exclusion list, if any, shall be checked to ensure that the applicant is not listed.¹⁰¹
- 3.11.3.6 Professional liability insurance shall be verified.
- 3.11.3.7 The applicant's health status as applicable to their ability to perform the clinical privileges requested shall be verified in accordance with Article Three, Section 3.1.8, and as part of information requested from the applicant's peers, or from the applicant's Department Chairperson.¹⁰²
- 3.11.3.8 One letter of reference shall be required for applicants for reappointment or renewal of clinical privileges.
- 3.11.3.9 The information regarding the applicant's number of cases, treatment results and conclusions drawn from quality assessment, performance improvement activities, and other information regarding the applicant's history of meeting the criteria for membership or clinical privileges including information about ability to adhere Hospital policies regarding personal and professional conduct, as defined in these Bylaws, shall be assembled for review. Relevant applicant-specific information from organization performance improvement activities shall be considered and compared to aggregate information when evaluating professional performance, judgment, and clinical or technical skills at the time of reappointment, or renewal or revision of clinical privileges.¹⁰³
- 3.11.3.10 With regard to applicants for reappointment, or new clinical privileges who are not active at the Hospital, evidence of qualifications and competence shall be verified through correspondence with the Medical Staff offices of other facilities where the applicant is affiliated and actively practicing.¹⁰⁴

3.11.4 REAPPLICATION PROCESSING

After verification is accomplished and the reapplication is fully complete it shall be reviewed and processed as follows:¹⁰⁵

- 3.11.4.1 Department Report: The Medical Staff Office shall make available the reapplication and all supporting materials to the Chairperson of Department in which the applicant seeks clinical privileges. In the event that the applicant is the Department Chairperson, the Chief of Staff or the Department Vice-Chairperson shall make the evaluation and recommendations. Following the Department Chairperson(s)' evaluation and recommendations, the report shall then be transmitted to the Credentials Committee. The time frame for completion of the Department report(s) shall be within 30 days of receipt of a complete application.¹⁰⁶
- 3.11.4.2 Credentials Committee Report: The Credentials Committee shall receive from the Department Chairperson and review the application, supporting materials; the report of the Department Chairperson and any such other available information as may be relevant to the applicant's qualifications. The Credentials Committee shall prepare a written report and recommendations for the Medical Executive Committee as to Staff reappointment, and clinical privileges to be granted, and any special conditions to be placed on the clinical privileges to be granted. In the event there are any adverse recommendations, the reasons shall be stated. The time frame for completion of the Credentials Committee action

¹⁰¹ HCA, Ethics & Compliance Policy QM.002

¹⁰² MS.4.10, MS.4.20, MS.4.40

¹⁰³ MS.4.20, 42 C.F.R. §482.22(a)(2)

¹⁰⁴ MS.4.10, MS.4.20, MS.4.40, MS.4.70, 42 C.F.R. §482.22(a)(2)

¹⁰⁵ MS.1.20, MS.4.20, MS.4.40

¹⁰⁶ MS.1.20, MS.4.20, MS.4.40, LD.2.20

shall be at the next regular meeting of the committee following receipt of the Department report, to be within 30 days.

3.11.4.3 Criteria for Additional Inquiry: Additional inquiry shall be conducted by the Department Chairman, Credentials Committee, or Medical Executive Committee for any of the reasons listed below. Additional inquiry may include a personal interview with the applicant, a request for a letter of explanation from the applicant, further contact with sources of information, or any other means appropriate to resolving questions about the application. The reapplication shall be deemed incomplete until additional inquiry is completed, and questions about the following matters are explained to the satisfaction of the Department Chairman, Credentials Committee, Medical Executive Committee or Board of Trustees.:

3.11.4.3.1 Any evidence of an unusual pattern or excessive number of professional liability actions, to include two or more professional liability claims, settlements or judgments;¹⁰⁷

3.11.4.3.2 Any other inconsistent or less than favorable information about the applicant's professional qualifications, competence or character, as judged by the Department Chairman Credentials Committee, Medical Executive Committee or Board of Trustees.

3.11.4.4 Medical Executive Committee Recommendation: The Medical Executive Committee shall receive from the Credentials Committee and review the reapplication, supporting materials; the reports of the Department Chairperson and the Credentials Committee, and any such other available information as may be relevant to the applicant's qualifications. The Medical Executive Committee shall prepare a written report and recommendations for the Board as to Staff reappointment, clinical privileges to be granted, and any special conditions to be placed on the clinical privileges to be granted.¹⁰⁸ In the event there are any adverse recommendations, the reasons shall be stated. The time frame for the Medical Executive Committee to decide on a recommendation to the Board shall be at the next regular meeting of the committee following receipt of the Credentials Committee report, to be within 30 days.

3.11.4.5 Effect of MEC Recommendation

Deferral: The MEC may defer making a recommendation where the deferral is not solely for the purpose of causing delay. A decision by the MEC to defer the reapplication for further consideration shall state the reasons for deferral, provide direction for further investigation, and state time limits for such further investigation. As soon as practical after the deferral, such decision to defer the reapplication shall be followed with a subsequent favorable or adverse recommendation. The MEC may delegate the responsibility for further consideration to the Credentials Committee or Department Chairperson as deemed appropriate.

3.11.4.5.2 Favorable Recommendation: When the recommendation is completely favorable, the reapplication shall be forwarded promptly to the Board for action at the Board's next regular meeting.

3.11.4.5.3 Adverse Recommendation: If the recommendation of the MEC is adverse under Article Seven of these Bylaws, the Chief of Staff

¹⁰⁷ MS.4.20, MS.4.40

¹⁰⁸ 42 C.F.R. §482.22(a)(2), MS.1.40

shall promptly notify the applicant. Such notice shall contain the information prescribed in Article Seven of these Bylaws. In such case, the applicant shall be entitled to procedural rights provided in Article Seven of these Bylaws, and the recommendation need not be transmitted to the Board until after the applicant has exercised or waived such rights.

3.11.4.6 Board Action: Unless subject to the provisions of the fair hearing and appeal provisions in these Bylaws, the Board shall act on the reapplication at its next regular meeting following receipt of the recommendation from the MEC.¹⁰⁹ The action of the Board shall be taken within 30 days after receiving a recommendation from the MEC.

3.11.4.6.1 If the Board adopts the recommendation of the MEC, it shall become the final action of the Hospital.

3.11.4.6.2 If the Board does not adopt the recommendation of the MEC, the Board may either refer the matter back to the MEC with instructions for further review and recommendation and a time frame for responding to the Board, or the Board may take unilateral action. If the matter is referred back to the MEC, the MEC shall review the matter and shall forward its recommendation to the Board. If the Board adopts the recommendation of the MEC, it shall become the final action of the Hospital.

3.11.4.6.2 If the action of the Board is adverse to the applicant, the Secretary of the Board shall promptly send written notice to the applicant. Such notice shall contain the information prescribed in the Article Seven of these Bylaws. In such case, the applicant shall be entitled to procedural rights provided in the Article Seven of these Bylaws, and the adverse decision of the Board shall not become final until after the applicant has exercised or waived such rights. At its next regular meeting, after all of the applicant's hearing and appeal rights under these Bylaws have been exhausted or waived, the Board shall take final action.

3.11.4.6.3 All decisions to reappoint shall include a delineation of clinical privileges and the assignment of a staff category and any applicable conditions placed on the reappointment or clinical privileges. The applicant shall be so notified.

3.11.4.6.3 Subject to any applicable provisions of Article Seven, notice of the Board's final decision shall be given in writing through the Secretary of the Board to the applicant within five (5) working days of the final decision. In the event a hearing and/or appeal was held, Article Seven shall govern notice of the Board's final decision.

3.11.4.7 Extension of Appointment:

3.11.4.7.1 An application for reappointment must be completed by the member at least sixty (60) days before the end of the member's then current appointment term and must remain complete throughout the reappointment process. The Hospital shall use its best efforts to act upon a completed reappointment application, which is not subject to further inquiry, within such member's current appointment term.

¹⁰⁹ 42 C.F.R. §482.12(a)(2), 42 C.F.R. §482.22(a)(2), MS.1.20, MS.4.10, MS.4.20

- 3.11.4.7.2 If an application for reappointment has not been fully processed by the expiration date of a member's appointment term because of failure on the part of the member to timely submit a completed application for reappointment, or to maintain that application in complete fashion through the reappointment process, or timely provide additional documentation or explanation when an application is subject to further inquiry, the member's appointment and clinical privileges shall expire.
- 3.11.4.7.2 If a complete application for reappointment has been timely submitted including such additional documentation or explanation when an application is subject to further inquiry, and has not been processed because of delay solely on the part of the Medical Staff Leadership or Hospital, the member shall be granted temporary privileges in accordance with Section 5.3 for a period of up to 90 days in order to permit completion of the application review process.

3.12 CREDENTIALS SUBJECT TO ONGOING VERIFICATION

In addition to being verified at the time of initial appointment and initial granting of privileges, and at reappointment or renewal or revision of clinical privileges, the following credentials shall be subject to primary source verification, as described in Section 3.7 and Section 3.8 of this Article, at the time of expiration and renewal or as specified, and any failure to continuously maintain the following credentials during the entire term of appointment shall be reported to the Credentials Committee and actions shall be taken as provided in these Bylaws:

- 3.12.1 Current licensure;¹¹⁰
- 3.12.2 Drug Enforcement Administration registration;
- 3.12.3 Professional liability insurance;
- 3.12.4 Specialty board certification, if required for membership or any of the clinical privileges granted; and,
- 3.12.5 Not excluded, debarred, or otherwise ineligible to participate in the Federal Health Care Program. (The OIG Sanction Report, the GSA List and the State Exclusion List, if any, shall be checked every six months.)¹¹¹

3.13 ASSISTANCE WITH EVALUATION

The Board, the Medical Executive Committee, the Chief Executive Officer or any committee authorized to review or evaluate applications for Staff membership or clinical privileges, or conduct ongoing review or evaluation of performance of those who currently hold Staff membership or clinical privileges, may as part of these duties:

- 3.13.1 Obtain the assistance of an independent consultant or others to evaluate the healthcare professional being subject to review;
- 3.13.2 Consider the results of performance improvement or quality assessment activities of other hospitals or health care institutions with respect to the healthcare professional under evaluation;
- 3.13.3 Request or require the healthcare professional under evaluation to submit to interviews with consultants who may be retained to assist in the review or evaluation process;

¹¹⁰ MS.4.10, MS.4.20, MS.4.40

¹¹¹ HCA Ethics & Compliance Policy QM.002

- 3.13.4 Subject to Federal or State regulations, request that specific patient records or categories of records of patients treated by the healthcare professional under evaluation be submitted for review, subject to appropriate protection of patient confidentiality; and,
- 3.13.5 Require detailed statements, data and information concerning matters that may impact the qualifications, professional competence or conduct of the healthcare professional under evaluation, including information concerning threatened or pending legal or administrative proceedings.

3.14 PROFESSIONAL PRACTICE EVALUATION

The Board has ultimate responsibility for the quality and appropriateness of patient care services.¹¹² To meet this responsibility, the Board shall direct and enforce the establishment of a performance improvement and quality assessment program with the requisite quality assessment processes. Processes shall include the measurement, monitoring, analysis, and improvement of the quality and appropriateness of services provided by individual Medical Staff members and other individuals with clinical privileges. The Medical Staff shall participate in quality assessment and performance improvement activities as defined in the Hospital's Performance Improvement Plan.

The Medical Staff measurement, analysis and improvement activities shall be directed to assuring uniformly high quality and clinically appropriate care resultant from the performance of Staff members and others with clinical privileges. Such activities shall also be used to assure the fair and equitable treatment of each Staff member and others with clinical privileges in appointment, reappointment, peer review and privileging processes. The data measurements and profiling established by the Medical Staff shall include clinical and other indicators directly attributable to quality and patient outcomes. Measures and their resultant analysis and performance improvement shall be managed within the established peer and quality review committees and departments of the Medical Staff for maximization of information and individual protections by state and federal peer review protections and immunity including the Health Care Quality Improvement Act.

Relevant information from Hospital performance improvement activities that is specific to an individual shall be considered and compared to aggregate information when these measures are appropriate for comparative purposes in evaluating the individual's professional performance, judgment, clinical or technical skills. Any results of peer review regarding the individual's clinical performance shall also be included.¹¹³ The Hospital may use epidemiological and statistical methods to compare practice patterns of individuals on quality (including process and outcome) of care. The Hospital may consider resource consumption and quality of care by an individual through an examination of patterns of health care delivery. Profiles may be constructed for individuals or groups of individuals based on Hospital, geographic, specialty, and type of practice or other characteristics. Performance profiles, including the results of performance based measures such as patterns of treatment, health care outcomes, and patient satisfaction shall be taken into account in evaluating applications for appointment or reappointment. The data, measures and profiles may include, but are not limited to, clinical and other information regarding each individual's:

- 3.14.1 Quality and appropriateness of patient care, including patient care outcomes;
- 3.14.2 Review of operative and other clinical procedures performed and their outcomes;
- 3.14.3 Patterns of blood and pharmaceutical usage;
- 3.14.4 Requests for tests and procedures;
- 3.14.5 Length of stay patterns;
- 3.14.6 Morbidity and mortality data;
- 3.14.7 Practitioner's use of consultants;

¹¹² LD.1.20

¹¹³ MS.4.20, 42 U.S.C. §11135, 42 C.F.R. §482.21(c), 42 C.F.R. §482.22(a)(1)

- 3.14.8 Performance as related to Healthcare Quality Alliance (HQA) core measures, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) surveys, data about Hospital Acquired Conditions (HAC) and other publicly-reported evidence-based performance measures;
- 3.14.9 Malpractice and professional liability experience;
- 3.14.10 Timely, legible and accurate completion of patient medical records;
- 3.14.11 Professional conduct;
- 3.14.12 Attendance and participation in Medical Staff committee and Department meetings;
- 3.14.13 Attainment and maintenance of board certification;
- 3.14.14 Maintenance of required levels of professional liability insurance coverage;
- 3.14.15 Attainment of continuing education requirements; and,
- 3.14.16 Attribution to sentinel events, medical errors or other risk occurrences.

The Board of Trustees shall be responsible for assuring the use of clinical and other quality measurements for the improvement of patient care. The sources for the information shall be identified by the Hospital and data quality shall be verified. Recommendations from the Medical Staff regarding their conclusions from Medical Staff and Hospital performance improvement and quality assessment shall be reported to the Board for their decision making and enforcement of actions for the improvement of patient care and execution of the quality assessment process.

Medical staff members and other individuals with clinical privileges are required to participate in all aspects of Medical Staff activities designed to verify the individual's ongoing qualifications and competency. If at any time a Medical Staff member or other individual with clinical privileges fails to provide required information pursuant to a formal request by the Credentials Committee, Medical Executive Committee, or the Chief Executive Officer, the individual's clinical privileges shall be deemed to be voluntarily relinquished until the required information is provided to the satisfaction of the requesting party, without the individual having a right to a hearing or appeal. For purposes of this section, 'required information' shall refer to (1) physical or mental examination reports as specified elsewhere in these Bylaws, or (2) information from another healthcare facility or agency. If voluntary relinquishment of clinical privileges occurs while the individual is subject to an investigation, this will be reported in accordance with the requirements of the National Practitioner Data Bank

3.15 PROVISIONAL STATUS AND PROCTORING

The Medical Staff shall have a process to evaluate the privilege-specific competence of a practitioner who does not have documented evidence of performing the requested privilege at the Hospital. This process may also be used when a question arises regarding a currently privileged practitioner's ability to provide safe, high quality patient care. This process of focused professional practice evaluation shall be a time-limited period during which the Medical Staff evaluates and determines the practitioner's professional performance. Focused professional practice evaluation may entail the use of one or more types of evaluation, including but not limited to chart review, monitoring of clinical practice patterns, simulation, clinical proctoring, external peer review, and discussion with other individuals involved in the care of each patient (e.g., consulting physicians, assistants at surgery, nursing or administrative personnel).¹¹⁴ Clinical proctoring is an objective evaluation of an individual's actual clinical competence by a monitor or proctor who represents the Medical Staff and is responsible to the Medical Staff for monitoring and reporting only. When an initial applicant seeks clinical privileges, or an individual with existing clinical privileges seeks new privileges, or when the Medical Staff requires the individual's actual clinical competence to be evaluated for any other reason, the individual shall be proctored or observed while providing the services for which the privileges are requested. Proctors act as monitors to evaluate the technical and cognitive skills of another Practitioner and do not

¹¹⁴ MS.08.01.01

directly participate in patient care, have no physician/patient relationship with the patient being treated, do not receive a fee from the patient, represent the Medical Staff, and are responsible to the Medical Staff for monitoring and reporting only.

- 3.15.1 For initial appointment/initial clinical privileges: At the time of initial appointments and initial granting of clinical privileges, the medical staff shall determine a plan for conducting focused professional practice evaluation, during which the practitioner shall be on provisional status. The evaluation plan shall include method(s) and the time period of evaluation and may be subject to an extension of time for a total period not to exceed two years (24 months). A period of focused professional practice evaluation shall be implemented for all initially requested privileges.¹¹⁵ Each individual subject to provisional status may be subject to focused professional practice evaluation by one or more appropriate Member(s) of the Medical Staff as approved by Chairperson of the Department to which the individual is affiliated. The provisional status individual shall be subject to focused professional practice evaluation for the number and type of cases, procedures or treatments specified by the clinical Department as appropriate to the patient care and services provided by Department members. The care under evaluation shall be relevant to the privileges granted. The purpose of the observation is to determine the individual's eligibility for advancement from provisional status and for exercising the clinical privileges provisionally granted. If a proctor is assigned, the proctor shall complete a proctoring report with comments on the individual's performance. Each proctoring report will be evaluated when the case is completed in order to be aware of any undesirable trend or pattern that may be developing. At the end of the provisional period the individual must qualify for and be advanced to a non-provisional status, or be extended on provisional status for an additional period not to exceed a total of twenty-four (24) months. Advancement shall be based upon a favorable recommendation of the individual's Department Chairperson based on the Chairperson's review of the proctoring reports, chart reviews, peer review, and any other results of focused professional practice evaluation and a favorable recommendation of the Medical Care Evaluation Committee or the Surgical Care Evaluation Committee, Credentials Committee and Medical Executive Committee, and approved by the Board. No one may be on provisional status for a total period longer than twenty-four (24) months. Unless excused for good cause by the Medical Executive Committee and the Board, an individual's failure to complete the required number of cases needed to complete focused professional practice evaluation shall be deemed a voluntary relinquishment of membership and clinical privileges; such individual shall not be entitled to the hearing and appeal rights under these Bylaws. Failure to advance to a non-provisional status due to performance issues shall entitle the individual to the hearing and appeal rights under these Bylaws
- 3.15.2 For individuals with existing privileges who are requesting new privileges: A period of focused professional practice evaluation shall be implemented for all initially requested privileges.¹¹⁶ Medical Staff members or other individuals with existing clinical privileges who are requesting new privileges may be subject to focused professional practice evaluation by one or more appropriate Member(s) of the Medical Staff as approved by Chairperson of the Department to which the individual is affiliated. In the event new privileges are requested for which there are no other Medical Staff members or other individuals with existing clinical privileges and competence to proctor and evaluate someone in the new area of practice, the Credentials Committee, the Medical Executive Committee, and the Board shall have the option of specifying requirements for other evidence of competence, including but not limited to reports of completion of an accredited training program, evaluations from competent instructors, external peer review, and/or evidence of proctoring at another hospital. The individual requesting new

¹¹⁵ MS.08.01.01

¹¹⁶ MS.08.01.01

privileges shall be subject to focused professional practice evaluation for the number and type of cases, procedures or treatments specified by the clinical Department as appropriate to the new clinical privileges being requested. The care under evaluation shall be relevant to the privileges granted. The purpose of the observation is to determine the individual's actual clinical competence for the new clinical privileges granted. If a proctor is assigned, the proctor shall complete a proctoring report with comments on the individual's performance. Each proctoring report will be evaluated when the case is completed in order to be aware of any undesirable trend or pattern that may be developing. The individual's Department Chairperson shall review the proctoring reports, chart reviews, peer review, and any other results of focused professional practice evaluation and provide a report to the Medical Care Evaluation Committee or Surgical Care Evaluation Committee, the Credentials Committee, the Medical Executive Committee, and the Board.

3.15.3 For evaluating of clinical competence for privileges previously granted: Medical Staff members or other individuals with existing clinical privileges who are identified for review of actual clinical competence may be subject to focused professional practice evaluation¹¹⁷ by one or more appropriate Member(s) of the Medical Staff as approved by Chairperson of the Department to which the individual is affiliated. Focused professional practice evaluation may be indicated as the result of QA/PI, peer review or patient safety information, or due to inactivity with clinical privileges granted, or due to return from a leave of absence. The individual shall be subject to focused professional practice evaluation for the number and type of cases, procedures or treatments specified by the clinical Department as appropriate to the clinical privileges subject to review. The care under evaluation shall be relevant to the privileges granted. The purpose of the observation is to determine the individual's actual clinical competence for the clinical privileges subject to review. If a proctor is assigned, the proctor shall complete a proctoring report with comments on the individual's performance. Each proctoring report will be evaluated when the case is completed in order to be aware of any undesirable trend or pattern that may be developing. The individual's Department Chairperson shall review the proctoring reports, chart reviews, peer review, and any other results of focused professional practice evaluation and provide a report to Medical Care Evaluation Committee or Surgical Care Evaluation Committee, the Credentials Committee, the Medical Executive Committee, and the Board.

3.15.3.1 Duties of individuals on Provisional Status

3.15.3.2 During the provisional period, an individual must arrange for, or cooperate in the arrangement of, the required numbers and types of cases to be reviewed or observed by the Department Chairperson or other designated observers.

3.15.3.3 If a new member of the Medical Staff or other individual with clinical privileges fails, during the provisional period, to:

3.15.3.3.1 Participate in the required number of cases;

3.15.3.3.2 Cooperate with the monitoring and observation conditions; or

3.15.3.3.3 Fulfill all requirements of appointment, including but not limited to those relating to completion of medical records (provided, however, that the Medical Staff member shall be permitted to complete such records in a reasonable time period following treatment) and/or emergency service call responsibilities, the individual's Medical Staff appointment and the clinical privileges shall be automatically relinquished at the end of the provisional period, and the individual shall not be entitled to a hearing or

¹¹⁷ MS.08.01.01

appeal. The individual may not reapply for initial appointment or privileges until the next reappointment period.

- 3.15.3.4 If a member of the Medical Staff who has been granted additional clinical privileges or other individual granted additional clinical privileges fails, during the provisional period, to participate in the required number of cases or cooperate with the monitoring and observation conditions, the additional clinical privileges shall be automatically relinquished at the end of the provisional period, and the individual shall not be entitled to a hearing or appeal. The individual may not reapply for the privileges in question until the next reappointment period.
- 3.15.3.5 If a member of the Medical Staff or other individual with clinical privileges who has been in a provisional period for an evaluation of competence fails to participate in the required number of cases or cooperate with the monitoring and observation conditions, the clinical privileges under review shall be automatically relinquished at the end of the provisional period, and the individual shall not be entitled to a hearing or appeal. The individual may not reapply for the privileges in question until the next reappointment period.
- 3.15.3.6 When, based on the evaluation performed during the provisional period, clinical privileges are terminated, revoked, or restricted for reasons related to clinical competence and/or professional conduct, the individual shall be entitled to a hearing and appeal.

3.16 CONDITIONAL APPOINTMENT, REAPPOINTMENT OR PRIVILEGES

- 3.16.1 Recommendations for appointment, reappointment, initial granting of privileges and / or renewal of privileges may be contingent upon an individual's compliance with certain specific conditions. These conditions may relate to behavior (e.g., demonstration of compliance to code of conduct) or to clinical issues (e.g., general consultation requirements, requirements for proctoring, completion of CME requirements). Unless the conditions being imposed constitute a disciplinary action or are reportable as defined by the Health Care Quality Improvement Act, the imposition of such conditions does not entitle an individual to request the procedural rights set forth in Article Seven of these Bylaws.
 - 3.16.1.1 If the individual accepts conditional appointment, reappointment, or privileges and agrees to the conditions imposed, and successfully adheres to the conditions and completes the requirements, the individual shall be eligible to apply for full appointment, reappointment, or privileges.
 - 3.16.1.2 If the individual accepts conditional appointment, reappointment, or privileges and agrees to the conditions imposed, but does not adhere to the conditions or completes the requirements specified in the conditional appointment, reappointment, or privileges then corrective actions as set forth in Article Six of these Bylaws shall commence.
 - 3.16.1.3 If the individual refused to accept conditional appointment, reappointment, or privileges or any of the conditions or requirements imposed as part of a conditional appointment, reappointment, or privileges, then corrective actions as set forth in Article Six of these Bylaws shall commence.
- 3.16.2 Conditional appointment, reappointments, or privileges may be recommended for periods of less than two years in order to permit closer monitoring of an individual's compliance with any conditions that may be imposed. A recommendation for appointment, reappointment, or privileges for a period of less than two years does not, in and of itself, entitle an individual to the procedural rights set forth in Article Seven of these bylaws.
- 3.16.3 In the event an applicant for reappointment or renewal of privileges is the subject of an investigation or hearing at the time reappointment or renewal of privileges is being considered,

a conditional reappointment or conditional privileges may be granted for the limited amount of time needed to complete the investigation or hearing.

- 3.16.4 To end a term of conditional appointment, reappointment, or privileges the individual shall be required to undergo all usual reappointment and privileging procedures.

3.17 PREVIOUSLY DENIED OR TERMINATED APPLICANTS

Notwithstanding any other provisions in these Bylaws, if an application is tendered by an applicant who has been previously denied membership and/or clinical privileges, or who has had membership and/or clinical privileges terminated due to lack of sufficient qualifications required to maintain membership or clinical privileges, or whose prior application was deemed incomplete and withdrawn, and it appears that the application is based on substantially the same information as when previously denied, terminated, or deemed withdrawn, then the application shall be deemed insufficient by the Credentials Committee and returned to the applicant as unacceptable for processing. If an application is tendered by an applicant who has been previously denied membership and/or clinical privileges, or who has had membership and/or clinical privileges terminated due to circumstances that have permanently disqualify the applicant for membership, as has been so designated by prior action of the Board of Trustees, then the application shall be returned to the applicant as unacceptable for processing. No application shall be processed, and no right of hearing or appeal shall be available in connection with the return of such application.

3.18 MEDICO-ADMINISTRATIVE OFFICERS

3.18.1 DEFINED

A medico-administrative officer is a Practitioner who is employed by or contracts with the Hospital, or otherwise serves pursuant to a contract in a capacity that includes administrative responsibilities, and may also include clinical responsibilities.

3.18.2 STAFF APPOINTMENT, CLINICAL PRIVILEGES AND OBLIGATIONS

All individuals in administrative positions who desire Medical Staff membership or clinical privileges shall be subject to the same procedures as all other applicants for membership or privileges and shall be subject to the same obligations of Medical Staff membership or clinical privileges, as outlined in these Bylaws.¹¹⁸ Additional requirements for employment or a contractual agreement may be imposed. The Staff, as in the case of other Practitioners, shall delineate the clinical privileges of Medico-Administrative officers who request to admit and/or treat patients.

3.18.3 EFFECT OF REMOVAL FROM OFFICE OR ADVERSE CHANGE IN MEMBERSHIP STATUS OR CLINICAL PRIVILEGES

In the event a Practitioner who is employed by or has contracted with the Hospital, or otherwise serves in a Medico-Administrative position pursuant to a contract, is subject to removal from office through the termination or expiration of employment or of the contract, full effect shall be given to any specific provisions in the contract regarding the consequence such termination or expiration of the contract has on the Medical Staff membership and clinical privileges of the Practitioner. The underlying grounds for termination of the contract may themselves be cause for initiating adverse action under these Bylaws.

An adverse action, as defined in these Bylaws, against a medico-administrative practitioner for clinical reasons or for violation of these Bylaws shall be subject to the hearing and appeal procedures in Article Seven of these Bylaws. Pursuant to any specific provisions of the contract, such adverse change in membership status or clinical privileges may result in termination of the contract. In the event there is a conflict between the terms of the contract and these Bylaws, the terms of the contract shall control.

3.19 INDIVIDUALS PROVIDING PROFESSIONAL SERVICES BY CONTRACT OR EMPLOYMENT

¹¹⁸ MS.LD.3.60

3.19.1 QUALIFICATIONS AND SELECTION

3.19.2 Practitioners providing clinical services pursuant to a contract, agreement or other arrangement or through Hospital employment shall be subject to the same procedures as all other applicants for membership or privileges and shall be subject to the same obligations of Staff membership or clinical privileges, as outlined in these Bylaws.¹¹⁹ Additional requirements for employment or an agreement may be imposed. The Staff, as in the case of other Practitioners, shall recommend the clinical privileges to admit and/or treat patients for Practitioners who are Hospital employed, or providing services through a contract, agreement or other arrangement.

3.19.3 EFFECT OF CONTRACT TERMINATION ON MEDICAL STAFF MEMBERSHIP OR CLINICAL PRIVILEGES

The terms of any written contract between the Hospital and a Contract Practitioner or Contractor shall take precedence over these Bylaws as now written or hereafter amended. Such contract may provide, for example, that the Staff membership and clinical privileges of a Contract Practitioner or individuals providing services through a Contractor are automatically terminated or modified in the event of termination of the written contract, and the Contract Practitioner or individuals providing services through a Contractor have no rights to a hearing and appeal or otherwise with regard to such termination or modification of Staff membership or clinical privileges. The underlying grounds for termination of the contract may themselves be cause for initiating adverse action under these Bylaws. Notwithstanding the foregoing, if the Contract Practitioner would have been subject to corrective action pursuant to Article Six of these Bylaws but for the termination of the written contract between the Contract Practitioner and the Hospital and the resulting automatic termination of such Contract Practitioner's Medical Staff membership, the MEC may determine to continue to pursue an investigation and/or request for corrective action pursuant to the terms of these Bylaws.

3.20 LEAVE OF ABSENCE

A Medical Staff member or Advanced Practice Professional (APP) may request a voluntary leave of absence from the Staff by submitting a written notice to the Chief of Staff. The request must state the beginning date and ending date for the period of leave desired, which may not exceed one year, and includes the reasons for the request. The Medical Executive Committee, upon recommendation of the Credentials Committee shall review and recommend leave of absence requests to the Board of Trustees, but in extenuating circumstances such as military leave, the Chief Executive Officer or Chief of Staff shall have the authority to approve a leave of absence and their actions shall be reported to the Medical Executive Committee and Board of Trustees. During the period of leave, the Practitioner or APP shall not exercise clinical privileges at the Hospital, and membership prerogatives and responsibilities (e.g., meeting attendance, committee service, emergency service call obligations) shall be in abeyance. When the reasons for the leave of absence indicate that the leave is optional, the request shall be granted at the discretion of the Medical Executive Committee based on their evaluation of the abilities of the Medical Staff to fulfill the patient care needs that may be created in the Hospital by the absence of the Medical Staff member or APP requesting the leave. Exceptions shall be allowed only in the event that a Medical Staff member or APP has a physical or psychological condition that prevents him/her from completing records or concluding other Medical Staff or Hospital matters. A leave of absence may be granted for the following reasons:

3.20.1 MEDICAL LEAVE OF ABSENCE

A Medical Staff member or APP may request and be granted a leave of absence for the purpose of obtaining treatment for a medical or psychological condition, disability, or health issue as defined by these bylaws. If an individual is unable to request a medical leave of absence because of a physical or psychological condition or health issue, the Chief of Staff or Chairperson of the individual's Department may submit the written notice on his/her behalf. A certified letter will be sent to the individual informing him/her of this action. Reinstatement

¹¹⁹ MS.4.20, MS.4.40

of membership status and/or clinical privileges may be subject to production of evidence by the individual that he/she has the ability to perform the clinical privileges requested.

3.20.2 MILITARY LEAVE OF ABSENCE

A Medical Staff member or APP may request and be granted a leave of absence to fulfill military service obligations. Medical Staff members or APPs who are on active military duty for more than one year will be afforded an automatic extension of their leave until their active duty is completed. Reinstatement of membership status and/or clinical privileges may be subject to certain monitoring as determined by the Medical Executive Committee, based on an evaluation of the nature of activities during the leave.

3.20.3 EDUCATIONAL LEAVE OF ABSENCE

A Medical Staff member or APP may request and be granted a leave of absence to pursue additional education and training. Any additional clinical privileges that may be desired upon the successful conclusion of additional education and training must be requested in accordance with Article Five of these Bylaws.

3.20.4 PERSONAL/FAMILY LEAVE OF ABSENCE

A Medical Staff member or APP may request and be granted a leave of absence for a variety of personal reasons or family reasons. Reinstatement of membership status and clinical privileges may be subject to certain monitoring as determined by the Medical Executive Committee, based on an evaluation of the nature of activities during the leave.

3.20.5 REINSTATEMENT FOLLOWING A LEAVE OF ABSENCE

3.20.5.1 The Medical Staff Member or APP on leave of absence may request reinstatement of Medical Staff membership and/or clinical privileges by submitting a written notice to the Chief of Staff. The written request for reinstatement shall include an attestation that no changes have occurred in the status of any of the credentials listed in Article Three, or if changes have occurred, a detailed description of the nature of the changes. The Staff Member or APP shall submit a summary of relevant activities during the leave, which may include, but is not limited to the scope and nature of professional practice during the leave period and any professional training completed. If the leave of absence was for health reasons, the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges requested. If the medical leave of absence was for purposes of treatment for a health issue, then the conditions of reinstatement shall require compliance with the section of these Bylaws addressing practitioner health issues. If the leave of absence has extended past the Practitioner's or APP's reappointment time, he/she will be required to submit an application for reappointment in accordance with Article Three of these Bylaws and the reinstatement shall be processed as a reappointment. The Chief of Staff will forward the request for reinstatement to the individual's Department Chairperson for a recommendation. The Department Chairperson shall forward his/her recommendation to the Credentials Committee. The Credentials Committee shall make a recommendation and forward it to the Medical Executive Committee. The Medical Executive Committee shall forward a recommendation to the Board for approval. In acting upon a request for reinstatement, the Board may approve reinstatement either to the same or a different staff category, and may approve full reinstatement of clinical privileges, or a limitation or modification of clinical privileges, or approve new clinical privileges in accordance with the procedures in Article Five, An adverse decision regarding reinstatement of Staff membership or renewal of any clinical privileges held prior to the leave shall entitle the Practitioner to a fair hearing and appeal as provided in these Bylaws.

3.20.5.2 Absence for longer than one year will result in automatic relinquishment of Medical Staff appointment and clinical privileges unless an extension is granted by the Chief of Staff and the Chief Executive Officer. Extensions will be considered only in extraordinary cases where the extension of a leave is in the best interest of the Hospital.

3.20.5.3 Leaves of absence are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, this will result in automatic relinquishment of Medical Staff appointment and clinical privileges and the determination will be final, with no recourse to a hearing and appeal.

3.20.6 FAILURE TO REQUEST REINSTATEMENT

Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the Medical Staff and/or voluntary relinquishment of clinical privileges. A request for Medical Staff membership or clinical privileges subsequently received from a Medical Staff member or APP deemed to have voluntarily resigned shall be submitted and processed in the manner specified for applications for reappointment.

3.21 RESIGNATION

Resignations from the Medical Staff should be submitted in writing and should state the date the resignation becomes effective. Resignations shall be submitted to the Medical Staff Services. Resignation of Medical Staff membership and/or clinical privileges may be granted for a Practitioner or APP in good standing provided all incomplete medical records and Medical Staff and Hospital matters have been concluded. The Practitioner's or APP's Department Chairperson, the Medical Executive Committee, and the Board shall review letters of resignation. Once submitted, a resignation may not be withdrawn until it has been considered by the Board. If a Practitioner or APP requests to withdraw a resignation before the resignation is accepted by the Board, the request for withdrawal shall also be forwarded to the Board for consideration. The Board may, but is not required to, honor the request for withdrawal of the resignation. Upon acceptance of the resignation by the Board, the Practitioner or APP will be notified in writing. When a resignation is accepted or clinical privileges are relinquished during the course of an investigation regarding concerns about behavior, conduct, competence, or professional performance, a report shall be submitted to the state professional licensing board for reporting to the National Practitioner Data Bank (NPDB), as required by federal law and state law.¹²⁰

3.22 PRACTITIONER HEALTH ISSUES

This section of the Bylaws applies to all individuals who provide patient care services in the Hospital and who have been granted clinical privileges. The Hospital and its Medical Staff are committed to providing quality care, which can be compromised if an individual with clinical privileges is suffering from a health issue. "Health issue" means any physical, mental, or emotional condition, or personality disorder including alcohol or substance abuse, cognitive deterioration or loss of motor skills due to the aging process, and use of prescription medications, which could adversely affect an individual's ability to practice safely and competently.^{121,122} It also includes a contagious disease which could compromise patient safety or jeopardize other health care workers. The Medical Staff and Hospital leaders have a process to provide education about health issues related to Practitioners and others with clinical privileges, for the purpose of facilitating the timely recognition and reporting of health issues. It is the policy of this Hospital to properly investigate and act upon concerns that an individual who is a Member of the Medical Staff or who has clinical privileges has a health issue. The Hospital will conduct its investigation and act in accordance with pertinent state and federal law, including, but not limited to, the Americans with Disabilities Act (ADA).

3.22.1 SELF-REPORTING

¹²⁰ Health Care Quality Improvement Act, 42 U.S.C. §11135, 45 C.F.R. 60.9(a)(ii)(A)

¹²¹ MS.11.01.01

¹²² AMA Definition of Impairment

During the application process, all applicants must report information about their ability to perform the clinical privileges that they are requesting. Each Medical Staff Member or other individual with clinical privileges is responsible for reporting any change in his/her abilities that might possibly affect the quality of patient care rendered by him/her as related to the performance of his/her clinical privileges and/or Medical Staff duties. Such reports should be made within ten business days upon the individual becoming aware of the change.¹²³

3.22.1.1 An oral or preferably, a written report shall be given to the Chief Executive Officer, or the Chief of Staff, or the Chairperson of the individual's Medical Staff Department, and/or the Chairperson of the Credentials Committee. The recipient of the report shall submit it, along with a written request to investigate, to the Credentials Committee.

3.22.2 THIRD PARTY REPORTS

If a Medical Staff Member, Advanced Practice Professional, or Hospital employee witnesses symptoms of a health issue, they should report the incident. Patients, family members, or others who witness symptoms of a health issue shall be encouraged to report the incident to an appropriate patient care representative. The identity of any individual reporting symptoms of a health issue shall be kept strictly confidential.¹²⁴ Medical Staff members and others, as appropriate, shall be educated about recognition of health issues specific to physicians and others with clinical privileges, including education about warning signs.¹²⁵ Warning signs may include, but are not restricted to, perceived problems with judgment or speech, alcohol odor, emotional outbursts, behavior changes and mood swings, diminishment of motor skills, unexplained drowsiness or inattentiveness, progressive lack of attention to personal hygiene, or unexplained frequent illnesses.

3.22.2.1 An oral or, preferably, a written report shall be given to the Chief Executive Officer, the Chief of Staff, the Chairperson of the individual's Medical Staff Department, and/or the Chairperson of the Credentials Committee. Third party reports should be factual and include a description of the incident(s) that led to the belief that an individual may have a health issue. The person making the report does not need to have proof of the health issue, but must state the facts leading to the concern.

3.22.2.2 If, after discussing the incident(s) with the person who filed the report, the recipient of the report believes there is sufficient information to warrant further inquiry, the recipient of the report may:

3.22.2.2.1 Meet personally with the individual under inquiry or designate another appropriate person to do so; and/or,

3.22.2.2.2 Direct in writing that an investigation shall be instituted and a report thereof shall be rendered by the Credentials Committee or appropriate Peer Review Committee.

3.22.3 CONCERNS REQUIRING AN IMMEDIATE RESPONSE

3.22.3.1 Anyone who is concerned that an individual has a health issue that poses an immediate threat to the health and safety of patients or to the orderly operation of the Hospital, shall immediately notify the relevant Department Chairperson, the Chief of Staff, the Chief Medical Officer, or their designees.

3.22.3.2 The Department Chairperson, Chief of Staff, and/or the Chief Medical Officer (or their designees) shall immediately assess the individual and, if necessary to protect patients, may relieve the individual of patient care responsibilities. The affected individual's hospitalized patients may be assigned to another individual

¹²³ MS.11.01.01

¹²⁴ MS.11.01.01

¹²⁵ MS.11.01.01

with appropriate clinical privileges or to the appropriate practitioner on call. The wishes of the patient(s) shall be considered in the selection of a covering practitioner. The affected patients shall be informed that their practitioner is unable to proceed with their care due to illness.

- 3.22.3.3 Following the immediate response, the Department Chairperson, Chief of Staff, and/or the Chief Medical Officer (or their designees) shall file formal reports as described in these Bylaws, in order for the health issue to be more fully assessed and addressed by the Medical Executive Committee.

3.22.4 INVESTIGATION

Following a written request to investigate, the Peer Review Committee shall investigate the concerns raised and any and all incidents that led to the belief that the individual may be impaired. The Committee's investigation may include, but is not limited to, any of the following:¹²⁶

- 3.22.4.1 A review of any and all documents or other materials relevant to the investigation;
- 3.22.4.2 Interviews with any and all persons involved in the incidents or who may have information relevant to the investigation, provided that any specific inquiries made regarding the individual's health status are related to the performance of the individual's clinical privileges and Medical Staff duties and are consistent with proper patient care or the operations of the Hospital;
- 3.22.4.3 A requirement that the individual under investigation undergo a complete medical and/or psychological examination as directed by the Committee, so long as the exam is related to the performance of the individual's clinical privileges and Medical Staff duties and is consistent with proper patient care or the operations of the Hospital, with the results of the examination to be provided to the Committee;
- 3.22.4.4 A requirement that the individual under investigation undergo urine drug screening, serum alcohol/drug level testing or other appropriate testing, with the results of the screening and/or testing to be provided to the Committee.
- 3.22.4.5 The Committee may meet with the individual under investigation as part of its investigation. This meeting does not constitute a hearing under the due process provisions of the Hospital's Medical Staff Bylaws or pertinent policies and thus may not be attended by such individual's legal counsel. At this meeting, the Committee may ask the individual under investigation health-related questions so long as they are related to the concerns related to performance of the individual's clinical privileges and Medical Staff duties, and are consistent with proper patient care and operations of the Hospital. In addition, if the Committee feels that the individual may have an impairment that significantly affects his/her ability to perform essential functions concerning patient care, it may discuss with the individual under investigation whether a reasonable accommodation is needed or could be made so that the individual could competently and safely exercise his/her clinical privileges and/or the duties and responsibilities of Medical Staff appointment.

3.22.5 OUTCOME OF INVESTIGATION

Based on all of the information it reviews as part of its investigation, the Credentials Committee shall determine:

¹²⁶ MS.4.80

- 3.22.5.1 Whether the individual has a health issue, or what other problem, if any, is affecting the individual under investigation;
- 3.22.5.2 If the individual has a health issue, the nature of the health issue and whether it is classified as a disability;
- 3.22.5.3 If the individual's health issue is a disability, whether a reasonable accommodation can be made for the individual's health issue such that, with the reasonable accommodation, the individual would be able to competently and safely perform his/her clinical privileges and the essential duties and responsibilities of Medical Staff appointment;
- 3.22.5.4 Whether a reasonable accommodation would create an undue hardship upon the Hospital, such that the reasonable accommodation would be excessively costly, extensive, substantial or disruptive, or would fundamentally alter the nature of the Hospital's operations or the provision of patient care; and,
- 3.22.5.5 Whether the health issue could negatively impact the quality of care or the health or safety of the individual, patients, Hospital employees, physicians or others within the Hospital;
- 3.22.5.6 If the Credentials Committee determines that there is a reasonable accommodation that ensures patient safety, the Credentials Committee shall attempt to work out a voluntary agreement with the individual. The Chief Executive Officer shall be kept informed of the voluntary agreement before it becomes final and effective. Based on the severity and nature of the health issue, the Credentials Committee may recommend to the Medical Executive Committee that he or she:
 - 3.22.5.6.1 take a voluntary medical leave of absence to receive appropriate medical treatment or participate in a rehabilitation program; or
 - 3.22.5.6.2 voluntarily refrain from exercising some or all privileges until an accommodation can be made to ensure that the practitioner is able to practice safely and competently; or
 - 3.22.5.6.3 voluntarily agree to specific conditions.
- 3.22.5.7 If the Medical Executive Committee recommends that the individual receive medical treatment or participate in a rehabilitation program, it may assist the individual in identifying appropriate resources.
- 3.22.5.8 If the Credentials Committee determines that there is no reasonable accommodation that can be made, or if the Committee cannot reach a voluntary agreement with the individual, the then the Credentials Committee shall refer the matter with a recommendation to the Medical Executive Committee. The Medical Executive Committee may conduct its own investigation or adopt the recommendation of the Credential's Committee and shall make a recommendation and report to the Board of Trustees, as appropriate to the action to be taken. If the Medical Executive's recommendation would provide the individual with a right to a hearing as described in the Medical Staff Bylaws, the individual shall be promptly notified of the recommendation in writing, by certified mail, return receipt requested. The recommendation shall not be forwarded to the Board until the individual has exercised or has been deemed to waive the right to a hearing as provided under Article Seven of the Medical Staff Bylaws.
- 3.22.5.9 The original report, documentation of the investigation, and a description of the actions taken shall be included in the individual's credentials file. If the initial or follow-up investigation reveals that there may be some merit to the report, but not enough to warrant immediate action, the report shall be included in a

confidential portion of the individual's credentials file and further monitoring or other follow-up shall be at the discretion of the Medical Executive Committee or the Credentials Committee.

- 3.22.5.10 Throughout this process, all parties shall avoid speculation, conclusions, gossip, and any discussions of the matter with anyone outside those described in this section of the Bylaws.

3.22.6 TREATMENT/REHABILITATION AND REINSTATEMENT GUIDELINES

If it is determined that the individual has a health issue that could be reasonably accommodated through rehabilitation or medical/psychological treatment, the following are recommendations for rehabilitation or treatment and reinstatement:

- 3.22.6.1 An individual with a health issue shall not be reinstated until it is established, to the Medical Staff's satisfaction, that the individual has successfully completed a rehabilitation program in which the Medical Staff has confidence, or has received treatment for a medical or psychological health issue such that the condition is under sufficient control.
- 3.22.6.2 The Medical Staff is not required to extend membership or privileges to an individual with a health issue, and may monitor, test or order any appropriate requirements of the individual in order to consider or grant privileges or membership to the individual.
- 3.22.6.3 Upon sufficient proof that the individual who has been found to have a health issue has completed a program or received treatment as described above, the Medical Staff, in its discretion, may consider the individual for reinstatement of Medical Staff membership or clinical privileges.
- 3.22.6.4 In considering an individual for reinstatement, the Hospital and Medical Staff leadership must consider patient care interests paramount.
- 3.22.6.5 The Medical Staff must first obtain a letter from the physician director of the rehabilitation program where the impaired individual was treated, or the physician directing the impaired individual's medical or psychological treatment. The impaired individual must authorize the release of this information. The following information shall be requested in providing guidance to the physician director regarding the content of the letter:
 - 3.22.6.5.1 Whether the individual is participating in the program or treatment;
 - 3.22.6.5.2 Whether the individual is in compliance with all of the terms of the program or treatment plan;
 - 3.22.6.5.3 Whether the individual attends AA/NA meetings regularly (if appropriate);
 - 3.22.6.5.4 To what extent the individual's behavior and conduct are monitored;
 - 3.22.6.5.5 Whether, in the opinion of the treating physician, the individual is rehabilitated or the health issue is under control;
 - 3.22.6.5.6 Whether any conditions are required to allow the individual to safely resume practicing (e.g., supervision, limitation on work hours, limitation on privileges);
 - 3.22.6.5.7 Whether an after-care program has been recommended to the individual (if appropriate), and if so, a description of the after-care program; and,

- 3.22.6.5.8 Whether, in the opinion of the treating physician, the individual is capable of resuming practice and providing continuous, competent care to patients.
- 3.22.6.6 The Medical Staff has the right to require opinion(s) from other physician consultants of its choice. Before making a recommendation on a request for reinstatement or lifting conditions, the Credentials Committee may request the practitioner to undergo an examination by a physician of its choice to obtain a second opinion on the practitioner's ability to practice safely and competently. The Credentials Committee shall make a recommendation to the Medical Executive Committee.
- 3.22.6.7 Assuming all of the information received indicates that the individual is sufficiently in recovery or rehabilitated or the medical/psychological condition is under control, the Medical Staff shall take the following additional precautions when restoring clinical privileges:
 - 3.22.6.7.1 The individual must identify a physician or peer who is willing to assume responsibility for the care of his/her patients in the event of his/her inability or unavailability;
 - 3.22.6.7.2 If the practitioner was granted a formal medical leave of absence, the final decision to reinstate an individual's clinical privileges must be approved pursuant to the Leave of Absence process set forth in the Medical Staff Bylaws;
 - 3.22.6.7.3 The individual shall be required to obtain periodic reports for the Medical Staff from the rehabilitation program, after-care program, or treating physician – for a period of time specified by the Medical Executive Committee – stating that the individual is continuing treatment or therapy, as appropriate, and that his/her ability to treat and care for patients in the Hospital is not impaired.
- 3.22.6.8 The individual must agree to submit to an alcohol or drug-screening test (if appropriate) at the request of the Chief of Staff, the Chairperson of the Credentials Committee, and the pertinent Department Chairperson.
- 3.22.6.9 As a condition of reinstatement, the individual's credentials shall be re-verified from the primary source and the verification documented, in accordance with the procedures of Article Three, Section of these Bylaws. Minimally, licensure, DEA, state narcotics registration, and professional liability insurance shall be verified. Additionally, the Hospital shall query the National Practitioner Data Bank, the OIG Sanction Report and the GSA List. The Hospital may also re-verify any other qualification or competence if there is reasonable belief that it may have been adversely affected by the circumstances related to the health issue.
- 3.22.6.10 If at any point during the process of investigation, rehabilitation or treatment, or reinstatement the individual refuses or fails to comply with these procedures, he/she will be subject to a suspension from the Medical Staff and afforded due process as defined in the provisions of the Medical Staff Bylaws, unless the individual's contract with the Medical Executive Committee states otherwise, such as when automatic termination is the penalty stated in the contract.
- 3.22.6.11 If at any time during the diagnosis, treatment, or rehabilitation phase of this process it is determined that the individual is unable to safely perform the privileges he/she has been granted, the matter shall be forwarded to the Medical

Executive Committee for appropriate corrective action that includes strict adherence to any state or federally mandated reporting requirements.¹²⁷

- 3.22.6.12 If at any time it becomes apparent that a particular matter cannot be handled internally, or jeopardizes the safety of the individual or others, the Chief Medical Officer or Chief Executive Officer may contact law enforcement authorities.
- 3.22.6.13 Nothing in this Section precludes immediate referral to the Medical Executive Committee or the elimination of any particular steps in this Section in dealing with conduct that may compromise patient care.
- 3.22.6.14 All requests for information concerning the individual shall be forwarded to the Chief Executive Officer and Chief of Staff for response. Information concerning an individual seeking referral or referred for assistance shall be maintained with confidentiality, except as limited by law, ethical obligation or when the safety of a patient is threatened.¹²⁸

3.23 REQUIREMENTS REGARDING PROFESSIONAL CONDUCT

- 3.23.1 Collaboration, communication, and collegiality are essential for the provision of safe and competent patient care. Thus it is the policy of the Hospital to require all individuals working in the Hospital, including Medical Staff members, APPs, and other individuals with clinical privileges to treat others with respect, courtesy, and dignity and to conduct themselves in a professional and cooperative manner. In dealing with incidents of unprofessional or inappropriate conduct, the protection of patients, employees, physicians, and others in the Hospital and the orderly operation of the Hospital are paramount concerns.
- 3.23.2 Unprofessional or inappropriate conduct or behavior is defined as that which adversely affects or impacts the Hospital operations or the ability of others to get perform their jobs done competently, or interferes or tends to interfere with the provision of safe, quality patient care at the Hospital. For the purposes of these Bylaws, examples of “unprofessional or inappropriate conduct” include, but are not limited to:
 - 3.23.2.1 Rude, threatening or abusive behavior or comments to Hospital personnel, Advanced Practice Professionals, patients, or Practitioners.
 - 3.23.2.2 Negative comments to patients about other Practitioners, nurses or other Hospital personnel or Medical Staff members or about their care and treatment in the Hospital.
 - 3.23.2.3 Verbal attacks, which are of a personal, irrelevant or go beyond fair, professional conduct, and that are directed to Hospital personnel, Medical Staff, Advanced Practice Professionals, contracted staff, or patients.
 - 3.23.2.4 Irrelevant or inappropriate comments, drawings, or illustrations made in a patient’s medical records or other Hospital business records, impugning the quality of care in the Hospital, or attacking particular Practitioners, Advanced Practice Professionals, nurses, other Hospital personnel, or Hospital policies.
 - 3.23.2.5 Criticism that is addressed to a recipient in such a manner as to that intimidates, undermines confidence, belittles or implies stupidity or incompetence or some other type of public humiliation.
 - 3.23.2.6 Disruption of Hospital operations, Hospital or Medical Staff committee(s) or departmental affairs.
 - 3.23.2.7 Imposing onerous requirements on the nursing staff, other Hospital staff, Hospital-affiliated providers, APPs, or contractors, such as assigning work that

¹²⁷ MS.4.80

¹²⁸ MS.4.80

is outside of their scope of practice as allowed under their state license, or outside of the scope of their Hospital job description, Hospital-approved duties, or clinical privileges, or contrary to Hospital policies and procedures, or that would otherwise jeopardize patient safety, quality of patient care or the Hospital's or staff member's compliance with laws, regulations or standards.

- 3.23.2.8 Lying, cheating, knowingly making false accusations, altering, or falsifying any patient's medical records or Hospital documents.
- 3.23.2.9 Verbal or physical maltreatment of another individual, including physical or sexual assault.
- 3.23.2.10 Harassment, including words, gestures and actions, verbal or physical, that interferes with a person's ability to competently perform his or her job.
- 3.23.2.11 Conduct or behavior that causes a hostile or offensive work environment. Behaviors that engender a hostile or offensive work environment may include, without limitation: offensive comments, jokes, innuendos, sexually-oriented statements, printed material, material distributed through electronic media or items posted on walls or bulletin boards. Hostile Work Environment may also be created by conduct or behavior that is directed at a specific person or persons that causes substantial emotional distress.
- 3.23.2.12 Sexual harassment including conduct or behavior that includes unwelcome sexual advances, requests for sexual favors, and all other verbal or physical conduct of a sexual or otherwise offensive nature, particularly if:
 - 3.23.2.12.1 Submission to such conduct is made either explicitly or implicitly a term or condition of employment.
 - 3.23.2.12.2 Submission to or rejection of such conduct is used as the basis for decisions affecting an individual's employment.
 - 3.23.2.12.3 Such conduct has the purpose or effect of creating an intimidating, hostile, or offensive work environment. Behaviors that engender a hostile or offensive work environment may include, without limitation, offensive comments, jokes, innuendos and other sexually oriented statements, printed material, material distributed through electronic media, or items posted on walls or bulletin boards.
 - 3.23.2.12.4 Sexual harassment can also include making or threatening reprisal following a negative response to the verbal or physical sexual conduct or behavior, and any other such behavior or conduct as defined by state and federal law and regulations.
- 3.23.3 Conduct of a criminal nature, including but not limited to assault and battery, rape, or theft shall be handled through local law enforcement officials in accordance with Hospital policy, local and State laws.
- 3.23.4 The Medical Staff leadership and Hospital leaders may provide education to all Medical Staff members and other individuals with clinical privileges regarding appropriate professional behavior and conduct. The Medical Staff leaders and Hospital leaders shall also make employees, members of the Medical Staff, and other personnel in the Hospital aware of policies associated with appropriate professional conduct and shall institute procedures to facilitate prompt reporting of inappropriate or unprofessional conduct, and prompt action as appropriate under the circumstances.
- 3.23.5 An employee who engages in unprofessional or inappropriate conduct shall be dealt with in accordance with the Hospital's Human Resources policies. A Member of the Medical Staff and other individual with clinical privileges who engages in unprofessional or inappropriate conduct shall be dealt with in accordance with this Section of the Bylaws. Unprofessional or

inappropriate conduct resulting from a health issue as defined in the Practitioner Health Issues section of these Bylaws should be dealt with using whichever Section is most appropriate for the conduct in question. If the matter involves an employed Practitioner or APP, the Chief Executive Officer shall consult with appropriate Medical Staff leaders, and legal counsel will determine which of any applicable policies will be applied.

- 3.23.6 In the event of any apparent or actual conflict between these Bylaws and the Rules and Regulations, policies of the Medical Staff, or other policies, the provisions of these Bylaws shall control.
- 3.23.7 This section of the Bylaws outlines initial collegial steps (i.e., warnings and meetings with a Practitioner) that may be taken in an attempt to resolve complaints about unprofessional or inappropriate conduct exhibited by a Practitioner. However, there may be a single incident of unprofessional or inappropriate conduct, or a continuation of conduct, that is so unacceptable as to make such collegial steps inappropriate and that requires immediate disciplinary action. Therefore, nothing in these Bylaws precludes immediate referral to the Chief Executive Officer, the Medical Executive Committee or to the Board, with the Chief Executive Officer, Medical Executive Committee or the Board implementing immediate actions, which may include but is not limited to summary suspension, the filing of criminal charges, or the elimination of any particular step outlined herein so as to take immediate action in dealing with a complaint regarding unprofessional or inappropriate conduct.
- 3.23.8 Nurses, other Hospital employees, or other individuals who observe, or are subjected to, unprofessional or inappropriate conduct by a Practitioner shall notify their supervisor about the incident or, if their supervisor's behavior is at issue, they shall notify the Chief Executive Officer (or designee). Any Practitioner who observes such behavior shall notify the Chief Executive Officer directly. Upon learning of the occurrence of an incident of unprofessional or inappropriate conduct, the supervisor/Chief Executive Officer shall request that the individual who reported the incident document it in writing. If the observer of inappropriate or unprofessional conduct does not wish to provide a written report, the supervisor/Chief Executive Officer may document it, while also attempting to ascertain the observer's reasons for declining and providing encouragement to do so.
- 3.23.9 The documentation shall, to the extent possible, include:
 - 3.23.9.1 The date and time of the questionable behavior;
 - 3.23.9.2 A factual description of the questionable behavior;
 - 3.23.9.3 The name of any patient or patient's family members who were involved in the incident, including any patient or family Member who witnessed the incident;
 - 3.23.9.4 The circumstances which precipitated the incident;
 - 3.23.9.5 The names of other witnesses to the incident;
 - 3.23.9.6 Consequences, if any, of the unprofessional or inappropriate conduct as it relates to patient care, personnel, or Hospital operations;
 - 3.23.9.7 Any action taken to intervene in, or remedy, the incident; and,
 - 3.23.9.8 The name and signature of the individual reporting the matter.

- 3.23.10 The supervisor shall forward a documented report to the Chief Executive Officer, who shall immediately notify the Chief of Staff. The Chief Executive Officer and the Chief of Staff shall review the report and may meet with the individual who prepared it and/or any witnesses to the incident to ascertain the details of the incident.
- 3.23.11 If a reporting individual is unwilling or uncomfortable with reporting unprofessional or inappropriate conduct using the procedure described in Section 3.21.8, then a report of the incident may be made to the Hospital's Ethics & Compliance Officer or the Ethics Line at 1-800-455-1996.
- 3.23.12 The supervisor/Chief Executive Officer who took the report shall follow-up with the individual who made the report by informing the individual that the matter is being reviewed, thanking the individual for reporting the matter, and instructing the individual to report any further incidents of inappropriate or unprofessional conduct. The individual making the report shall also be informed that, due to legal confidentiality requirements, no further information can be provided regarding the review of the matter.
- 3.23.13 After a determination that the incident of unprofessional or inappropriate conduct has occurred, the Chief of Staff and/or Chief Executive Officer (or their respective designees) shall meet with the Practitioner. If appropriate, this initial meeting should be collegial. During the meeting, the Practitioner shall be advised of the nature of the incident that was reported and shall be requested to provide his/her response and/or perspective concerning the incident. The Practitioner shall be advised that, if the incident occurred as reported, his/her conduct was inappropriate and inconsistent with the standards of the Hospital and the Bylaws. The identity of the individual preparing the report of unprofessional or inappropriate conduct shall not be disclosed at this time, unless the Chief Executive Officer and Chief of Staff agree in advance that it is appropriate to do so. In all cases, the Practitioner shall be advised that any retaliation of any type by him/her against the person reporting the incident or anyone involved in the incident will be grounds for his/her immediate exclusion from all Hospital facilities.
- 3.23.14 This initial meeting may also be used to educate the Practitioner about administrative channels that are available for registering complaints or concerns about quality or services. Other sources of support or counseling may also be identified for the Practitioner, as appropriate.
- 3.23.15 The Practitioner shall be advised that a summary of the meeting shall be prepared and a copy provided to him or her. The Practitioner may prepare a written response to the summary. The Chief of Staff shall cause the summary and any response that is received to be kept in the confidential portion of the Practitioner's credentials file. The Chief Executive Officer shall cause the written report(s) of the incident, summary of the meeting, and any other records regarding the incident or the meeting to be kept as a confidential risk management record.

- 3.23.16 If another report of unprofessional or inappropriate conduct involving the Practitioner is received, a second meeting shall be held. At least three people (e.g., the Chief of Staff, the Chairperson of the Credentials Committee, other medical staff leader, and/or the Chief Executive Officer, or legal counsel) shall be present to meet with the Practitioner. At this meeting, the Practitioner shall be informed of the nature of the incident and be advised that such conduct is unacceptable. The Practitioner shall be advised that the matter may be referred to the Medical Executive Committee or to the Board of Trustees for more formal action.
- 3.23.17 Following this meeting, a letter shall be sent to the Practitioner. The letter shall describe the unprofessional or inappropriate conduct, outline the steps that have been taken in the past to correct that conduct, and detail the kind of behavior that is acceptable and unacceptable. The letter should also confirm that the Practitioner could be excluded from all Hospital facilities for a period of time, a request that a formal investigation could be commenced pursuant to the Bylaws, and any other remedies could be taken to adequately protect the patients, hospital staff and others from continued unprofessional or inappropriate conduct. The letter will also define the conditions of continued practice at the Hospital which shall make continued Medical Staff membership and clinical privileges contingent on the Practitioner's adherence to the conditions and expectations for professional conduct. The Practitioner shall be required to sign it. The Chief of Staff shall cause records of the second meeting and the letter to the Practitioner to be filed in the confidential portion of the credentials file. The Chief Executive Officer shall cause records of the second meeting and the letter to the Practitioner to be filed in confidential risk management files. If the Practitioner refuses to sign the letter, the Chief Executive Officer and/or the Chief of Staff shall request that a formal investigation be commenced pursuant to the Bylaws and the advice of legal counsel should be obtained.
- 3.23.18 The Medical Executive Committee shall be fully apprised of the previous warnings issued to the Practitioner and the actions taken to address the concerns.
- 3.23.19 The Medical Executive Committee may, at any point in the investigation, refer the matter to the Board without a recommendation. Any further action, including hearing or appeal, shall then be conducted under the direction of the Board.
- 3.23.20 When, despite prior warning, the Practitioner continues to engage in unprofessional or inappropriate conduct, the Practitioner may be excluded from the Hospital's facilities and a precautionary suspension imposed during which time an investigation shall be conducted to determine the need for a professional review action. Immediate exclusion and precautionary suspension may also be imposed for a single event when a Practitioner's conduct is so unprofessional or inappropriate that failure to take such action may result in an imminent danger to the health of any individual.¹²⁹ Precautionary suspension shall be imposed in accordance with Article Six of these Bylaws.

¹²⁹ Health Care Quality Improvement Act, 42 U.S.C. §11112(c)(1 – 2)

ARTICLE FOUR: CATEGORIES OF THE MEDICAL STAFF

4.1 CATEGORIES

The Staff shall include the categories of Active Staff, Affiliate Staff, and Ambulatory Staff. At the time of appointment and at the time of each reappointment, the Medical Staff Member's staff category shall be recommended by the Medical Executive Committee and approved by the Board.¹³⁰

4.2 LIMITATIONS ON PREROGATIVES

The prerogatives of Medical Staff membership in these Bylaws are general in nature and may be limited or restricted by special conditions attached to a Practitioner's appointment or reappointment, by state of federal law or regulations, or other provisions of these Bylaws, the Rules and Regulations, or other policies, commitments, contracts or agreements of the Hospital.

4.3 ACTIVE STAFF

4.3.1 REQUIREMENTS FOR ACTIVE STATUS

The Active Staff category shall consist of Practitioners (including those practitioners who are in the first year provisional status) who actively support the Medical Staff and the Hospital by contributing to efforts to fulfill Medical Staff functions. The Active Staff category shall consist of Practitioners who regularly admit, or personally provide services to patients in the Hospital and who are located (primary or satellite office and permanent or temporary residence) within a reasonable distance and/or travel time, ("reasonable" to be determined by the Board based on the Practitioner's specialty and scope of care at the Hospital) to provide continuous care to their patients. Active staff will provide patient service to at least twelve (12) patients per year to include admissions, surgeries, procedures and consults. Hospital-based Practitioners who do not admit patients may be members of the active Medical Staff if otherwise qualified. The Active Staff category of Practitioners shall be responsible for oversight of care, treatment and services provided by the Medical Staff, and members in the Active Staff category shall have the requisite skills for providing such oversight.¹³¹

4.3.2 PREROGATIVES OF ACTIVE STAFF

Members of the Active Staff shall be eligible to vote and hold office within the Medical Staff organization. Any Active Staff Member may attend Medical Staff and department meetings and serve on committees of the Board, Medical Staff or Hospital. Members in the Active Staff category shall compose the group defined as the Organized Medical Staff.

4.3.3 OBLIGATIONS OF ACTIVE STATUS

Each member of the Active Staff shall discharge the basic obligations of staff members as required in these Bylaws and any future changes to these Bylaws; accept emergency on-call coverage for emergency care services within his/her Medical Staff Department as specified by the requirements of the assigned Medical Staff Department¹³²; provide continuous care and supervision of his/her patients in the Hospital or arrange a suitable alternative; actively participate in the quality assessment and performance improvement activities of the Hospital; attend Medical Staff and Department meetings; and perform such further duties as may be required of him/her under these Bylaws or Rules and Regulations including any future changes to these Bylaws or Rules and Regulations, and comply with directives issued by the Medical Executive Committee.

¹³⁰ 42 C.F.R. §482.22(c)(3)

¹³¹ MS.4.10, Forward

¹³² 42 C.F.R. §482.55(b)(2)

Active staff will provide patient service to twelve (12) patients per year to include admissions, surgeries, procedures and consults.

Active Staff appointees who have served on the ER On-Call schedule of this Hospital fifteen (15) or more years shall be exempt and such removal has been recommended by the Executive Committee and approved by the Board of Trustees. Appointees may be reinstated to the ER On-Call schedule if needed to maintain adequate ER coverage. This recommendation would be made after consideration by the Medical Executive Committee, but must be approved by the Board of Trustees.

4.4 AFFILIATE STAFF

4.4.1 REQUIREMENTS FOR AFFILIATE STAFF

The Affiliate Staff category shall consist of Practitioners who are not actively involved in Medical Staff affairs and are not major contributors to fulfillment of Medical Staff functions, due to practicing primarily at another hospital or in an office-based specialty, or other reasons, but who wish to remain affiliated with the Hospital for consultation, call coverage, referral of patients, or other patient care purposes.

4.4.2 PREROGATIVES OF AFFILIATE STAFF

Members of the Affiliate Staff shall not be eligible to vote or hold office within the Medical Staff Organization.

4.4.3 OBLIGATIONS OF AFFILIATE STAFF

4.4.3.1 Each member of the Affiliate staff shall discharge the basic obligations of staff members as required in these Bylaws; accept emergency on-call coverage for emergency care services within his/her clinical specialty as may be specified by the requirements of the assigned Medical Staff Department¹³³; provide continuous care and supervision of his/her patients in the Hospital or arrange a suitable alternative; and perform such further duties as may be required of him/her under these Bylaws or Rules and Regulations.

4.4.3.2 Affiliate Staff shall not admit or operate on more than twelve (12) patients per year in the Hospital. Affiliate Staff appointees who exceed twelve (12) patient contacts during the past year shall be reviewed at the end of the appointment term and, if reappointed, shall be appointed to the Active Staff for a minimum of twelve (12) months, and will be expected to fulfill all of the responsibilities pertaining thereto.

4.4.3.3 Each Affiliate Staff appointee, by accepting appointment, shall agree to assume all of the functions and responsibilities of appointment to the Affiliate Staff including, where appropriate, participation in the Quality/Performance Improvement Program and monitoring activities, including full cooperation and participation in the provisional appointment evaluation process.

4.4.3.4 Affiliate Staff appointees shall be located close enough to the Hospital to fulfill their responsibilities and to provide timely and continuous care for their patients in the Hospital.

4.4.3.5 Affiliate Staff appointees shall take Emergency Room call at the discretion of the Department Chief and the Chief Executive Officer.

4.5 AMBULATORY STAFF

4.5.1 REQUIREMENTS FOR AMBULATORY STAFF

The Ambulatory Staff category shall consist of Practitioners who do not practice in the Hospital but still desire to maintain medical staff appointment to provide continuity of care to

¹³³ 42 C.F.R. §482.55(b)(2)

their patients or to satisfy a criterion of medical staff membership and access to in-network hospital services that may be required for participation in managed care organization panel(s). The Ambulatory Staff category is a membership-only category of the Medical Staff with no clinical privileges, and limited medical staff responsibilities and prerogatives. As Members of the Medical Staff, Ambulatory Staff shall be fully credentialed and shall be granted membership based on a recommendation by the Medical Staff, with approval by the Governing Body. Since no clinical privileges are granted, Ambulatory Staff shall not be subject to the requirements for focused professional practice evaluation or ongoing professional practice evaluation.

4.5.2 PREROGATIVES OF AMBULATORY STAFF

Members of the Ambulatory Staff may visit their hospitalized patients, and review their patients' medical records, but they exercise no clinical privileges and may not write orders, progress notes, or other notations in the medical record, provide any patient care, or perform any procedures. Ambulatory Staff shall not be eligible to vote or hold office within the Medical Staff organization.

4.5.3 OBLIGATIONS OF AMBULATORY STAFF

Each Member of the Ambulatory Staff shall discharge the basic obligations of staff members as required in these Bylaws; but they shall not provide emergency on-call coverage or perform any other duties for which clinical privileges are required. Each Member of the Ambulatory Staff shall establish appropriate referral and coverage arrangements with an Active or Affiliate Staff Member for the medical care of his/her patients that require Hospital services.

4.6 HONORARY RECOGNITION

4.6.1 REQUIREMENTS FOR HONORARY RECOGNITION

Honorary Recognition shall be granted to Practitioners retired from professional practice who are recognized for their noteworthy contributions to the health and medical sciences, or previous long-standing service to the Hospital. Due to being retired, Practitioners with Honorary Recognition are not eligible for Medical Staff membership or clinical privileges, and therefore shall not be subject to any credentialing process.

4.6.2 PREROGATIVES OF HONORARY RECOGNITION

Practitioners with Honorary Recognition shall be invited and welcome to attend educational and social functions of the Hospital and Medical Staff.

4.7 CHANGE IN STAFF CATEGORY

Pursuant to a request by the Medical Staff member, upon a recommendation by the Credentials Committee, or pursuant to its own action, the Medical Executive Committee may recommend a change in medical staff category of a member consistent with the requirements of the Bylaws. The Board shall approve any change in category.

4.8 MEDICAL STUDENTS, INTERNS, EXTERNS, RESIDENTS, AND FELLOWS

The terms, "medical students," "interns," "externs," "residents," and "fellows," (hereinafter referred to collectively as "house staff") as used in these Bylaws, refer to Practitioners who are currently enrolled in the Largo Medical Center graduate medical education program approved by the Medical Executive Committee and the Board, and who, as part of their educational program, will provide health care services at the Hospital. House staff shall not be considered Independent Practitioners, shall not be eligible for clinical privileges or medical staff membership, and shall not be entitled to any of the rights, privileges, or to the hearing or appeal rights under these Bylaws. House staff shall be credentialed by the sponsoring medical school or training program in accordance with provisions in a written affiliation agreement between the Hospital and the school or program; credentialing information shall be made available to the Hospital upon request and as needed by the Medical Staff in making any training assignments and in the performance of their supervisory function. The school or program shall provide a written description of the role, responsibilities, and patient care activities of

participants in the training program.¹³⁴ In compliance with federal laws, it shall not be necessary to submit a query to the National Practitioner Data Bank prior to permitting a house staff Practitioner to provide services at this Hospital. House staff Practitioners may render patient care services at the Hospital only pursuant to and limited by the following:

- 4.8.1 House staff Practitioners who have completed the basic level of training for licensure shall be licensed in this State and shall be limited by applicable provisions of the professional licensure requirements of this State;
- 4.8.2 A written affiliation agreement between the Hospital and the sponsoring medical school or training program. Such agreement shall identify the individual or entity responsible for providing professional liability insurance coverage or the financial responsibility for professional liability claims involving house staff Practitioner in an amount acceptable to the hospital.
- 4.8.3 The protocols or policies established by the Medical Executive Committee, in conjunction with the sponsoring medical school or training program regarding the scope of a house staff Practitioner's authority (e.g., authority and circumstances under which they may write patient care orders and make entries in the patient record, subject to supervision and countersignature by a supervising LIP), mechanisms for the direction and supervision of a house staff Practitioner (e.g., mechanisms for the supervising LIP and the school's program director to make decisions about each house staff Practitioner's progressive involvement and independence in specific patient care activities), and other conditions imposed upon a house staff Practitioner by this Hospital or the Medical Staff.¹³⁵
- 4.8.4 While functioning in the Hospital, house staff Practitioners shall abide by all provisions of the Medical Staff Bylaws, Rules and Regulations, and Hospital and Medical Staff policies and procedures, and shall be subject to limitation or termination of their ability to function at the Hospital at any time in the discretion of the Chief Executive Officer or the Chief of Staff. House staff Practitioners may perform only those services set forth in the training protocols developed by the applicable training program to the extent that such services do not exceed or conflict with the Rules and Regulations of the Medical Staff or Hospital policies, and to the extent approved by the Board. A house staff Practitioner shall be responsible and accountable at all times to a member of the Medical Staff, and shall be under the supervision and direction of a member of the Medical Staff. House staff Practitioners may be invited or required to attend meetings of the Medical Staff, Medical Staff Departments, Divisions, or committees, but shall have no voting rights.
- 4.8.5 The Graduate Medical Education Committee or Director of Medical Education shall be responsible for overseeing house staff Practitioners and shall communicate to the Medical Executive Committee and the Board about the patient care provided by, and the related educational and supervisory needs of, the participants in the professional graduate education programs, including demonstrated compliance with any residency review committee citations as applicable to the program.¹³⁶
- 4.8.6 As defined in Section 4.8 above, house staff Practitioners are distinguished from Practitioners who, although currently enrolled in a graduate medical education program, provide patient care services independently at the Hospital (e.g., "moonlighting" or locum tenens coverage) and not as part of their educational program. Such Practitioners who provide independent services must meet the qualifications for Medical Staff membership and clinical privileges as provided in these Bylaws and shall be subject to the credentialing procedures specified in these Bylaws in the same manner as a Practitioner seeking appointment to the Medical Staff.

4.9 ADVANCED PRACTICE PROFESSIONALS

¹³⁴ MS.2.30

¹³⁵ MS.2.30

¹³⁶ MS.04.01.01

The term, “Advanced Practice Professional” (APP) refers to individuals, other than those defined as a Practitioner, who provide direct patient care services in the Hospital under a defined degree of supervision, exercising judgment within the areas of documented professional competence and consistent with applicable law. Categories of APPs eligible for clinical privileges shall be approved by the Board and shall be credentialed through the same processes as a Medical Staff member, as described in Article Three, and shall be granted clinical privileges as either a dependent or independent healthcare professional as defined by State laws and in these Bylaws. Although APPs are credentialed as provided in these Bylaws, in Article Three, they are not eligible for Medical Staff membership. They may provide patient care services only to the extent of the clinical privileges that have been granted. The Board has determined the categories of individuals eligible for clinical privileges as an APP are physician assistants (PA), certified registered nurse anesthetists (CRNA), certified nurse midwives (CNM), advanced registered nurse practitioners (ARNP).¹³⁷

Other categories of dependent healthcare professionals who are not hospital employees but who provide patient care services in support of, or under the direction of a Medical Staff Member shall have their qualifications and ongoing competence verified and maintained through a process administered by the Hospital. Categories of dependent healthcare professionals subject to such Hospital processes, policies and procedures shall include, without limitation, Health Care Industry Representatives (HCIRs), operating room nurses and technicians, perfusionists, surgical first assistants, clinical assistants, autotransfusionists, orthotists/prosthetists, registered and practical nurses, dental technicians, lactation consultants, doulas, and medical assistants. Hospital policies and procedures shall govern the actions and patient care services provided by dependent healthcare professionals. *These categories of dependent healthcare professionals are not considered Advanced Practice Professionals.* Although a Medical Staff Member may provide employment, sponsorship and supervision of a non-hospital-employed dependent healthcare professional through the terms of a sponsorship agreement, which shall impose binding responsibilities upon the Medical Staff Member, *these Bylaws shall not apply to such dependent healthcare professionals.* Dependent healthcare professionals are listed here only to distinguish them from APPs.

A Medical Staff Member who fails to fulfill the responsibilities as outlined in the Rules and Regulations and/or in a sponsorship agreement for the supervision of an APP or a dependent healthcare professional shall be subject to appropriate actions provided by these Bylaws

4.10 REQUIREMENTS FOR ADVANCED PRACTICE PROFESSIONALS

As permitted by state law, APPs shall be responsible and accountable at all times to a Member of the Medical Staff, and shall be under the supervision and direction of a Member of the Medical Staff. The terms of the accountability of the APP to the Medical Staff Member and the terms for supervision of the APP by a Medical Staff Member shall be documented in a sponsorship agreement between the APP and the sponsoring Medical Staff Member. In addition to a complete application, as defined in these Bylaws, a sponsorship agreement shall be on file at the Hospital. The sponsorship agreement and requests for clinical privileges shall contain all of the following information:

- 4.10.1 Name of the sponsoring Medical Staff member and name of any alternative sponsoring Medical Staff members;
- 4.10.2 Completed sponsoring Medical Staff member’s evaluation;
- 4.10.3 Requested clinical privileges shall specify the degree of supervision required for the performance of each clinical privilege, and shall be signed by the sponsoring Medical Staff member(s);

¹³⁷ 42 C.F.R. §482.12(a)(1)

4.10.4 Signed agreement by the sponsoring Medical Staff Member(s) to provide required supervision and accept responsibility for the patient care services provided by the APP.

4.11 PREROGATIVES OF ADVANCED PRACTICE PROFESSIONALS

APPs shall not be eligible to vote, or hold office within the Medical Staff organization. An APP may attend Medical Staff or Department/Division meetings if invited. An APP may admit patients to the Hospital only if eligible for admitting privileges if allowed by State laws, and only if granted admitting privileges by the Board of Trustees. Patients admitted by an APP shall be under the care of a physician.¹³⁸

4.12 OBLIGATIONS OF ADVANCED PRACTICE PROFESSIONALS:

Each APP shall discharge the basic obligations of Staff members as required in these Bylaws; abide by these Bylaws, the Rules and Regulations, and all other rules, policies and procedures, guidelines, and other requirements of the Medical Staff and the Hospital, as applicable to his/her activities in association with the Hospital

5. ARTICLE FIVE: CLINICAL PRIVILEGES

5.1 EXERCISE OF PRIVILEGES

Every Practitioner or Advanced Practice Professional providing direct clinical services at this Hospital, by virtue of Medical Staff membership or otherwise, shall, in connection with such practice and except as provided in Sections 5.3 and 5.4 below, be entitled to exercise only those clinical privileges specifically granted to him/her by the Board.¹³⁹ The privileges must be Hospital-specific, within the scope of the license authorizing the individual to practice in this State or any certificate or other legal credential authorizing practice in this State and consistent with any restrictions thereon, within the scope of the individual's current competence, and shall be subject to the Rules and Regulations of the Department. Clinical privileges may be granted, continued, modified, or terminated by the Board upon the recommendation of the Medical Staff, for reasons directly related to quality of patient care and other provisions of the Bylaws, and following the procedures outlined in these Bylaws. Each Practitioner must obtain consultation with another Practitioner who possesses appropriate clinical privileges in any case when the clinical needs of the patient exceed the clinical privileges of the Practitioner(s) currently attending the patient.¹⁴⁰ Additionally, consultation must be obtained when required by these Bylaws, the Medical Staff and Department Rules and Regulations, and other policies of the Medical Staff and the Hospital, which set forth criteria to determine which clinical procedures or treatments, or medical, surgical or psychiatric conditions require consultation.¹⁴¹

5.2 DELINEATION OF PRIVILEGES

5.2.1 Application

Clinical privileges may be granted only upon formal request on forms provided by the Hospital with subsequent processing and approval. Every application for appointment and reappointment must contain a request for the specific clinical privileges desired by the applicant. An application for clinical privileges without a request for Medical Staff membership shall contain the same information as an application for Staff membership. An applicant for clinical privileges shall be subject to the same obligations as are imposed upon an applicant for Staff appointment, as provided in Article Three, Section 3.5. Only those clinical privileges supported by evidence of competence and proof that the applicant meets the

¹³⁸ 42 C.F.R. §482.12(c)(2)

¹³⁹ MS.1.40, MS.4.20

¹⁴⁰ MS.2.20

¹⁴¹ MS.2.20

criteria for each privilege will be processed through the application process. Pursuant to Section 3.7.3, the responsibility for producing a complete application and request for clinical privileges shall be the applicant's.

5.2.2 ADMITTING PRIVILEGES

Only Medical Staff members with clinical privileges or qualified Practitioners granted temporary privileges may be granted admitting privileges. The privilege to admit shall be delineated, and is not automatic.¹⁴²

5.2.3 ADDITIONS TO CLINICAL PRIVILEGES

A request by an individual with clinical privileges for additional clinical privileges or modifications in clinical privileges may be made at any time, but such requests must be supported by documentation of training and/or experience supportive of the request. In processing such a request, the National Practitioner Data Bank will be queried, and the response used by the Medical Staff and the Board in considering the request.¹⁴³ The following documentation shall be included with any requests for an increase in clinical privileges and new clinical privileges:

- 5.2.3.1.1 Any additional license, certification or registration required for the new clinical privileges or increased clinical privileges requested shall be verified.¹⁴⁴
- 5.2.3.1.2 Training, continuing education, and experience related to the new clinical privileges or increased clinical privileges requested shall be verified.¹⁴⁵
- 5.2.3.1.3 Evidence of current competence related to the new clinical privileges or increased clinical privileges requested shall be verified. This shall include a review of relevant practitioner-specific performance data when available.¹⁴⁶
- 5.2.3.1.4 Information provided by peers of the applicant shall be included in deliberations when increasing privileges.
- 5.2.3.1.5 An evaluation provided by peers of the applicant shall be included in deliberations when adding or increasing privileges. The peer evaluation shall be in writing and address medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism.
- 5.2.3.1.6 Applicants are required to report malpractice insurance coverage information for the new privileges requested.
- 5.2.3.1.7 The hospital shall query the National Practitioner Data Bank (NPDB) when new clinical privileges or increased clinical privileges are requested.¹⁴⁷
- 5.2.3.1.8 When adding or increasing clinical privileges the applicant shall be required to attest to his/her health status as related to ability to perform the new or increased clinical privileges being requested and health status shall be verified.¹⁴⁸
- 5.2.3.1.9 When adding or increasing clinical privileges the applicant shall be required to respond to queries regarding whether there have been any:
 - 5.2.3.1.9.1.1 Previously successful or currently pending challenges, or voluntary or involuntary relinquishment, of licensure or registration.¹⁴⁹

¹⁴² MS.2.10, MS.4.20

¹⁴³ 42 U.S.C. §11135, C.F.R. §60.10

¹⁴⁴ MS.06.01.05

¹⁴⁵ MS.12.01.01

¹⁴⁶ MS.06.01.05

¹⁴⁷ MS.06.01.05; 42 U.S.C. §11135, C.F.R. §60.10

¹⁴⁸ MS.06.01.05

- 5.3.3.1.10.2 Voluntary or involuntary reduction in privileges or termination of privileges or membership.¹⁵⁰
- 5.3.3.1.10.3 Involvement in any liability actions, including any final judgments or settlements

5.2.4 BASIS FOR PRIVILEGE DETERMINATION

There shall be criteria for granting, renewing or revising clinical privileges that are directly related to the quality of healthcare and pertain to the evidence of current competence and ability to perform the privileges requested.¹⁵¹ Applications and requests for clinical privileges shall be evaluated on the basis of the applicant’s education, training, current competence, the ability to perform the clinical privileges requested, professional references, and peer recommendations that include written information about the applicant’s medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, professionalism information from the applicant’s current or past facility affiliations regarding membership status and current competence, professional liability experience and insurance coverage, and other relevant information, including an evaluation by the Chairperson of the Clinical Department in which the privileges have been sought.¹⁵² The criteria for granting clinical privileges shall also include the ability of the Hospital to provide supportive services for the applicant and his/her patients.¹⁵³ Clinical privileges that are granted, renewed, or revised shall be appropriate to the scope of services and service capabilities of the Hospital, meaning that in approving privileges, considerations shall include not only the applicant’s qualifications but also the availability of equipment, the number, type and qualifications of staff, and/or the appropriateness of the physical environment and resources in a particular Hospital setting, and clinical privileges may be restricted by the Board of Trustees to only certain settings within the Hospital, as appropriate to each setting.¹⁵⁴

The basis for privilege determinations for continuation of privileges shall include, in addition to the above listed information, the results of ongoing professional practice,¹⁵⁵ as provided for in Article Three of these Bylaws. Additionally, all individuals with delineated clinical privileges are required to participate in continuing education as related to their privileges,¹⁵⁶ and the applicant’s participation in continuing education shall be considered when renewing or revising such privileges.¹⁵⁷ Before clinical privileges are granted, renewed, or revised by the Board of Trustees, the Medical Staff shall evaluate each applicant with regard to the following information and make a recommendation based on the following information:¹⁵⁸

- 5.3.4.1 For applicants in fields performing operative and other procedures, the types of operative procedures performed as the surgeon of records, the handling of complicated deliveries, or the skill demonstrated in performing invasive procedures, including information about appropriateness and outcomes of the procedures;
- 5.3.4.2 For applicants in non-surgical fields, the types and outcomes of medical conditions managed by the applicant as the responsible physician;
- 5.3.4.3 The applicant’s clinical judgment and technical skills;

¹⁴⁹ MS.06.01.05

¹⁵⁰ MS.06.01.05

¹⁵¹ MS.4.40

¹⁵² MS.4.20

¹⁵³ MS.1.20, MS.4.10

¹⁵⁴ MS.4.20

¹⁵⁵ MS.3.20

¹⁵⁶ MS.5.10

¹⁵⁷ MS.5.10

¹⁵⁸ MS.4.10, 4.20, MS.4.40

- 5.3.4.4 Any evidence of unusual patterns of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant;
- 5.3.4.5 Information from quality assessment and performance improvement, including but not limited to review of operative and other procedures, use of blood and blood products, use of medications, review of medical records, utilization management/medical necessity review, risk management data, and patient safety data;
- 5.3.4.6 Relevant practitioner-specific data that are compared to aggregate data;
- 5.3.4.7 Morbidity and mortality data, when available.
- 5.3.4.8 Practitioner's use of consultants;
- 5.3.4.9 Practitioner's performance relative to approved standards of practice, patient care protocols, and evidence-based clinical practice guidelines, including but not limited to compliance with core measures protocols.

The information used in the ongoing professional practice evaluation may be acquired through periodic chart review, direct observation, monitoring of diagnostic and treatment techniques, and discussion with other individuals involved in the care of each patient including the consulting physicians, assistant at surgery, nursing and administrative personnel. Additionally, in considering any request to grant, continue, modify, or increase clinical privileges, the Hospital, including any committee of the Medical Staff, or the Board may, in its discretion, obtain assistance with their evaluation, as provided for in Article Three of these Bylaws.

5.2.5 DELINEATION

Requests for clinical privileges shall be processed pursuant to the procedures outlined in Article Three of these Bylaws. Clinical privileges shall be delineated on an individual basis. In evaluating an applicant who requests renewal or revision of clinical privileges, the evaluation shall include ensuring that the applicant does not practice outside the scope of privileges granted, and information about the applicant's change in scope of practice shall be reflected when updated privilege delineation is made, and only approved privileges that are within the scope of practice shall be permitted.¹⁵⁹ The delineation of an individual's privileges shall include the limitations, if any, on the individual's privileges to admit or treat patients or direct the course of treatment of the patients who have been admitted.¹⁶⁰

5.2.6 LOCUM TENENS PRIVILEGES

Clinical privileges may be granted to a Practitioner qualified as described in Article three, Section 3.1, who plans to practice within the Hospital on an intermittent or substitute basis. Unless requested, a locum tenens Practitioner shall not be granted medical staff membership. The locum tenens Practitioner shall be credentialed as described in Article Three, and if qualified may be granted requested delineated clinical privileges for a period limited to the time during which the Practitioner is serving as a substitute for a Medical Staff member, or for the time of intermittent coverage, but in no case shall the term of privileges be greater than two years from the date the clinical privileges were approved. The locum tenens Practitioner may be eligible for temporary privileges in accordance with Section 5.3 of these Bylaws. The locum tenens Practitioner shall be subject to the Medical Staff Bylaws, Rules and Regulations, and policies, including requirements for focused professional practice evaluation and ongoing professional practice evaluation, and right to a fair hearing.

5.2.7 PRIVILEGES TO SUPPORT POST-RESIDENCY/FELLOWSHIP SURGICAL TRAINING

¹⁵⁹ MS.06.01.07, MS.08.01.03

¹⁶⁰ MS.06.01.07; MS.08.01.03

To support the introduction of a new procedure or new technology at the Hospital, the Board of Trustees in conjunction with the Medical Executive Committee or Medical Leadership shall determine the appropriateness of the Hospital as a training site, based on whether the Hospital has the resources necessary to support a request to conduct training, such as sufficient space, equipment, staffing, and financial resources, and whether the new procedure or new technology or the offering of training for the procedure/technology fits within the Hospital's operational planning and is appropriate for the Hospital's patient population.¹⁶¹ Training shall not be conducted until first approved by the Board of Trustees in conjunction with the Medical Executive Committee or Medical Leadership based on a recommendation from the Medical Executive Committee. The preceptor/trainer and the preceptee/trainee shall be credentialed as described in Article Three of these Bylaws to verify the qualifications necessary for these roles. Clinical privileges shall be specifically delineated for the role in which the individual shall serve, and the new procedure or new technology to be taught. The preceptor/trainer and the preceptee/trainee shall be subject to the Medical Staff Bylaws, Rules & Regulations, and policies, specifically including any relevant requirements related to patient rights, informed consent, and if applicable, requirements related to the conduct of research. After completion of training, the preceptee/trainee may be eligible to request clinical privileges for the new procedure or new technology, provided that competency in the privilege has been validated. For purposes of this Section, the following definitions shall apply:

- 5.2.7.1 Preceptor/trainer: An expert surgeon/physician who undertakes to impart his or her clinical knowledge and skills in a defined setting to a preceptee. The preceptor must be appropriately privileged, skilled, and experienced in the procedure(s) and or technique(s) in question. To serve as a preceptor in a specific procedure or technique, the surgeon/physician (preceptor) must be a recognized authority (e.g., through publications, presentations, extensive clinical experience) in the particular field of expertise.
- 5.2.7.2 Preceptee/trainee: A surgeon/physician with appropriate basic knowledge and experience seeking individual training in skills and/or procedures not learned in prior formal training. The trainee must have appropriate background knowledge, basic skills, and clinical experience relevant to the proposed curriculum. The trainee should be board-eligible as defined in these Bylaws or certified in the appropriate specialty or possess equivalent board certification from outside the United States.

5.2.8 NEW/TRANSPECIALTY PRIVILEGES

Prior to accepting request of a privileges, the resources necessary to support the privilege shall be determined to be currently available, or available within a specified time frame. Hospital leaders shall determine whether sufficient space, equipment, staff, and financial resources are in place or will be available within a specified time frame to support each privilege. The clinical privileges available for request shall be approved by the Board of trustees, in conjunction with the Medical Executive Committee or Medical Leadership based on this determination of hospital leaders. Any request for clinical privileges that are either new to the Hospital or that overlap more than one Department shall initially be reviewed by the Credentials Committee. The Credentials Committee shall review the need for, and appropriateness of a new procedure or service. The Credentials Committee shall facilitate the establishment of hospital-wide credentialing criteria for the new or transspecialty procedure, with the input of all appropriate Departments, with a mechanism designed to ensure that the same level of quality of patient care is provided by all individuals with such clinical privilege.¹⁶² In establishing the criteria for such clinical privileges, the Credentials Committee may establish an ad-hoc committee with representation from all appropriate Departments or the committee members may undertake the process themselves. Information may be requested from one or more Practitioners or Departments, or from outside sources such as professional literature or specialty associations. The recommendation of the Credentials Committee shall

¹⁶¹ MS.06.01.01

¹⁶² MS.1.10

be forwarded to the Medical Executive Committee for its review. The recommendation of the Medical Executive Committee and the approval of the Board shall be based in part on whether the new procedure or service is appropriate to the Hospital.

5.2.9 CLOSING/DISCONTINUING A SERVICE OR ENTERING AN EXCLUSIVE CONTRACT

As part of the process for ongoing evaluation and planning of patient care services, the Board of Trustees may determine that a particular patient care service shall be closed or discontinued, or that a particular service shall be provided through an exclusive contract. In the event that a patient care service is closed, discontinued, or shall be provided only through an exclusive contract, the Board of Trustees shall retract the clinical privileges associated with the provision of those services and notify the affected Practitioners and APPs of the clinical privileges that have been retracted.¹⁶³ Clinical privileges shall be retracted due to changes in the services provided by the Hospital, and retraction of clinical privileges shall not be considered an adverse action, therefore, there shall be no right to hearing and appeal in association with decisions to change the services offered by the Hospital.

5.2.10 TELEMEDICINE PRIVILEGES

Practitioners who wish to provide telemedicine services, as defined in these Bylaws, in prescribing, rendering a diagnosis, or otherwise providing clinical treatment to a Hospital patient, without clinical supervision or direction from a Medical Staff Member, shall be required to apply for and be granted clinical privileges for these services as provided in these Bylaws.¹⁶⁴ The Medical Staff shall define in the Rules and Regulations or Medical Staff policy which clinical services are appropriately delivered through a telemedicine medium, according to commonly accepted quality standards.¹⁶⁵ Consideration of appropriate utilization of telemedicine equipment by the telemedicine practitioner shall be encompassed in clinical privileging decisions.¹⁶⁶ In addition to meeting all other qualification for clinical privileges, the following credentialing procedures shall be followed:

- 5.2.10.1.1.1 When a telemedicine provider is providing services from a different State, licensure will be verified for both the State where the hospital is located and the State where the practitioner is located¹⁶⁷

5.2.11 USE OF ANCILLARY SERVICES BY NON-PRIVILEGED PRACTITIONERS

A Practitioner who is not a Medical Staff member and who has not been granted clinical privileges may order outpatient ancillary services and the Hospital may accept and execute orders for outpatient ancillary services from Practitioners who are not members of the Medical Staff and who have not been granted any clinical privileges at the Hospital only if all the following conditions are met:

- 5.2.11.1 The Practitioner shall provide proof of current licensure within this State, which shall be verified by the Hospital;¹⁶⁸
- 5.2.11.2 The non-privileged Practitioner shall provide proof of current licensure within this State, which shall be verified by the Hospital, or provide proof of being an active duty military Practitioner who is acting within the scope of military duties and providing care to a member of the military or a military dependant;¹⁶⁹

¹⁶³ MS.06.01.07

¹⁶⁴ MS.13.01.01

¹⁶⁵ MS.13.01.01 – MS.13.01.03

¹⁶⁶ MS.13.01.01 – MS.13.01.03

¹⁶⁷ 42 C.F.R. §482.26(c)(1), Interpretive Guidelines

¹⁶⁸ 42 C.F.R. §482.11(c), HCA, Ethics & Compliance Policy QM.002

¹⁶⁹ 42 C.F.R. §482.11(c), HCA, Ethics & Compliance Policy QM.002

- 5.2.11.3 If medications are being ordered, the Practitioner shall provide proof of current, unrestricted DEA registration;
- 5.2.11.4 The Hospital shall ensure that the Practitioner is eligible to participate in Federal and State Health Programs by checking the OIG Sanction Report and the GSA List at the time of ordering tests or services and at least every six months thereafter;¹⁷⁰
- 5.2.11.5 The Hospital shall ensure that the non-privileged Practitioner is eligible to participate in Federal and State Health Programs by checking the OIG Sanction Report and the GSA List at the time of ordering tests or services and the exclusion lists shall be rechecked according to the frequencies defined by hospital policy;¹⁷¹
- 5.2.11.6 The Practitioner shall be limited to ordering only those tests or services that are within the scope of his/her license to order, as established by State law. The orders shall be confined to those for outpatient laboratory, non-invasive radiology, rehabilitation services (including physical therapy, occupational therapy, and speech therapy), diagnostic cardiopulmonary or electrodiagnostic testing, or medications
- 5.2.11.7 The order must be of a type that can be executed within the standards of the applicable disciplines under which the order is to be performed without the presence or supervision of the ordering non-privileged Practitioner.
- 5.2.11.8 The ordering professional does not hold himself to be associated or affiliated with the Hospital or its Medical Staff.
- 5.2.11.9 The Practitioner's ordering practices shall be subject to a review for medical appropriateness and necessity. Orders that lack evidence of medical appropriateness or necessity shall not be performed and the Practitioner shall be notified immediately to be given the opportunity to clarify/justify the order.
- 5.2.11.10 All diagnostic tests that require an interpretation by a Practitioner with a delineated clinical privilege to do so shall be subject to interpretation by a member of the Medical Staff with such privileges and the interpretation shall be provided to the non-privileged Practitioner.

5.2.12 LIMITED LICENSURE PRACTITIONERS

Requests for clinical privileges from limited licensure Practitioners (e.g., Licensed Independent Practitioners who are not physicians) shall be processed in the manner and based on the same conditions as for any applicant for clinical privileges. Patients admitted by a limited licensure Practitioner with admitting privileges shall be under the care of a physician member of the Medical Staff with respect to any medical or psychiatric problem that is present on admission or develops during hospitalization that is outside the scope of practice of the admitting Practitioner.¹⁷² All patients admitted by a limited licensure Practitioner shall have a history and physical examination by a qualified physician member of the Medical Staff as defined in these Bylaws.¹⁷³ The limited licensure Practitioner shall be responsible for securing the services of such physician member of the Medical Staff prior to the admission of the patient and shall supply the name of the physician to the Hospital. The limited licensure Practitioner shall be responsible for performing the part of the history and physical examination related to the care he/she will provide:

- 5.2.12.1 Dentists are responsible for the part of their patients' history and physical examination that relates to dentistry.¹⁷⁴
- 5.2.12.2 Podiatrists are responsible for the part of their patient's history and physical examination that relates to podiatry.¹⁷⁵

¹⁷⁰ HCA, Ethics & Compliance Policy QM.002

¹⁷¹ HCA, Ethics & Compliance Policy QM.002

¹⁷² 42 C.F.R. §482.12(c)(4); MS.2.20

¹⁷³ MS.2.10, MS.4.20

¹⁷⁴ MS.2.10

- 5.2.12.3 Clinical Psychologists are responsible for the part of their patient’s history and physical examination as it relates to psychologist.
- 5.2.12.4 An oral and maxillofacial surgeon who has successfully completed a postgraduate program in oral and maxillofacial surgery accredited by a nationally recognized accrediting body approved by the U. S. Department of Education, and who has been determined by the Medical Staff to be currently competent to perform a history and physical examination, may be granted the clinical privilege to perform the medical history and physical examination.¹⁷⁶
- 5.2.12.5 Other Licensed Independent Practitioners who are permitted to provide patient care services independently may perform all or part of the medical history and physical examination, if granted such privileges. The findings, conclusions, and assessment of risk shall be confirmed or endorsed by a qualified physician prior to major high-risk (as defined by the Medical Staff in the Rules & Regulations or policy) diagnostic or therapeutic interventions.¹⁷⁷
- 5.2.12.6 In addition, as permitted by state law and by the Medical Staff as specified in policy, individuals who are not Licensed Independent Practitioners may perform part or all of a patient’s medical history and physical examination under the supervision of, or through appropriate delegation by, a specific qualified physician. The specific qualified physician shall retain accountability for the patient’s medical history and physical examination.¹⁷⁸

5.2.13 UNAVAILABLE CLINICAL PRIVILEGES

Notwithstanding any other provisions of these Bylaws, to the extent that any requested clinical privilege is not available at the Hospital, the request shall be denied. Because such a denial of clinical privileges is unrelated to the applicant’s qualifications or competence, an applicant whose request is so denied shall not be entitled to the Fair Hearing and Appeal rights under these Bylaws and is not subject to reporting to the National Practitioner Data Bank via the state professional licensure agency.

5.3 TEMPORARY PRIVILEGES

Temporary clinical privileges shall be granted only to individuals defined as Practitioners in these Bylaws, to fulfill an important patient care need that cannot be otherwise met by the existing members of the Medical Staff. Therefore, temporary privileges shall be granted only rarely. In granting temporary privileges, special requirements may be imposed in order to monitor and assess the quality of care rendered by the Practitioner exercising such privileges. A Practitioner shall not be entitled to the procedural rights of fair hearing or appeal afforded by these Bylaws because of his/her inability to obtain temporary privileges or because of any termination of temporary privileges.

5.3.1 QUALIFICATIONS

Prior to temporary privileges being granted, an applicant for such privileges must demonstrate that he/she possesses a current license within this State, a current and unrestricted DEA registration reflecting an in-state address for the State of Florida (unless the applicant will be providing temporary coverage of less than 60 days duration, and there are no plans for additional assignments¹⁷⁹) and required State registration (if the practitioner will be prescribing or administering controlled substances), evidence of ability to perform the temporary privileges requested, current competence related to the temporary privileges requested, documentation of

¹⁷⁵ MS.2.10

¹⁷⁶ MS.2.10

¹⁷⁷ MS.2.10

¹⁷⁸ MS.2.10, MS.4.20, MS.4.40

¹⁷⁹ Federal Register, Volume 71, No. 231, Friday, 12/1/2006, Page 69478 – 69480, Clarification of Registration Requirements for Individual Practitioners

professional liability insurance coverage as required by the Board¹⁸⁰ except as specified in Section 5.3.2.3 in this Article, and for Practitioners a signed Physician Acknowledgement Statement must be submitted prior to performing any patient care.¹⁸¹ Qualifications for temporary privileges shall be verified from a primary source or designated agent of the primary source,¹⁸² and documented. The National Practitioner Data Bank shall be queried prior to the granting of temporary privileges. Additionally, the Hospital shall verify the applicant's status as an Ineligible Person.¹⁸³ For this purpose, the applicant shall provide his/her Medicare NPI, and the Hospital shall check the OIG Sanction Report, the GSA List, and the State Exclusion List. If the applicant is excluded from such participation, temporary privileges shall not be granted; any exclusion subsequent to having been granted temporary privileges shall result in immediate termination of such privileges. When applying for temporary privileges, each applicant shall agree to be bound by the Medical Staff Bylaws, Rules and Regulations, departmental rules and regulations, and applicable Hospital policies.

5.4.1 CONDITIONS AND AUTHORITY FOR GRANTING TEMPORARY PRIVILEGES

Temporary privileges may be granted by the Chief Executive Officer upon receiving a recommendation from the appropriate Department Chairperson or Chief of Staff under the conditions noted below.¹⁸⁴ Individuals practicing based on temporary privileges shall be acting under the supervision of the Chairperson of the Department to which he/she is assigned. All temporary privileges shall be time-limited, as specified for the type of temporary privileges listed below.¹⁸⁵ During the time temporary privileges are in effect, the exclusion lists shall be rechecked according to the frequencies defined by hospital policy.¹⁸⁶ Temporary privileges shall automatically terminate at the end of the specific period for which they were granted, without the Hearing and Appeal rights set forth in these Bylaws. Temporary privileges shall be specifically delineated, and may include the privilege to admit patients.¹⁸⁷ A request for temporary privileges shall be made in writing, on forms approved for that purpose by the Hospital.

5.4.1.1 Pendency of Application: After receipt of complete application for Medical Staff membership, as defined in these Bylaws, which includes a written request for temporary privileges, an applicant qualified as described in Article Five, Section 5.3.1 may be granted temporary privileges while his/her application undergoes processing. Temporary privileges granted under this condition shall not exceed one hundred and twenty (120) consecutive days.¹⁸⁸ An applicant waiting for processing of an application for Medical Staff membership shall be eligible for temporary privileges only after submitting a complete application and only under the following conditions:¹⁸⁹

- 5.4.1.1.1 There are no current or previously successful challenges to licensure or registration;
- 5.4.1.1.2 There are no adverse membership actions at another hospital; and,
- 5.4.1.1.2.1 There are no adverse actions against the applicant's privileges at another hospital.

¹⁸⁰ MS.06.01.13

¹⁸¹ 42 C.F.R §412.46(c)

¹⁸² MS.06.01.03

¹⁸³ HCA, Ethics & Compliance Policy QM.002

¹⁸⁴ MS.06.01.13

¹⁸⁵ MS.06.01.13

¹⁸⁶ HCA, Ethics & Compliance Policy QM.002

¹⁸⁷ MS.06.01.07, MS.08.01.03

¹⁸⁸ MS.4.100

¹⁸⁹ MS.4.100

- 5.4.1.1.3 The application has been reviewed and approved by the Credentials Committee and the Medical Executive Committee and pending approval by the Board of Trustees.
- 5.4.1.2 Care of Specific Patient(s): Temporary privileges may be granted on a case-by-case basis when an important patient care need justifies the authorization to practice, for a limited period of time as defined herein. After receipt of a written request for temporary privileges, a Practitioner or APP qualified as described in Article Five, Section 5.3.1 may be granted temporary privileges if the Practitioner or APP has a specific skill not possessed by a privileged Practitioner or APP, and the specific skill is needed by a specific patient or specific group of patients, authorization may be granted to provide care for that specific patient or group of patients. Temporary privileges granted under this condition shall not exceed the length of stay of the specific patient(s) or one hundred and twenty (120) consecutive days, whichever is less.¹⁹⁰ A Practitioner or APP may be granted temporary privileges under this condition for no more than two instances in a twelve-month period. After a Practitioner or APP has been granted temporary privileges under this condition for the second instance within twelve months, he/she shall be required to apply for Medical Staff membership and/or clinical privileges before providing additional patient care, treatment or services at the Hospital.
- 5.4.1.3 Disaster Response and Recovery:¹⁹¹ Potential disaster situations shall be described in the Hospital Emergency Operations Plan¹⁹² and is defined as any occurrence that inflicts destruction or distress and that creates demands exceeding the capacities or capabilities of the Hospital to handle in a normal or routine way. Such occurrence may be due to a natural disaster or a man-made disaster. Upon activation of the Hospital's Emergency Operations Plan and in a situation in which the Hospital is not able to meet immediate patient needs,¹⁹³ temporary disaster privileges may be granted to an appropriately qualified Practitioner as described in Article Five, Section 5.3.1, based upon the needs of the Hospital to augment staffing due to the disaster situation. Privileges shall be approved by the Hospital Emergency Incident Commander (Chief Executive Officer/designee) or the Operations Chief, if that position is activated as part of the Hospital Emergency Operations Plan (EOP), upon recommendation by the Chief of Staff or the EOP designated Medical Staff Director.¹⁹⁴ All decisions to grant temporary disaster privileges are at the discretion of the Hospital Emergency Incident Commander or designees, and shall be evaluated on a case-by-case basis in accordance with Hospital and patient care needs.¹⁹⁵ Approvals shall be documented in writing. The Chief of Staff or the EOP designated Medical Staff Director shall also assign a Member of the Medical Staff to responsibilities for supervising Practitioners granted temporary disaster privileges, through direct observation, mentoring, or clinical record review.¹⁹⁶ Practitioners who are employees of any Federal agency, and Practitioners acting on behalf of a Federal agency in an official capacity, temporarily or permanently in the service of the United States government, whether with or without compensation, are immune from professional liability for malpractice committed within the scope of employment under the provisions of the Federal Tort Claims Act, and are therefore exempt from the requirement to have professional liability insurance

¹⁹⁰ MS.06.01.13

¹⁹¹ EM.02.02.13

¹⁹² EM.02.01.01

¹⁹³ EM.02.02.13

¹⁹⁴ EM.02.02.13

¹⁹⁵ EM.02.02.13

¹⁹⁶ EM.02.02.13

coverage.¹⁹⁷ Temporary privileges granted to Practitioners who are acting as agents of the Federal government shall be limited in their privileges at this Hospital to the scope of their Federal employment. Temporary privileges granted to anyone under a disaster situation shall not exceed the disaster response and recover period or one hundred and twenty (120) consecutive days, whichever is less.¹⁹⁸ In the event that the disaster creates extreme urgencies as defined in Section 5.4, a Practitioner would be permitted to provide patient care using emergency privileges.

- 5.4.1.3.1 Temporary disaster privileges may be granted upon presentation of a government-issued photo identification and any of the following, and the qualifications required in Section 5.3.1 of this Article shall be verified as soon as the immediate disaster situation is under control, using a process identical to granting temporary privileges for an immediate patient care need, and verification shall be completed within 72 hours from the time the volunteer Practitioner presents to the organization, or as soon as possible in an extraordinary situation that prevents verifications within 72 hours.¹⁹⁹
 - 5.4.1.3.1.1 A current picture hospital ID card;
 - 5.4.1.3.1.2 A current license to practice in the State of **Florida**.
 - 5.4.1.3.1.3 Primary source verification of the license;
 - 5.4.1.3.1.4 Identification indicating that the individual is a Member of a Disaster Medical Assistance Team (DMAT), or MRC, ESAR-VHP, or other recognized state or federal organization or group;
 - 5.4.1.3.1.5 Identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state or municipal entity; or,
 - 5.4.1.3.1.6 Presentation by a current hospital or medical staff member(s) with personal knowledge regarding the practitioner's identity.
- 5.4.1.3.2 The following order of preference should be used in granting temporary disaster privileges:
 - 5.4.1.3.2.1 Expert Practitioners from government agencies and medical staff members from other HCA hospitals;
 - 5.4.1.3.2.2 Volunteer Practitioners sent from known agencies (e.g., American Red Cross); Presentation by a current hospital or medical staff member(s) with personal knowledge regarding the practitioner's identity.
 - 5.4.1.3.2.3 Volunteers from the community or surrounding areas.
- 5.4.1.3.3 If possible, photocopies of the above-listed credentials should be made and retained as part of a credentials file.
- 5.4.1.3.4 Upon approval, the Practitioner should be issued appropriate Hospital security identification as required by the Hospital, and should be assigned to a Medical Staff member if possible, with whom to collaborate in the care of disaster victims.
- 5.4.1.3.5 The Medical Staff shall oversee the professional practice of volunteer Practitioners.²⁰⁰

¹⁹⁷ 28 U.S.C. §2671; 42 U.S.C. §233(a),(g)

¹⁹⁸ MS.06.01.13

¹⁹⁹ EM.02.02.13

²⁰⁰ EM.02.02.13

- 5.4.1.3.6 In the event that verification of information results in negative or unsubstantiated information about qualifications of the Practitioner, privileges should be immediately terminated. When the emergency situation no longer exists, or when Medical Staff members can adequately provide care, temporary disaster privileges terminate.
- 5.4.1.3.7 The Hospital shall make a decision, based on information obtained regarding the credentials and professional practice of the Practitioner, within 72 hours of the volunteer Practitioner presenting to the Hospital regarding whether to continue the disaster privileges initially granted. Continuing privileges shall be approved by the Hospital Emergency Incident Commander (Chief Executive Officer/designee) or the Operations Chief, if that position is activated as part of the EOP, upon recommendation by the Chief of Staff or the EOP designated Medical Staff Director.²⁰¹ In the event that verification of information results in negative or unsubstantiated information about qualifications of the Practitioner, privileges should be immediately terminated. When the emergency situation no longer exists, or when Medical Staff members can adequately provide care, temporary disaster privileges terminate.

5.5 EMERGENCY PRIVILEGES

In an emergency, any Practitioner, to the extent permitted by his/her license, and regardless of Medical Staff membership status, staff category or clinical privileges, shall be permitted to do everything possible to save the life of a patient or to save the patient from serious injury, including the loss of limb or function. When the emergency no longer exists, care of the patient shall be assigned to a Medical Staff member with the appropriate clinical privileges to provide the care needed by the patient. If the Practitioner who provided emergency care wishes to continue to care for the patient, but does not possess the appropriate clinical privileges, the Practitioner may request such privileges if properly qualified. An emergency is a condition in which serious or permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

6. ARTICLE SIX: CORRECTIVE ACTIONS

6.1. CRITERIA FOR INITIATION

Any person may provide information to the Medical Staff about the conduct, performance, or competence of its members or other individuals with clinical privileges. When reliable information, including the results of quality assessment or performance improvement activities, indicates that an individual may have exhibited acts, demeanor, conduct or professional performance reasonably likely to be (1) detrimental to patient safety or to the delivery of quality of patient care within the Hospital, (2) unethical,²⁰² (3) unprofessional, inappropriate, disruptive or harassing, (as defined in these Bylaws and in Hospital policies, including sexual harassment),²⁰³ (4) contrary to the Medical Staff Bylaws or Rules and Regulations, or (5) below applicable professional standards, the Chief of Staff, appropriate Department Chairperson, Credentials Committee Chairperson, or Chief Executive Officer shall make sufficient inquiry to satisfy him/herself that the concern or question raised is credible. A determination will then be made as to whether to refer the matter to the Medical Executive Committee or to deal with the matter in accordance with the relevant Medical Staff policy. If it is determined to direct the matter to the Medical Executive Committee, a written request for investigation shall be prepared, making specific reference to the performance information, activity or conduct that gave rise to the request. The investigation shall be conducted pursuant to the peer review provisions in these Bylaws.²⁰⁴

²⁰¹ EM.02.02.13

²⁰² HCA Ethics & Compliance Policies

²⁰³ HCA Ethics & Compliance Policies

²⁰⁴ MS.01.01.01

6.2. ALTERNATIVES TO CORRECTIVE ACTION

Initial collegial efforts may be made prior to resorting to formal corrective action, when appropriate. Such collegial interventions on the part of Medical Staff leaders in addressing the conduct or performance of an individual shall not constitute corrective action, shall not afford the individual subject to such efforts to the right to a Hearing and Appeal, and shall not require reporting to the state licensure board or the NPDB, except as otherwise provided in these Bylaws. Alternatives to corrective action may include:

6.3. COLLEGIAL INTERVENTIONS

These Bylaws encourage the use of progressive steps by medical staff leaders beginning with collegial and educational efforts, to address issues pertaining to clinical competence or professional conduct. The goal of these efforts is to arrive at voluntary actions by the individual to resolve an issue that has been raised. Initial collegial efforts may be made prior to resorting to formal corrective action, when appropriate. Such collegial interventions on the part of Medical Staff leaders in addressing the conduct or performance of an individual shall not constitute corrective action, shall not afford the individual subject to such efforts to the right to a Hearing and Appeal, and shall not require reporting to the state licensure board or the NPDB, except as otherwise provided in these Bylaws.

- 6.3.1. Informal discussions or formal meetings regarding the concerns raised about conduct or performance, including the actions outlined in Section 3.19 that may be taken to address disruptive conduct;
- 6.3.2. Written letters of guidance, reprimand or warning regarding the concerns about conduct or performance;
- 6.3.3. Notification that future conduct or performance shall be closely monitored and notification of expectations for improvement;
- 6.3.4. Suggestions or requirements that the individual seek continuing education, consultations, or other assistance in improving performance;
- 6.3.5. Warnings regarding the potential consequences of failure to improve conduct or performance; and/or,
- 6.3.6. Requirements to seek assistance for impairment, as provided in these Bylaws.²⁰⁵
- 6.3.7. Advising colleagues of applicable policies, such as policies regarding appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;
- 6.3.8. Informal discussions or formal meetings regarding the concerns raised about conduct or performance, including the actions outlined in Section 3.21 that may be taken to address unprofessional or inappropriate conduct;
- 6.3.9. Proctoring, monitoring, consultation, and letters of guidance;
- 6.3.10. Sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist individuals to conform their practices to appropriate norms;
- 6.3.11. Written letters of guidance, reprimand or warning regarding the concerns about conduct or performance;
- 6.3.12. Notification that future conduct or performance shall be closely monitored and notification of expectations for improvement;
- 6.3.13. Suggestions or requirements that the individual seek continuing education, consultations, or other assistance in improving performance;

²⁰⁵ MS.4.80

- 6.3.14 Warnings regarding the potential consequences of failure to improve conduct or performance; and/or,
 - 6.3.15 Requirements to seek assistance for a health issue, as provided in these Bylaws.²⁰⁶
 - 6.3.16 The relevant Medical Staff leader(s), in conjunction with the Chief Executive Officer, may determine whether a matter should be handled in accordance with another policy (e.g., code of conduct policy, practitioner health policy, peer review policy) or should be referred to the MEC for further action.
 - 6.3.17 The relevant Medical Staff leader(s) will determine whether to document a collegial intervention effort. Any documentation that is prepared will be placed in an individual's confidential file. The individual will have an opportunity to review the documentation and respond to it. The response will be maintained in the individual's file along with the original documentation.
- 6.4 PRECAUTIONARY SUSPENSION OR PRECAUTIONARY RESTRICTION OF CLINICAL PRIVILEGES
- 6.4.1 Grounds for Precautionary Suspension or Restriction:
 - 6.4.1.1 Whenever a practitioner or other individual with clinical privileges willfully disregards these Bylaws or the Medical Staff Rules & Regulations or Hospital Policies, or whenever his/her conduct may require that immediate action be taken to protect the life of any patient(s) or to reduce the substantial likelihood of immediate injury or damage to the health or safety of any patient, employee, or other person present in the hospital, or to prevent interference with the orderly operation of the Hospital, the Chief of Staff, the chief of a clinical department, the Chief Executive Officer, the Board Chairperson, or the Medical Executive Committee shall each have the authority to (1) suspend or restrict all or any portion of an individual's clinical privileges; and (2) afford the individual an opportunity to voluntarily refrain from exercising privileges pending an investigation.
 - 6.4.1.1.1 A precautionary suspension or restriction can be imposed at any time including, but not limited to, immediately after the occurrence of an event that causes concern, following a pattern of occurrences that raises concern, or following a recommendation of the Medical Executive Committee that would entitle the individual to request a hearing.
 - 6.4.1.1.2 Precautionary suspension or restriction is an interim step in the professional review activity, but it is not a complete professional review action in and of itself. It shall not imply any final finding of responsibility for the situation that caused the suspension or restriction.
 - 6.4.1.1.2 A precautionary suspension or restriction shall become effective immediately upon imposition, shall immediately be reported in writing to the Chief Executive Officer and the Chief of Staff, and shall remain in effect unless it is modified by the Chief Executive Officer or the Medical Executive Committee. The Department Chairperson for the department to which a suspended or restricted practitioner is assigned shall be responsible for arranging appropriate medical coverage for any of the practitioner's patients hospitalized at the time of the suspension or restriction. The wishes of each patient shall be considered, when feasible, in choosing a substitute practitioner. A suspended or restricted practitioner's elective admissions and procedures shall be rescheduled pending reinstatement or reassigned to another practitioner as requested by each patient.
 - 6.4.2 Reporting Requirement:
 - 6.4.2.1 In compliance with the Health Care Quality Improvement Act of 1996, reports to the National Practitioner Data Bank shall include actions based on professional

²⁰⁶ MS.11.01.01

competence or conduct which adversely affects or could affect the health or welfare of a patient, or the surrender of privileges as a result of, or during, an investigation that affects an individual's privileges for more than thirty (30) days. Any organization taking action as set forth in this section shall report that action to the department within 30 days of its initial occurrence, regardless of the pendency of appeals therefrom. The notification shall identify the disciplined physician, the action taken, and the reason for such action.

6.4.3 Medical Executive Committee Procedure:

- 6.4.3.1 As soon as possible after such precautionary suspension, the Medical Executive Committee shall be convened to review the matter resulting in a precautionary suspension or restriction and consider the action taken. Prior to, or as part of, this review, the individual may be given an opportunity to meet with the Medical Executive Committee. The individual may propose ways other than precautionary suspension or restriction to protect patients, employees and/or the orderly operation of the Hospital, depending on the circumstances.
- 6.4.3.2 After considering the matters resulting in the suspension or restriction and the individual's response, if any, the Medical Executive Committee shall determine whether there is sufficient information to warrant a final recommendation, or whether it is necessary to commence an investigation. The Medical Executive Committee must determine whether the precautionary suspension or restriction should be continued, modified, or terminated pending the completion of the investigation (and hearing, if applicable).

6.4.4 Reporting Requirement:

- 6.4.4.1 If the Medical Executive Committee's recommendation is not adverse to the practitioner as defined in Article Seven of these Bylaws, the practitioner shall not be entitled to a hearing and appeal.
- 6.4.4.2 If the Medical Executive Committee's recommendation is adverse to the practitioner as defined in Article Seven of these Bylaws, the practitioner shall be afforded procedural rights to an appellate review as outlined in Article Seven of these Bylaws. The terms of the precautionary suspension shall remain in effect pending a decision by the Board of Trustees.

6.5 INVESTIGATION/PEER REVIEW PROCESS

6.5.1 Initiation of Investigation:

- 6.5.1.1 When a question involving clinical competence or professional conduct is referred to, or raised by the Medical Executive Committee, the Medical Executive Committee shall review the matter and determine whether to conduct an investigation or to direct the matter to be handled pursuant to another policy, such as the; practitioner health issues policy; peer review policy, or to proceed in another manner. In making this determination, the Medical Executive Committee may discuss the matter with the individual. An investigation shall begin only after a formal determination by the Medical Executive Committee to do so.
- 6.5.1.2 The Medical Executive Committee shall inform the individual that an investigation has begun. Notification may be delayed if, in the Medical Executive Committee's judgment, informing the individual immediately would compromise the investigation or disrupt the operation of the Hospital or Medical Staff.
- 6.5.1.3 The Board of Trustees may also determine to commence an investigation and may delegate the investigation to the Medical Executive Committee, a subcommittee of the Board of Trustees, or an ad hoc committee.
- 6.5.1.4 The Chief of Staff shall keep the Chief Executive Officer fully informed of all action taken in connection with an investigation.

6.5.2 An investigation may be initiated in response to the circumstances in a single case, or to investigate a pattern or trend in performance. The investigation may involve an interview with the Practitioner and/or an interview of other individuals or groups deemed appropriate by the investigating body. If the investigation is conducted by a group or individual other than the Medical Executive Committee, that group or individual must forward a written report of the investigation to the Medical Executive Committee as soon as practical after the assignment to investigate has been made. The Medical Executive Committee may at any time within its discretion, and shall at the request of the Board of Trustees, terminate the investigation process and proceed with action as provided below. The investigation procedures do not constitute a hearing and need not be conducted in accordance with the formal procedures for a fair hearing.

6.6.3 The investigation shall include:

6.5.3 Conformance to the peer review procedures outlined in Article Ten, Section 10.4.13.

6.5.4 As deemed necessary by the investigating body, a review of the medical record for specific cases, a review of aggregate performance data, a review of comparative data when available, a review of any verbal or written reports regarding any specific incidents, conduct or behavior, or any other information material to the matter being investigated;

6.5.5 A report of the investigation, including all material evidence, and a recommendation to the Medical Executive Committee.

6.6 ACTION ON INVESTIGATION REPORT

As soon as practicable after the conclusion of an investigation, the Medical Executive Committee or the Board may:

6.6.1 Determine that corrective action is not warranted and dismiss the matter;

6.6.2 Determine that corrective action is warranted, and use one of the alternatives to corrective action, as described in paragraph 6.2 of these Bylaws; or,

6.6.3 Determine that corrective action is warranted, and recommend an adverse action, which shall entitle the individual subject to such action to the procedural rights described in Article Seven.

6.7 AUTOMATIC SUSPENSION OR TERMINATION

If an individual fails to maintain a legal credential authorizing him/her to practice, or other qualification necessary for Medical Staff membership or clinical privileges, upon confirmation of the circumstances by the Chief Executive Officer, the individual shall be immediately and automatically suspended from practicing in the Hospital by the Chief Executive Officer, and the individual's membership may be automatically terminated. The Chief Executive Officer shall notify the individual in writing of the automatic suspension, but the suspension is effective immediately and not subject to prior notice.²⁰⁷ The Chief Executive Officer shall also notify the Chief of Staff and Hospital staff members, and take necessary steps to enforce the suspension.

6.7.1 The following circumstances shall constitute conditions for automatic suspension, and if indicated, automatic termination:

6.7.2 LICENSURE

If an individual's license to practice is revoked or suspended by a state licensing authority, or if an individual fails to maintain a current license, he/she shall be immediately automatically suspended from practicing in the Hospital.

6.7.3 CONTROLLED SUBSTANCE REGISTRATION

6.7.3.1 Controlled Substance Registration

²⁰⁷ MS.01.01.01

If an individual's DEA or State controlled substance registration is revoked, suspended, or restricted, (i.e., disciplinary action is taken by the DEA or State) he/she may be automatically suspended from practicing in the Hospital. If an individual fails to maintain a current unrestricted registration, (i.e., there is a lapse in renewal or failure to request all schedules needed for the prescribing privileges granted) the individual's prescribing privileges for the schedule(s) of drugs affected by the restrictions on the DEA or State controlled substance registration shall be immediately automatically suspended.

6.7.4 LIABILITY INSURANCE

If an individual's professional liability insurance is revoked or the individual fails to maintain ongoing coverage as required in these Bylaws, he/she shall be immediately automatically suspended from practicing in the Hospital.

6.7.5 ELIGIBILITY TO PARTICIPATE IN FEDERAL PROGRAMS

The occurrence of any of the following events shall result in immediate automatic suspension from practicing in the Hospital:

6.7.5.1 Becoming an Ineligible Person;²⁰⁸ or,

6.7.5.2 A criminal conviction.

6.7.6 MEDICAL RECORDS

The process for suspension for failure to complete medical records shall be as outlined in the Medical Staff Rules and Regulations.

6.7.7 MISREPRESENTATION

Whenever it is discovered that an individual misrepresented, omitted or erred in answering the questions on an application for Medical Staff membership or clinical privileges or in answering interview queries, and the misrepresentation or omission is a material or substantive misrepresentation, as judged by the Medical Executive Committee, the individual's membership and clinical privileges shall be automatically terminated. Substantial or material misrepresentation of the applicant's qualifications, competence or character may be grounds for the Board of Trustees to permanently disqualify an individual from applying for membership or clinical privileges or to set a specific time period after which the applicant may reapply.

6.7.8 Reporting Requirement

6.7.8.1 In compliance with the Health Care Quality Improvement Act of 1996, reports to the National Practitioner Data Bank shall include actions based on professional competence or conduct which adversely affects or could affect the health or welfare of a patient, or the surrender of privileges as a result of, or during, an investigation that affects an individual's privileges for more than thirty (30) days. Any organization taking action as set forth in this section shall report that action to the department within 30 days of its initial occurrence, regardless of the pendency of appeals therefrom. The notification shall identify the disciplined physician, the action taken, and the reason for such action.

6.8 FAILURE TO PROVIDE REQUESTED INFORMATION

Failure of an individual to provide information pertaining to that individual's qualifications for Medical Staff membership or clinical privileges, in response to a written request from the Credentials Committee, the Medical Executive Committee, or any other committee authorized to request such information within a timeframe specified in the written request, will result in the automatic relinquishment of all clinical privileges until the information is provided to the satisfaction of the requesting party.

²⁰⁸ HCA, Ethics & Compliance Policy QM.002

6.9 CRIMINAL ARREST OR INDICTMENT

In the event that an individual is arrested or indicted for alleged criminal acts, an immediate investigation into the circumstances of the arrest or indictment shall be made. The Medical Executive Committee shall review the circumstances leading to the arrest or indictment and may determine if further action is warranted prior to the outcome of the legal action. If the Medical Executive Committee recommends use of a corrective action that fits the definition of an adverse action, this shall entitle the individual subject to such action to notification and the right to a hearing and appeal as set forth in Article Seven.

6.10 REINSTATEMENT FOLLOWING A SUSPENSION

6.10.1 Requests for reinstatement will be reviewed by the relevant department chief, the Chair of the Credentials Committee and the Chief of Staff. If all these individuals make a favorable recommendation on reinstatement, the Medical Staff member or other individual with clinical privileges who has been subject to suspension may immediately resume clinical practice at the Hospital. This determination will then be forwarded to the Credentials Committee, Medical Executive Committee, and the Board of Trustees for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, Medical Executive Committee, and Board of Trustees for review and recommendation.

6.11 AUTOMATIC RESIGNATION

6.11.1 RELOCATION

Unless otherwise approved by the Board upon recommendation of the Medical Executive Committee, any member of the staff or other individual with clinical privileges who takes up permanent residence in a location that would impede the delivery of patient care services due to geographic inaccessibility to the hospital shall be deemed to have resigned from the Staff and relinquished all clinical privileges.

6.11.2 FAILURE TO APPLY FOR REAPPOINTMENT OR RENEWAL OF PRIVILEGES

A term of medical staff membership or the granting of clinical privileges shall be for a period of no more than two years (24 months). In the event that reappointment or a renewal of clinical privileges has not occurred for whatever reason prior to the expiration of the current term of appointment, the membership and clinical privileges of the individual shall be terminated. The individual shall be notified of the termination and the need to submit a new application if continued membership or clinical privileges are desired.²⁰⁹

6.11.3 FAILURE TO BE REINSTATED FOLLOWING AUTOMATIC SUSPENSION

When an individual is automatically suspended due to failure to maintain a current license, a controlled substance registration, liability insurance, or eligibility to participate in Federal programs, or the automatic suspension is due to failure to complete medical records timely, or any other reason for automatic suspension, and the automatic suspension continues for more than 60 days without verified evidence of reinstatement of the expired credential, reinstatement as a participant in Federal programs, or completion of medical records, then the individual shall be deemed to have voluntarily resigned from the Staff, voluntarily relinquished all clinical privileges, and waived any rights to fair hearing or appeal process. The individual shall be notified of the automatic voluntary resignation and the need to submit a new application if reinstatement of membership or clinical privileges is desired.

7. ARTICLE SEVEN: HEARING AND APPELLATE REVIEW PROCEDURES

7.1. OVERVIEW

Fair hearing and appellate review procedures shall be used when professional review actions are being taken when it involves an individual applying for Medical Staff membership, for an existing Medical

²⁰⁹ MS.4.20

Staff member, and for any other individual applying for or holding clinical privileges. The fair hearing and appeal process shall be the same for applicants for Medical Staff membership and existing Medical Staff members. Professional review actions are taken when there is a reasonable belief that the action shall be in the furtherance of quality healthcare, and after a reasonable effort to obtain the facts of the matter, and in reasonable belief that the action is warranted by the facts, and after adequate notice and hearing procedures and other procedures as are fair to the individual are afforded to the individual subject to professional review actions.²¹⁰ Individuals with clinical privileges who are not applying for Medical Staff membership and who are not Medical Staff members are afforded a fair hearing and appeal process but that process shall be modified.²¹¹ The hearing and appeal procedures for individuals with clinical privileges who are not applying for Medical Staff membership and who are not Medical Staff members is described in Article Seven, Section 7.10.4 of these Bylaws.

7.1.1. COLLEGIAL ACTIONS

The practitioner does not have a right to a hearing in any of the following circumstances when collegial action(s) is taken, or when an adverse action is recommended by not taken:

- 7.1.1.1. Advising colleagues of applicable policies, such as policies regarding appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;
- 7.1.1.2. Informal discussions or formal meetings regarding the concerns raised about conduct or performance, including the actions outlined in Section 3.21 that may be taken to address unprofessional or inappropriate conduct;
- 7.1.1.3. Proctoring, monitoring, consultation, and letters of guidance;
- 7.1.1.4. Sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist individuals to conform their practices to appropriate norms;
- 7.1.1.5. Written letters of guidance, reprimand or warning regarding the concerns about conduct or performance;
- 7.1.1.6. Notification that future conduct or performance shall be closely monitored and notification of expectations for improvement;
- 7.1.1.7. Suggestions or requirements that the individual seek continuing education, consultations, or other assistance in improving performance;
- 7.1.1.8. Warnings regarding the potential consequences of failure to improve conduct or performance; and/or,
- 7.1.1.9. Requirements to seek assistance for a health issue, as provided in these Bylaws.²¹²
- 7.1.1.10. A request for an adverse action involving the practitioner that has been recommended but denied.

7.2. EXCEPTIONS TO HEARING AND APPEAL RIGHTS

7.2.1. AVAILABILITY OF FACILITIES, EXCLUSIVE CONTRACTS, MEDICAL STAFF DEVELOPMENT PLAN

The hearing and appeal rights under these Bylaws do not apply to an individual whose application or request for extension of privileges was declined on the basis that the clinical privileges being requested are not able to be supported with available facilities or resources within the Hospital, or are not granted due to closed staff or exclusive contract or in accord

²¹⁰42 USCS §11112(a)(1) – (4)

²¹¹ MS.4.50

²¹² MS.11.01.01

with a Medical Staff development plan. The hearing and appeal rights under these Bylaws do not apply to an individual who has clinical privileges retracted or automatically terminated due to the Hospital closing or discontinuing a service, or entering into an exclusive contract.

7.2.2. MEDICO-ADMINISTRATIVE OFFICER OR OTHER CONTRACT PRACTITIONER

The terms of any written contract between the Hospital and a Contract Practitioner or Contractor shall take precedence over these Bylaws as now written or hereafter amended. The hearing and appeal rights of these Bylaws shall only apply to the extent that membership status or clinical privileges, which are independent of the individual's contract, are also removed or suspended, unless the contract includes a specific provision establishing alternative procedural rights applicable to such decisions.

7.2.3. AUTOMATIC SUSPENSION, TERMINATION, OR RELINQUISHMENT OF PRIVILEGES

The hearing and appeal rights under these Bylaws do not apply if an individual's Staff membership or clinical privileges are automatically suspended, terminated, or voluntarily relinquished in accordance with these Bylaws for reasons not related to the Practitioner's qualifications, competence or professional conduct.

7.2.4. REMOVAL FROM EMERGENCY CALL PANEL

Participation on the emergency on-call panel is not a benefit or privilege of Staff membership, but rather is an obligation. No hearing or appeal rights under these Bylaws are available for any action or recommendation affecting a Practitioner's emergency on-call panel obligation(s).

7.2.5. HOSPITAL POLICY DECISION

The hearing and appeal rights of these Bylaws are not available if the Hospital makes a policy decision (e.g., closing a department or service, or a physical plant change) that adversely affects the Staff membership or clinical privileges of any Staff member or other individual and the applicable provisions of these Bylaws have been complied with by the Hospital.

7.2.6. ADMINISTRATIVE ACTIONS

A practitioner does not have the right to a hearing in any of the following circumstances:

- 7.2.6.1. Change to specific medical staff membership prerogatives (as examples: voting privileges, eligibility for committee membership, eligibility to hold office, etc.) if the reasons are unrelated to professional competence or conduct;
- 7.2.6.2. Denial, termination or reduction of temporary privileges if the reasons are unrelated to professional competence or conduct;
- 7.2.6.3. Denial of reinstatement from a leave of absence if the reasons are unrelated to professional competence or conduct;
- 7.2.6.4. Any other actions except those listed in Section 7.3.

7.2.7. ADVERSE RECOMMENDATIONS OR ACTIONS

Only individuals who are subject to an adverse recommendation or action are entitled to a hearing under these Bylaws if recommended by the Medical Executive Committee or if taken by the Board contrary to a favorable recommendation by the Medical Executive Committee under circumstances where a right to hearing exists. The following recommendations or actions shall be deemed adverse and entitle the individual affected thereby to a hearing:

- 7.2.7.1. Denial of initial staff appointment;
- 7.2.7.2. Denial of reappointment;
- 7.2.7.3. Suspension of staff membership;

- 7.2.7.4. Revocation of staff membership;
- 7.2.7.5. Limitation of the right to admit patients other than limitations applicable to all individuals in a Staff category or a clinical specialty, or due to licensure limitations;
- 7.2.7.6. Denial of requested clinical privileges;
- 7.2.7.7. Involuntary reduction in clinical privileges;
- 7.2.7.8. Precautionary suspension or restriction of clinical privileges, as defined in Article Six;
- 7.2.7.9. Revocation of clinical privileges; or,
- 7.2.7.10. Involuntary imposition of significant consultation requirements where the supervising Practitioner has the power to supervise, direct, or transfer care from the Practitioner under review (excluding monitoring incidental to provisional status or the granting of new privileges).

7.2.8. NOTICE OF ADVERSE RECOMMENDATION OR ACTION

A Practitioner against whom an adverse recommendation or action has been taken pursuant to Section 7.3.1 shall promptly be given special written notice of such action by hand delivery or by certified mail. Such notice shall:²¹³

- 7.2.8.1. State the reasons for an adverse recommendation or action, with enough specifics to allow response;
- 7.2.8.2. Advise the Practitioner of his/her right to a hearing pursuant to the provisions of the Medical Staff Bylaws and of this Fair Hearing Plan.
- 7.2.8.3. Advise the Practitioner that the Practitioner has thirty (30) days following receipt of the notice to submit a written request for a hearing.
- 7.2.8.4. State that failure to request a hearing within thirty (30) days shall constitute a waiver of rights to a hearing and to an appellate review of the matter, and the recommendation for adverse action will become final upon approval by the Board of Trustees.
- 7.2.8.5. State a summary of the Practitioner's rights at the hearing.
- 7.2.8.6. State that upon receipt of his/her hearing request, the Practitioner will be notified of the date, time and place of the hearing.

7.2.9. REQUEST FOR HEARING

A Practitioner shall have thirty (30) days following his/her receipt of a notice pursuant to Section 7.3.2 to file a written request for a hearing. Such requests shall be delivered to the Chief Executive Officer either in person or by certified mail.²¹⁴

7.2.10. FAILURE TO REQUEST A HEARING

A Practitioner who fails to request a hearing within the time and in the manner specified in Section 7.3.3 waives any right to such a hearing and to any appellate review to which he/she might otherwise have been entitled. Such waiver in connection with:

- 7.2.10.1. An adverse recommendation by the MEC shall constitute acceptance of that recommendation, which shall become effective pending the final approval of the Board.

²¹³ 42 USCS §11112(b)(1)(A-C)

²¹⁴ 42 USCS §11112(b)(1)(B)(i – ii)

- 7.2.10.2. An adverse action by the Board shall constitute acceptance of that action, which shall become immediately effective as the final decision by the Board.

7.3. HEARING PREREQUISITES

7.3.1. SPECIAL WRITTEN NOTICE

Upon receipt of a timely request for a hearing, the Chief Executive Officer shall deliver such request to the Chief of Staff or to the Trustees, depending on whose recommendation or action prompted the request for hearing. At least thirty (30) days prior to the hearing, the Practitioner shall be sent a special written notice stating the following:

- 7.3.1.1. The place, time, and date, of the hearing, which date shall not be less than 30 days after the date of the notice, unless both parties agree otherwise;²¹⁵
- 7.3.1.2. A list of the witnesses (if any) expected to testify at the hearing on behalf of the body whose action gave rise to the hearing request;²¹⁶
- 7.3.1.3. The Practitioner involved has the right:²¹⁷
- 7.3.1.3.1. To be present at the hearing;
 - 7.3.1.3.2. To representation by an attorney or other person of the Practitioner's choice;
 - 7.3.1.3.3. 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;
 - 7.3.1.3.4. To call, examine, and cross-examine witnesses;
 - 7.3.1.3.5. To present evidence determined to be relevant by the chairman of the hearing committee, regardless of its admissibility in a court law; and,
 - 7.3.1.3.6. To submit a written statement at the close of the hearing.
- 7.3.1.4. Upon completion of the hearing, the Practitioner involved has the right:²¹⁸
- 7.3.1.4.1. To receive a record of the proceedings upon payment of a reasonable charge;²¹⁹
 - 7.3.1.4.2. To receive the written recommendation of the hearing committee, including a statement of the basis for the recommendations; and,
 - 7.3.1.4.3. To receive a written decision of the Board of Trustees, including a statement of the basis for the decision.
- 7.3.1.5. The right to the hearing may be forfeited if the Practitioner fails, without good cause, to appear.

7.3.2. APPOINTMENT OF HEARING COMMITTEE

- 7.3.2.1. By Medical Staff: A hearing occasioned by an adverse recommendation of the MEC shall be conducted by an ad hoc hearing committee appointed by the Chief of Staff .

²¹⁵ 42 USCS §11112(b)(2)(A)

²¹⁶ 42 USCS §11112(b)(2)(B)

²¹⁷ 42 USCS §11112(b)(3)(i – v)

²¹⁸ 42 USCS §11112(b)(3)(D)(i – ii)

²¹⁹ 42 USCS §11112(b)(3)(C)(ii)

- 7.3.2.2. By Board of Trustees: A hearing occasioned by an adverse action of the Board shall be conducted by a hearing committee appointed by the Chairperson of Board.
- 7.3.2.3. Composition of Hearing Committee: The Hearing Committee shall be composed of at least three members. One of the members so appointed will be designated as the chairman. The chairman will preside over the hearing. No member may serve who has acted as accuser, investigator, fact finder, or initial decision maker in the matter. Knowledge of the matter shall not preclude a member from serving. No member shall be appointed who is in direct economic competition with the Practitioner, or is a member of the Medical Executive Committee or Board of Trustees. If possible, at least one member shall be of the same medical subspecialty as the Practitioner. All of the members shall be members of the Medical Staff. However, if there are not a sufficient number of Medical Staff members willing or able to serve on the Hearing Committee, the Medical Executive Committee or the Board may appoint Practitioners who are not members of the Medical Staff.
- 7.3.2.4. Challenges for Cause: The Practitioner may question hearing panel members regarding potential bias, prejudice or conflict of interest and challenge any member of the hearing committee for any cause, which would indicate bias or predisposition. The Chairperson, or if challenged, the Chief of Staff, shall decide the validity of such challenges. His/her decision shall be final.

7.4. HEARING PROCEDURE

7.4.1. PERSONAL PRESENCE

The personal presence of the Practitioner who requested the hearing shall be required. A Practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his/her rights in the same manner and with the same consequence as provided in Section 7.3.4. Existence of good cause shall be determined by the Chairperson of the Hearing Committee.

7.4.2. PRESIDING OFFICER

The Chairperson of the hearing panel shall be the presiding officer. The presiding officer shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. He/she shall be entitled to determine the order of procedure during the hearing and shall make all rulings on matters of law, procedure, and the admissibility of evidence.

APPOINTMENT OF A HEARING OFFICER OR LEGAL CONSULTANT

The use of a hearing officer to preside at an evidentiary hearing is optional. The use and appointment of such an officer shall be determined by the Chief of Staff. A hearing officer may or may not be an attorney at law, but must be experienced in conducting hearings. He/she shall act as the presiding officer of the hearing. Alternatively, the Chief of Staff may appoint an attorney to be a legal consultant to the Hearing Committee. The hearing officer or legal consultant may be present during deliberations, but shall not vote.

7.4.3. REPRESENTATION

The Practitioner who requested the hearing shall be entitled to be accompanied and represented at the hearing by an attorney or another person of his/her choice.²²⁰ The Medical executive Committee or the Board, depending on whose recommendation or action promoted the hearing, shall appoint an individual to present the facts and argument in support of its adverse recommendation or action, and to examine witnesses. The Medical Executive

²²⁰ 42 USCS §11112(b)(3)(C)(i)

Committee or Board of Trustees has the right to be accompanied and represented at the hearing by an attorney.

7.4.4. RIGHTS OF PARTIES

During a hearing, each of the parties shall have the right to:²²¹

- 7.4.4.1. Call and examine witnesses;
- 7.4.4.2. Introduce exhibits;
- 7.4.4.3. Cross-examine any witness on any matter relevant to the issues;
- 7.4.4.4. Impeach any witness;
- 7.4.4.5. Rebut any evidence; and
- 7.4.4.6. Request that the record of the hearing be made by use of a court reporter or an electronic recording unit.

7.4.5. PROCEDURE AND EVIDENCE

The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be admitted, regardless of the admissibility of such evidence in a court of law. The concern of the hearing committee is with determining the truth of the matter, providing adequate safeguards for the rights of the parties and ultimate fairness to both parties. The hearing panel shall also be entitled to consider all other information that can be considered, pursuant to these Bylaws, in connection with applications for appointment or reappointment to the Medical Staff and for clinical privileges. At the hearing panel Chairperson's discretion, each party shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of law or fact, and such memoranda shall become part of the hearing record. There shall be no closing arguments.

7.4.6. BURDEN OF PROOF

The body whose adverse recommendation or action occasioned the hearing shall have the initial obligation to present evidence in support of their recommendation or action, but the Practitioner shall thereafter be responsible for supporting his/her challenge to the adverse recommendation or action by a preponderance of the evidence that the recommendation or action lacks any substantial factual basis or that the adverse recommendation or action is either arbitrary, unreasonable, or capricious.

7.4.7. RECORD OF HEARING

A record of the hearing shall be kept that is of sufficient accuracy to permit a valid judgment to be made by any group that may later be called upon to review the record and render a recommendation or decision in the matter. The hearing committee may select the method to be used for making the record, such as court reporter, electronic recording unit, detailed transcription, or minutes of the proceedings. A court reporter shall be present if requested by any party (at the expense of the requesting party).

7.4.8. POSTPONEMENT

Request for postponement of a hearing shall be granted by the Chairperson or Hearing Officer, if appointed, to a date agreeable to the hearing committee only by stipulation between the parties or upon a showing of good cause.

7.4.9. PRESENCE OF HEARING PANEL MEMBERS AND VOTE

²²¹ 42 USCS §11112(b)(3)(C)(iii – v)

A majority of the hearing panel, but in no event less than three members, must be present throughout the hearing and deliberations. If a panel member is absent from any part of the proceedings, that member shall not be permitted to participate in the deliberations or to vote.

7.4.10. RECESSES AND ADJOURNMENT

The hearing panel may recess the hearing and reconvene the hearing for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The hearing committee shall, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon conclusion of its deliberations, the hearing shall be declared finally adjourned.

7.5. HEARING COMMITTEE REPORT AND FURTHER ACTION

7.5.1. HEARING COMMITTEE REPORT

Within fourteen (14) days after the final adjournment of the hearing, the hearing panel shall make a written report of its findings and recommendations in the matter, as decided by a majority of the entire hearing committee, and shall forward the same, together with the hearing record and all other documentation considered by it, to the Chief Executive Officer and the Chief of Staff for distribution to the Medical Executive Committee and the Practitioner.

7.5.2. ACTION ON HEARING COMMITTEE REPORT

Within 30 days after receipt of the written report of the Hearing Panel, the Medical Executive Committee or Board, as the case may be, shall consider the report and affirm, modify or reverse its recommendations or action in the matter. It shall transmit the result, together with the hearing record, the report of the hearing committee and all other documentation considered, to the Chief Executive Officer. The Medical Executive Committee or Board, as the case may be, may also request a status report by the Chairman of the hearing committee during the 30-day review period.

7.5.3. NOTICE AND EFFECT OF RESULT

7.5.3.1. Notice: The Chief Executive Officer shall promptly send a copy of the result and report to the Practitioner by special notice, to the Chief of Staff, to the Medical Executive Committee and to the Board.

7.5.3.2. Effect of Favorable Result:

7.5.3.2.1. Adopted by the MEC: If the Medical Executive Committee's recommendation is favorable to the Practitioner, the Chief Executive Officer shall promptly forward it, together with all supporting documentation, to the Board for its final action. The Board shall take action thereupon by adopting, rejecting, or modifying the MEC's recommendation in whole or in part, or by referring the matter back to the MEC for further reconsideration. Any such referral back shall state the reasons for the referral, set a time limit within which a subsequent recommendation to the Board must be made, 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 within 31 days take final action. The Chief Executive Officer shall promptly send the Practitioner notice informing him/her of each action taken pursuant to this Section.

7.5.3.2.2. Adopted by the Board: If the Board's initial hearing action is favorable to the Practitioner, such result shall become the final decision of the Board and the matter shall be considered closed.

- 7.5.3.3. Effect of Adverse Result for Practitioner: If the result of the MEC or of the Board continues to be adverse to the Practitioner in any of the respects listed in Section 7.3.1, the notice required by this Section shall inform the Practitioner of his/her right to request an appellate review by the Board as provided in Section 7.7.1.

7.6. APPELLATE REVIEW

7.6.1. Time for Appeal

- 7.6.1.1. Within 30 days after receipt of notice of the Hearing Panel's recommendation either party may request an appeal. The request shall be in writing, delivered to the Chief Executive Officer either in person or by certified mail, return receipt requested, and shall include a statement of the reasons for appeal and the specific facts or circumstances which justify further review. If an appeal is not requested within 10 days, an appeal is deemed to be waived and the Hearing Panel's report and recommendation shall be forwarded to the Board for final action.

7.6.2. Grounds for Appeal:

- 7.6.2.1. The grounds for appeal shall be limited to the following:

- 7.6.2.1.1. There was substantial failure to comply with the Bylaws of the Hospital or Medical Staff during or prior to the hearing, so as to deny a fair hearing; and/or
- 7.6.2.1.2. The recommendations of the Hearing Panel were made arbitrarily or capriciously and/or were not supported by credible evidence.

7.6.3. Time, Place and Notice

- 7.6.3.1. Whenever an appeal is requested as set forth in the preceding Sections, the Chairperson of the Board shall schedule and arrange for an appeal. The individual shall be given special notice of the time, place, and date of the appeal. The appeal shall be held as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved.

7.6.4. Nature of Appellate Review

- 7.6.4.1. The Chairperson of the Board shall appoint a Review Panel composed of no less than three persons, either members of the Board or others, including, but not limited to, reputable persons outside the Hospital, to consider the record upon which the recommendation before it was made and recommend final action to the Board; provided however, that a majority of the members of the Review Panel must be active members of the Medical Staff.
- 7.6.4.2. Each party shall have the right to present a written statement in support of its position on appeal. The party requesting the appeal shall submit a statement first and the other party shall then have ten days to respond. In its sole discretion, the Review Panel may allow each party or its representative to appear personally and make oral argument not to exceed 30 minutes.
- 7.6.4.3. The Board Review Panel may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Hearing Panel proceedings. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence, or that any opportunity to admit it at the hearing was improperly denied, and then only at the discretion of the Review Panel.

7.6.5. Appellate Review in the Event of Board Modification or Reversal of Hearing Panel Recommendation

- 7.6.5.1. If the Board determines to modify or reverse the recommendation of a Hearing Panel in a matter in which the individual did not request appellate review, and such action would adversely affect the individual, the Board shall notify the affected individual through the Chief Executive Officer that he or she may appeal the proposed modification or reversal in accordance with these bylaws. The Board shall take no final action until the individual has exercised or has waived that appeal provided in these Bylaws. The Board has the final say in the matter, regardless of what the Hearing Panel recommends, as long as the decision of the Board reasonably relates to the operation of the hospital and is administered fairly.

7.7 FINAL DECISION OF THE BOARD

- 7.7.1 Within 30 days after the Board i) receives the recommendation from a separate Review Panel, or (ii) receives the Hearing Panel's report and recommendation when no appeal has been requested, the Board shall consider the matter and take final action.

- 7.7.2 The Board may review any information that it deems relevant including, but not limited to, the findings and recommendations of the Medical Executive Committee, Hearing Panel, and Review Panel. The Board may adopt, modify, or reverse any recommendation that it receives or, in its discretion, refer the matter for further review and recommendation, or make its own decision based upon the Board's ultimate legal authority for the operation of the Hospital and the quality of care provided; provided, however, that the Board shall give great weight to the findings of the Review Panel.

- 7.7.3 The Board shall render its final decision in writing, including specific reasons, and shall send special notice to the individual. A copy shall also be provided to the Medical Executive Committee for its information.

- 7.7.4 Further Review

Except where the matter is referred by the Board for further action and recommendation by any individual or committee, the final decision of the Board shall be effective immediately and shall not be subject to further review. If the matter is referred for further action and recommendation, such recommendation shall be promptly made to the Board in accordance with the instructions given by the Board.

7.8 RIGHT TO ONE HEARING AND ONE APPEAL ONLY

No member of the Medical Staff shall be entitled to more than one hearing and one appellate review on any matter. If the Board denies initial appointment to the Medical Staff or reappointment or revokes the appointment and/or clinical privileges of a current member of the Medical Staff, that individual may not apply for staff appointment or for those clinical privileges for a period of five years unless the Board provides otherwise.

7.9 CHAIRPERSON GENERAL PROVISIONS

7.9.4 NUMBER OF HEARINGS AND REVIEWS

Notwithstanding any other provision of the Medical Staff Bylaws, no Practitioner shall be entitled as a right to more than one evidentiary hearing and appellate review with respect to a specific adverse recommendation or action.

7.9.5 RELEASE

By requesting a hearing or appellate review under this Article, a Practitioner agrees to be bound by the provisions of Article Twelve in these Bylaws relating to immunity from liability in all matters relating thereto.

7.9.6 CONFIDENTIALITY

The investigations, proceedings and records conducted or created for the purpose of carrying out the provisions of the Fair Hearing Plan or for conducting peer review activities under the Medical Staff Bylaws are to be treated as confidential, protected by State and Federal Law.

7.9.7 HEARING AND APPEAL PROCEDURES FOR ADVANCED PRACTICE PROFESSIONALS

Individuals with clinical privileges who are not eligible for Medical Staff membership and who are not Medical Staff members (i.e., Advanced Practice Professionals - APPs) are afforded a fair hearing and appeal process but that process shall be a modification of that for Medical Staff members or applicants for Medical Staff membership.²²² The following procedures shall be used for APPs:

7.9.7.1 Notice: Written notice of an adverse recommendation or action and the right to a hearing shall be promptly given to the APP subject to the adverse recommendation or action. The notice shall state that the APP has 30 days in which to request a hearing. If the APP does not request a hearing within 30 days, the APP shall have waived right to a hearing.

7.9.7.2 Hearing Panel: The Chief Executive Officer shall appoint a hearing panel, which will include three members. The panel members shall include the Chief Executive Officer, the Chief of Staff or another officer of the Medical Staff, and a peer of the APP. None of the panel members shall have had a role in the adverse recommendation or action.

7.9.7.3 Rights: The APP subject to the adverse recommendation or action shall have the right to present information, but cannot have legal representation or call witnesses.

7.9.7.4 Hearing Panel Determination: Following presentation of information and panel deliberations, the panel shall make a determination:

7.9.7.4.1A determination favorable to the APP shall be reported in writing to the body making the adverse recommendation or action.

7.9.7.4.2A determination adverse to the APP shall result in notice to the APP of the right to appeal the decision to the Board.

7.9.7.5 Final Decision: The decision of the Chairperson Board shall be final.

7.9.8 EXTERNAL REPORTING REQUIREMENTS

The Hospital shall submit a report regarding a final adverse action to the appropriate state professional licensure board (i.e., the state agency that issued the individual's license to practice) and all other agencies as required by all applicable Federal and/or State law(s) and in accordance with Hospital policy and procedures.²²³

8 ARTICLE EIGHT: MEDICAL STAFF OFFICERS

8.1 ELECTED OFFICERS OF THE STAFF

8.1.1 IDENTIFICATION

The officers of the Medical Staff shall be the Chief of Staff, the Chief of Staff-Elect, the Secretary-Treasurer, the Immediate Past Chief of Staff.

²²² MS.4.50

²²³ 42 USCS §11133(a)

8.1.2 QUALIFICATIONS

Officers must be members of the active staff in good standing at the time of nomination and election and must continuously maintain such status during their terms of office and must satisfy the following criteria.²²⁴

- 8.1.2.1 Have no pending adverse recommendations concerning Staff appointment or clinical privileges;
- 8.1.2.2 Have demonstrated interest in maintaining quality medical care at the hospital;
- 8.1.2.3. Not be presently serving as a Medical Staff or corporate officer, or on the Board at another hospital, and shall not so serve during the term of office;
- 8.1.2.4. Have constructively participated in Medical Staff affairs, including quality improvement;
- 8.1.2.5. Be willing to discharge faithfully the duties and responsibilities of the position to which the individual is elected or appointed;
- 8.1.2.6. Be knowledgeable concerning the duties of the office;
- 8.1.2.7. Possess written and oral communication skill; and
- 8.1.2.8 Possess and have demonstrated ability for harmonious interpersonal relationships.
- 8.1.2.1 Be appointed in good standing to the Active Staff, and have served on the Active Staff for at least five years;

8.2 TERM OF OFFICE AND ELIGIBILITY FOR RE-ELECTIONS

8.2.1 TERM OF OFFICE

Each officer shall serve a two (2) year term. The term of office shall commence on the first day of the medical staff year following the election. Each officer shall serve in office until the end his/her term or until a successor is duly elected and has qualified, unless he/she resigns, or is removed or recalled from office, or is otherwise unable to complete the term. At the end of the Chief of Staff's term, the Chief of Staff-Elect shall automatically assume that office and the Chief of Staff shall automatically serve as the Immediate Past Chief of Staff.²²⁵

8.2.2 ELIGIBILITY FOR RE-ELECTION

No person may serve in the same position for more than two consecutive terms.

8.3 ATTAINMENT OF OFFICE

8.3.1 NOMINATION

At least sixty (60) days before the annual Staff meeting of each even-numbered year, the Nominating Committee shall convene and submit to the Chief of Staff one or more qualified nominees for the offices of Chief of Staff-Elect and Secretary-Treasurer. The Nominating Committee shall report the names of the nominees to the Staff at least thirty (30) days before the annual meeting. Nominations may also be made by petition signed by at least ten percent of the appointees of the active staff, with a signed statement of willingness to serve by the nominee, filed with the Chief of Staff at least twenty (20) days before the annual meeting. As soon thereafter as reasonably possible, the names of the additional nominees will be reported to the Staff. If, before the election, all nominees refuse or are disqualified or are otherwise unable to accept nomination, the Nominating Committee shall submit one or more additional nominees at the annual meeting.

²²⁴ MS.1.20

²²⁵ MS.1.20

8.3.2 ELECTION

Voting at the annual meeting shall be by written ballot. Voting by proxy shall be permitted if the vote is given to the Department Chairman and/or Chief of Staff to read and counted at the meeting and recorded in the minutes. A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate for an office receives a majority vote, the majority vote of the Medical Executive Committee shall decide the election for the nominee presented. The votes of Medical Executive Committee members shall be by secret written ballot at its next meeting or a special meeting called for that purpose. The election shall become effective upon approval of the Board.²²⁶

If, at the time of ratification, the Board of Trustees is in disagreement with the Medical Staff's selection of nominee(s) for Officer(s), a joint meeting of the Board of Trustees and the Medical Executive Committee will convene to discuss the reasons for the disparity before final decision is made by the Board of Trustees.

8.3.3 BOARD APPROVAL/INDEMNIFICATION

To afford the Medical Staff officers and others the full protections of the Healthcare Quality Improvement Act, the Board shall ratify the appointments of Medical Staff officers and other leaders, such as Department officers. Who will perform professional review regarding competence or professional conduct of Practitioners and other individuals requesting clinical privileges, such as credentialing or quality assessment/performance improvement activities.²²⁷ The Board's ratification shall serve as evidence that they are charged with performing important Hospital functions when engaging in credentialing or quality assessment/performance improvement activities. Such activities shall have the following characteristics:²²⁸

- 8.3.3.1 The activities such leaders undertake shall be performed on behalf of the Hospital;
- 8.3.3.2 The activities shall be performed in good faith,
- 8.3.3.3 That any professional review action shall be taken:
 - 8.3.3.3.1 In the reasonable belief that the action was in the furtherance of quality health care;
 - 8.3.3.3.2 After a reasonable effort to obtain the facts of the matter;
 - 8.3.3.3.3 After adequate notice and hearing procedures are afforded to the individual involved or after such other procedures as are fair to the individual under the circumstances; and,
 - 8.3.3.3.4 In the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting this Section.
- 8.3.3.4 The activities shall follow procedures set forth in these Bylaws, rules and regulations, or policies;
- 8.3.3.5 Medical Staff leaders who are performing activities meeting the above listed criteria shall qualify for indemnification for those activities through the Hospital.

²²⁶ MS.1.20

²²⁷ 42 USCS §11111

²²⁸ 42 USCS §11112(a)(1-4)

8.4 VACANCIES

8.4.1 WHEN CREATED

Vacancies in office may occur from time to time, such as upon the death, disability, resignation, removal, or recall from office of an officer, or upon an officer's failure to maintain active staff status in good standing.

8.4.2 FILLING A VACANCY IN THE OFFICE OF THE CHIEF OF STAFF

When a vacancy occurs in the office of the Chief of Staff, then the Chief of Staff-Elect shall serve the remaining term of the former Chief of Staff. The vacancy then created in the office of Chief of Staff-Elect shall be filled as described in these Bylaws. In the event of the simultaneous vacancy in both the Chief of Staff and Chief of Staff-Elect positions or in all of the officer positions, the Board shall appoint interim officers to fill these positions and an election shall be conducted within ninety (90) days. An ad hoc nominating committee appointed by the Board shall convene as soon as possible to nominate candidates to fill the unexpired terms of office. Following nomination of candidates, the Medical Staff shall hold a special meeting to conduct elections for these offices, using the election procedures described in these Bylaws.

8.4.3 FILLING A VACANCY IN THE OFFICES OF THE CHIEF OF STAFF-ELECT, SECRETARY-TREASURER OR THE IMMEDIATE PAST CHIEF OF STAFF

When a vacancy occurs in the office of the Chief of Staff-Elect, the Medical Executive Committee shall appoint an interim officer to fill the office until the next regular election, when both a Chief of Staff and Chief of Staff-Elect shall be elected. When a vacancy occurs in the office of the Secretary-Treasurer, the Medical Executive Committee shall appoint an interim officer to fill the office until the next regular election. When a vacancy occurs in the office of the Immediate Past Chief of Staff, the office shall remain vacant until after the next election.

8.5 RESIGNATION, REMOVAL, AND RECALL FROM OFFICE

8.5.1 RESIGNATION

Any medical staff officer may resign at any time by giving written notice to the Medical Executive Committee and the acceptance of such resignation shall not be necessary to make it effective.

8.5.2 REMOVAL

Any Medical Staff officer or a member of the Medical Executive Committee may be removed from office for cause. Removal shall occur with the majority vote of the Medical Executive Committee as to whether there is sufficient evidence for grounds for removal from office for cause, with approval by the Board, or with the majority vote of the Board. Grounds for removal may include any one or more of the following causes, without limitations:²²⁹

- 8.5.2.1 Failure to perform the duties of office;
- 8.5.2.2 Failure to comply with or support the enforcement of the hospital and Medical Staff Bylaws, Rules and Regulations, or policies;
- 8.5.2.3 Failure to support the compliance of the Hospital and the Medical Staff to applicable Federal and State laws and regulations, and the standards or other requirements of any regulatory or accrediting agency having jurisdiction over the Hospital or any of its services;
- 8.5.2.4 Failure to maintain qualifications for office, specifically, failure to maintain active staff status in good standing; and/or,

²²⁹ MS.01.01.01

- 8.5.2.5 Failure to adhere to professional ethics or any other action(s) deemed injurious to the reputation of, or inconsistent with the best interests of the Hospital or the Medical Staff.

8.5.3 RECALL FROM OFFICE

Any Medical Staff officer or a member of the Medical Executive Committee may be recalled from office, with or without cause. Recall of a Medical Staff officer or a member of the Medical Executive Committee may be initiated by a majority of members of the Medical Executive Committee or by a petition signed by at least one-third of the medical staff members eligible to vote in Medical Staff elections. Recall shall be considered by the Medical Staff at a special meeting of the Medical Staff called for that purpose. A recall shall require two-thirds of the votes of the Medical Staff members attending the specially called meeting who are eligible to vote. Sealed and authenticated votes mailed by Medical Staff members eligible to vote shall also be counted at the special meeting. The recall shall become effective upon approval of the Board.

8.6 RESPONSIBILITIES AND AUTHORITY OF THE ELECTED OFFICERS²³⁰

8.6.1 CHIEF OF STAFF

The Chief of Staff shall serve as the chief administrative officer of the Medical Staff and shall have responsibility for supervision of the general affairs of the Medical Staff.²³¹ The specific responsibilities, duties, and authority of the Chief of Staff are to:

- 8.6.1.1 Call, preside at, and be responsible for the agenda of all general and special meetings of the Medical Staff;
- 8.6.1.2 Serve as chairperson of the Medical Executive Committee and calling, presiding at, and being responsible for the agenda of all meetings thereof;
- 8.6.1.3 Serve as ex-officio member of all other Medical Staff committees without vote, unless otherwise specified;
- 8.6.1.4 Appoint and discharge the Chairpersons of all Medical Staff standing and ad hoc committees, recommend to the Medical Executive Committee the members of all Medical Staff standing and ad hoc committees, and appoint Medical Staff members of Hospital and Board committees, except when these memberships are designated by position or by specific direction of the Board;
- 8.6.1.5 Be responsible for the enforcement of these Bylaws, the Rules and Regulations, and Hospital policies, implement sanctions when indicated, and enforce the Medical Staff's compliance with procedural safeguards in all instances in which corrective action has been requested or initiated against a Practitioner or other individual with clinical privileges;
- 8.6.1.6 Be accountable and responsible to the Board for the quality and efficiency of clinical services and professional performance of the Medical Staff in the provision of patient care services;
- 8.6.1.7 Communicate and represent the opinions, policies, concerns, needs, and grievances of the Medical Staff to the Chief Executive Officer and the Board, and serve as an ex-officio member of the Board, with a vote;
- 8.6.1.8 Receive and interpret the opinions, policies, and directives of the Administration and the Board to the Medical Staff;

²³⁰ MS.1.20

²³¹ 42 C.F.R. §482.22(b)(3)

- 8.6.1.9 Act as the representative of the Medical Staff to the public as well as to other health care providers, other organizations, and regulatory or accrediting agencies in external professional and public relations; and,
- 8.6.1.10 Perform all other functions as may be assigned to the Chief of Staff by these Bylaws, the Medical Staff, the Medical Executive Committee, or by the Board.
- 8.6.1.11 Conduct surveillance of the professional performance of all individuals who have clinical privileges.²³²

8.6.2 CHIEF OF STAFF-ELECT

The Chief of Staff-Elect shall perform the duties of the Chief of Staff in the absence or temporary inability of the Chief of Staff to perform. The Chief of Staff-Elect shall serve as the vice-chairperson of the Medical Executive Committee and shall perform such additional duties as may be assigned by the Chief of Staff or the Board.

8.6.3 SECRETARY-TREASURER

The Secretary-Treasurer shall be a member of the Medical Executive Committee. The duties of the Secretary-Treasurer are to:

- 8.6.3.1 Maintain a roster of Medical Staff members;
- 8.6.3.2 Keep accurate and complete minutes of all Medical Executive Committee and general Medical Staff meetings;
- 8.6.3.3 Assure that all notices of Medical Staff meetings are given as provided in these Bylaws, on order of the Chief of Staff;
- 8.6.3.4 Be custodian of Staff records and attend to all appropriate correspondence and notices on behalf of the Medical Staff; and,
- 8.6.3.5 Maintain a record of Medical Staff dues, collections, and accounts, and sign checks for the Medical Staff fund expenditures pursuant to his/her authority.

8.6.4 IMMEDIATE PAST CHIEF OF STAFF

As an individual with unique knowledge of Medical Staff affairs, the Immediate Past Chief of Staff shall serve as an advisor and mentor to the Chief of Staff, shall participate as a member of the Medical Executive Committee and other standing committees of the Medical Staff as specified in these Bylaws, and shall perform other duties as requested by the Chief of Staff.

8.7 CHIEF MEDICAL OFFICER

The Chief Medical Officer shall be a physician who is employed or under contract with the Hospital to perform administrative duties related to the medical staff affairs of the Hospital. The Chief Medical Officer is not elected by the Medical Staff and therefore is not one of the officers of the Medical Staff organization. The Chief Medical Officer is a Medico-Administrative Officer, and as such, the provisions of Article Three, Section 3.16 of these Bylaws apply.

8.7.1 QUALIFICATIONS

The Chief Medical Officer shall possess all of the qualifications for Medical Staff membership if the Chief Medical Officer desires Medical Staff membership or clinical privileges to provide patient care services.

8.7.2 RESPONSIBILITIES AND AUTHORITY

The Chief Medical Officer shall serve as an advisor to the officers of the Medical Staff and as a liaison between the Medical Staff and the Administration of the Hospital. The authority of the

²³² MS.4.20, MS.4.40

Chief Medical Officer shall be that of an administrator of the Hospital, as assigned by the Chief Executive Officer. Specific responsibilities include, but are not limited to:

- 8.7.2.1 Administratively oversee the Medical Staff Services in performance of the credentialing function;
- 8.7.2.2 Serve as a designee of the Chief Executive Officer in reviewing and approving applications for temporary privileges;
- 8.7.2.3 Serve as an ex-officio Member of all Medical Staff committees, without vote;
- 8.7.2.4 Advise and assist the officers of the Medical Staff in the performance of their duties, including providing orientation and education to Medical Staff leaders with regard to their leadership roles.

8.7.3 APPOINTMENT

After having received input from the Medical Executive Committee, Chief Medical Officer shall be appointed by the Chief Executive Officer and approved by the Board.

8.7.4 VACANCY

In the event of a vacancy in the position of Chief Medical Officer, the Chief of Staff shall ensure that any Medical Staff functions associated with the position are performed.

9 ARTICLE NINE: CLINICAL DEPARTMENTS AND SPECIALTY DIVISIONS

9.1 DESIGNATION

9.1.1 CURRENT CLINICAL DEPARTMENTS

The Medical Staff shall be organized into clinical Departments. The Medical Staff Departments are:²³³

- 9.1.1.1 Medicine Department
- 9.1.1.2 Surgery Department

9.1.2 SPECIALTY WITHIN A DEPARTMENT

Includes but is not limited to practitioners in the following specialties:²³⁴

- 9.1.2.1 For the Medicine Department:
 - 9.1.2.1.1 Allergy/Immunology
 - 9.1.2.1.2 Cardiology
 - 9.1.2.1.3 Dermatology
 - 9.1.2.1.4 Emergency Medicine
 - 9.1.2.1.5 Endocrinology
 - 9.1.2.1.6 Family Practice
 - 9.1.2.1.7 Gastroenterology
 - 9.1.2.1.8 Hematology
 - 9.1.2.1.9 Internal Medicine

²³³ MS.1.20, MS.4.20, LD.2.20

²³⁴ MS.1.20, MS.4.20, LD.2.20

- 9.1.2.1.10 Neurology
- 9.1.2.1.11 Nephrology
- 9.1.2.1.12 Oncology
- 9.1.2.1.13 Physical Medicine/Rehabilitation
- 9.1.2.1.14 Psychiatry
- 9.1.2.1.15 Pulmonology
- 9.1.2.1.16 Radiology
- 9.1.2.1.17 Rheumatology

9.1.2.2 For the Surgery Department:

- 9.1.2.2.1 Anesthesiology
- 9.1.2.2.2 Colon and Rectal Surgery
- 9.1.2.2.3 Dentistry
- 9.1.2.2.4 Ears, Nose and Throat (ENT)
- 9.1.2.2.5 General Surgery
- 9.1.2.2.6 Gynecology
- 9.1.2.2.7 Oral Surgery
- 9.1.2.2.8 Ophthalmology
- 9.1.2.2.9 Orthopedic Surgery
- 9.1.2.2.10 Pain Management
- 9.1.2.2.11 Pathology
- 9.1.2.2.12 Plastic Surgery
- 9.1.2.2.13 Podiatry
- 9.1.2.2.14 Thoracic Surgery
- 9.1.2.2.15 Urology
- 9.1.2.2.16 Vascular Surgery

9.2 CRITERIA TO QUALIFY AS A DEPARTMENT

The Medical Executive Committee may create, eliminate, subdivide or combine Departments, subject to approval by the Board, based on the evolving scope of clinical services of the Hospital and the need of the Medical Staff organization to most effectively support the oversight of quality of patient care. Since the primary function of a Department is to be responsible for the quality of patient care provided by the members of the Department, the primary criteria for creating a Department, or in eliminating or combining a Department shall be whether the Department has a sufficient number of active staff members and sufficient patient volume to support the quality assessment and performance improvement activities required of a Department.

9.3 REQUIREMENTS FOR AFFILIATION WITH DEPARTMENTS

Each Medical Staff member and other individuals with clinical privileges shall be assigned to one Department by the Board based on recommendations from the Medical Executive Committee. A member or other individual with clinical privileges may be granted clinical privileges in one or more other Departments. The exercise of clinical privileges within any Department shall be subject to the rules and regulations of the Department and the authority of the Department Chairperson.

9.4 FUNCTIONS OF DEPARTMENTS

The Departments shall meet as necessary, and no less than twice a year:

9.4.1 CLINICAL FUNCTIONS

- 9.4.1.1 Serve as a forum for the exchange of clinical information regarding services provided by Department members;
- 9.4.1.2 Provide recommendations to the Department Chairperson and/or the Medical Executive Committee with regard to the development of clinical practice guidelines related to care and services provided by Department members;
- 9.4.1.3 Provide recommendations to the Department Chairperson regarding professional criteria for clinical privileges designed to assure the Medical Staff and Board that patients shall receive quality care.²³⁵ The recommendations shall include:
 - 9.4.1.3.1 Criteria for granting, withdrawing and modifying clinical privileges;²³⁶
 - 9.4.1.3.2A procedure for applying these criteria to individuals requesting privileges.²³⁷
- 9.4.1.4 Ensure that patients receive appropriate and medically necessary care from a member of the Medical Staff during the entire length of stay with the Hospital;²³⁸
- 9.4.1.5 Ensure that the same level of quality of patient care is provided by all individuals with delineated clinical privileges, within the Department, across Departments, and between members and non-members of the Medical Staff with clinical privileges;²³⁹
 - 9.4.1.5.1 By establishing uniform patient care processes;²⁴⁰
 - 9.4.1.5.2 By establishing similar clinical privileging criteria for similar privileges;²⁴¹
 - 9.4.1.5.3 By using similar indicators in performance improvement activities.²⁴²
- 9.4.1.6 Provide recommendations to the Department Chairperson and/or the Medical Executive Committee with regard to issues related to standards of practice and/or clinical competence;
- 9.4.1.7 Ensure effective mechanisms for the clinical supervision of Allied Health Professionals, and House Staff practitioners, if any.

9.4.2 ADMINISTRATIVE FUNCTIONS

- 9.4.2.1 Provide information and/or recommendations to the Department Chairperson with regard to the criteria for granting clinical privileges within the Department;

²³⁵ MS.1.40, MS.4.20

²³⁶ 42 C.F.R. §482.22(c)(6), CMS Survey Procedures

²³⁷ 42 C.F.R. §482.22(c)(6), CMS Survey Procedures

²³⁸ MS.2.10

²³⁹ MS.1.10

²⁴⁰ LD.3.20

²⁴¹ MS.1.10

²⁴² MS.1.10

- 9.4.2.2 Ensure that individuals within the Department who admit patients have privileges to do so,²⁴³ and that all individuals within the Department with clinical privileges only provide services within the scope of privileges granted.²⁴⁴
- 9.4.2.3 Provide information and/or recommendations to the Department Chairperson and/or the Medical Executive Committee with regard to Medical Staff policies and procedures;
- 9.4.2.4 Provide recommendations to the Department Chairperson and/or the Medical Executive Committee with regard to ensuring appropriate call coverage by Department members.

9.4.3 QUALITY ASSESSMENT/PERFORMANCE IMPROVEMENT AND PATIENT SAFETY ACTIVITIES:²⁴⁵

- 9.4.3.1 Perform peer review and quality assessment activities relative to the performance of individuals with clinical privileges in the Department and report such activities to the Medical Executive Committee on a regular basis;
- 9.4.3.2 Provide leadership for activities related to patient safety, including proactive risk assessments, root cause analysis in response to an unanticipated adverse event, addressing patient safety alerts, and implementing procedures to comply with patient safety goals.²⁴⁶
- 9.4.3.3 Ensure appropriate quality control is performed, if applicable to the Department;
- 9.4.3.4 Receive reports regarding Hospital performance improvement results that are applicable to the performance of the Department and its members, and integrate the Department's performance improvement activities with that of the Hospital by taking a leadership and participatory role in such activities, as outlined in the Hospital Performance Improvement Plan.

9.4.4 COLLEGIAL AND EDUCATIONAL FUNCTIONS

- 9.4.4.1 Recommend medical educational programs to meet the needs of Department members, based on the scope of services provided by the Department, changes in medical practice or technology, and the results of Departmental performance improvement activities.²⁴⁷

9.5 OFFICERS OF DEPARTMENTS

9.5.1 IDENTIFICATION

The officers of the Departments shall be the Department Chairperson, the Department Vice-Chairperson.

9.5.2 QUALIFICATIONS

The officers of the Departments shall be active staff members in good standing. Each Department Chairperson and Vice-Chairperson shall have demonstrated ability in at least one of the clinical areas of the Department. All officers of the Departments shall be certified by

²⁴³ MS.2.10, MS.4.20

²⁴⁴ MS.4.40

²⁴⁵ MS.4.20, MS.4.40

²⁴⁶ MS.2.10; 42 C.F.R. §482.22

²⁴⁷ MS.5.10

an appropriate specialty board, or affirmatively establishes comparable competence through the credentialing process.²⁴⁸

9.5.3 ATTAINMENT OF OFFICE

Department officers shall be elected by a majority vote of the Department members eligible to vote and in attendance at the last meeting of the Department immediately preceding the end of the applicable year. The officers selected during the election shall be subject to ratification by the Medical Executive Committee and the Board and shall take office at the beginning of the subsequent medical staff year.²⁴⁹ If, at the time of ratification, the Board of Trustees is in disagreement with the Department's selection of nominee(s) for Office, a joint meeting of the Board of Trustees and the Medical Executive Committee will convene to discuss the reasons for the disparity before final decision is made by the Board of Trustees.

9.5.4 TERM OF OFFICE AND ELIGIBILITY FOR REAPPOINTMENT TO POSITION

Department officers shall serve a term of office of two years. No person may serve in the same position for more than two consecutive terms.²⁵⁰

9.5.5 RESIGNATION

Any Department officer may resign at any time by giving written notice to the Medical Executive Committee and the acceptance of such resignation shall not be necessary to make it effective.

9.5.6 REMOVAL

Any Department officer may be removed from office for cause. Removal shall occur with the majority vote of the Medical Executive Committee as to whether sufficient evidence exists for grounds for removal, with approval by the Board, or with the majority vote of the Board. Grounds for removal may include any one or more of the following causes, without limitations:²⁵¹

- 9.5.6.1 Failure to perform the duties of office;
- 9.5.6.2 Failure to comply with or support the enforcement of the Hospital and Medical Staff Bylaws, Rules and Regulations, or policies;
- 9.5.6.3 Failure to support the compliance of the Hospital and the Medical Staff to applicable Federal and State laws and regulations, and the standards or other requirements of any regulatory or accrediting agency having jurisdiction over the Hospital or any of its services;
- 9.5.6.4 Failure to maintain qualifications for office, specifically, failure to maintain active staff status in good standing and/or failure to maintain specialty board certification or comparable competence; and/or,
- 9.5.6.5 Failure to adhere to professional ethics or any other action(s) deemed injurious to the reputation of, or inconsistent with the best interests of the Hospital or the Medical Staff.

9.5.7 RECALL

Any Department officer may be recalled from office, with or without cause. Recall of a Department officer may be initiated by a petition signed by at least one-third of the Department members eligible to vote in medical Staff-Elections. Recall shall be considered by the members of the Department at a special meeting of the Department called for that purpose. A recall shall require two-thirds of the votes of the Department members attending

²⁴⁸ MS.1.20, MS.4.20, LD.2.20

²⁴⁹ MS.1.20

²⁵⁰ MS.1.20

²⁵¹ MS.1.20

the specially called meeting who are eligible to vote. Sealed, authenticated votes mailed by Department members eligible to vote shall also be counted at the special meeting. The recall shall become effective upon approval of the Board.

9.5.8 VACANCY

In the event of a vacancy in one of the Department officer positions, the Chief of Staff shall appoint an interim officer until an election can be held at the next Department meeting.

9.5.9 RESPONSIBILITY AND AUTHORITY²⁵²

9.5.9.1 Department Chairperson: Each Department Chairperson shall be responsible for the organization of the Department and delegation of duties to Department members to promote quality of patient care in the Department. Members of the Department and others with clinical privileges in the Department shall be responsible to the Department Chairperson. Each Department Chairperson shall be responsible for the following duties:

9.5.9.1.1 Presiding at all meetings of the Department;

9.5.9.1.2 Serving as an ex-officio member of all departmental committees if any, without vote, unless specifically stated in the Bylaws or Rules and Regulations otherwise;

9.5.9.1.3 Serving as a member of the Medical Executive Committee and be accountable to the Medical Executive Committee with regard to the activities and functioning of the Department, specifically to regularly report the quality assessment and performance improvement activities of the Department to the Medical Executive Committee;

9.5.9.1.4 Conducting all clinically related activities of the Department;²⁵³

9.5.9.1.5 Conducting all administratively related activities of the Department, unless otherwise provided by the Hospital;²⁵⁴

9.5.9.1.6 Continuing surveillance of the professional performance of all individuals in the Department who have delineated clinical privileges;²⁵⁵

9.5.9.1.7 Participating in the evaluation of Practitioners practicing within the department;²⁵⁶

9.5.9.1.8 Recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the Department;²⁵⁷

9.5.9.1.9 Recommending clinical privileges for each member of the Department;²⁵⁸

²⁵² MS.1.20, MS.4.20, LD.2.20

²⁵³ MS.1.20, MS.4.20, LD.2.20

²⁵⁴ MS.1.20, MS.4.20, LD.2.20

²⁵⁵ MS.1.20, MS.4.20, LD.2.20

²⁵⁶ MS.1.20, MS.4.20, LD.2.20

²⁵⁷ MS.1.20, MS.1.40, MS.4.20, LD.2.20, MS.5.4.1, 42 C.F.R. §482.22(c)(6)

²⁵⁸ MS.1.20, MS.4.20, LD.2.20

- 9.5.9.1.10 Assessing and/or recommending to the relevant Hospital authority off-site sources for needed patient care services not provided by the Department or the Hospital;²⁵⁹
 - 9.5.9.1.11 Integrating the Department into the primary functions of the Hospital;²⁶⁰
 - 9.5.9.1.12 Coordinating and integrating interdepartmental and intradepartmental services;²⁶¹
 - 9.5.9.1.13 Developing and implementing policies and procedures that guide and support the provision of services;²⁶²
 - 9.5.9.1.14 Recommending a sufficient number of qualified and competent persons to provide care or services;²⁶³
 - 9.5.9.1.15 Determining the qualifications and competence of department personnel who are not licensed independent practitioners and who provide patient care services;²⁶⁴
 - 9.5.9.1.16 Ensuring the continuous assessment and improvement of the quality of care and services provided;²⁶⁵
 - 9.5.9.1.17 Maintaining quality control programs, as appropriate;²⁶⁶
 - 9.5.9.1.18 Ensuring the orientation and continuing education of all persons in the Department;²⁶⁷
 - 9.5.9.1.19 Recommending appropriate space and other resources needed by the Department.²⁶⁸
- 9.5.9.2 Department Vice-Chairperson: The Vice-Chairperson shall assist the Department Chairperson in the performance of the Chairperson's duties, and shall assume the duties of the Chairperson in his/her absence. The Vice-Chairperson of each department shall serve as Chairman of the Medical Care Evaluation and Surgical Care Evaluation Committee meetings. The Vice Chairperson of each department shall serve as a member of the Medical Executive Committee.

10 ARTICLE TEN: FUNCTIONS AND COMMITTEES

10.1 FUNCTIONS OF THE STAFF

Individual members of the Medical Staff and others with clinical privileges care for patients within an organization context. Within this context, members of the Medical Staff and those individuals with clinical privileges, as individuals and as a group, interface with, and actively participate in important organization functions. Key functions of the Medical Staff are outlined below, and are performed through the Departments and committees that compose the Medical Staff structure.

²⁵⁹ MS.1.20, LD.3.30, LD.3.50

²⁶⁰ MS.1.20, LD.2.20, LD.3.70, LD.3.80, LD.3.90, LD.4.10

²⁶¹ MS.1.20, LD.2.20, LD.3.70, LD.3.80, LD.3.90, LD.4.10

²⁶² MS.1.20, LD.2.20, LD.3.70, LD.3.80, LD.3.90, LD.4.10

²⁶³ MS.1.20, LD.2.20, LD.3.70, LD.3.80, LD.3.90, LD.4.10

²⁶⁴ MS.1.20, LD.2.20, LD.3.70, LD.3.80, LD.3.90, LD.4.10

²⁶⁵ MS.1.20, LD.2.20, LD.3.70, LD.3.80, LD.3.90, LD.4.10

²⁶⁶ MS.1.20, LD.2.20, LD.3.70, LD.3.80, LD.3.90, LD.4.10

²⁶⁷ MS.1.20, LD.2.20, LD.3.70, LD.3.80, LD.3.90, LD.4.10

²⁶⁸ MS.1.20, LD.2.20, LD.3.70, LD.3.80, LD.3.90, LD.4.10

10.1.1 GOVERNANCE

The Medical Staff is organized to perform its required functions. The Medical Staff organization shall:

- 10.1.1.1 Establish a framework for self-governance of Medical Staff activities and accountability to the Board.²⁶⁹
- 10.1.1.2 Establish a mechanism for the Medical Staff to communicate with all levels of governance involved in policy decisions affecting patient care services in the Hospital.²⁷⁰

10.1.2 PLANNING

The leaders of the Hospital include members of the Board, the Chief Executive Officer and other senior managers, Department leaders, the elected and the appointed leaders of the Medical Staff and the Medical Staff Departments and other Medical Staff members in medico-administrative positions, and the Chief Nursing Officer and other senior nursing leaders.²⁷¹ Medical Staff leaders, as defined above, shall participate individually and collectively in collaborating with other Hospital leaders in the performance of the following leadership planning activities:

- 10.1.2.1 Planning patient care services;²⁷²
- 10.1.2.2 Planning and prioritizing performance improvement activities;²⁷³
- 10.1.2.3 Budgeting;²⁷⁴
- 10.1.2.4 Providing for uniform performance of patient care processes, including providing a mechanism to ensure that the same level of quality of patient care is provided by all individuals with delineated clinical privileges, within Medical Staff Departments, across Departments, and between members and non-members of the Medical Staff who have delineated clinical privileges;²⁷⁵
- 10.1.2.5 Recruitment, retention, development, and continuing education of all staff;²⁷⁶
- 10.1.2.6 Consideration and implementation of clinical practice guidelines as appropriate to the patient population.²⁷⁷
- 10.1.2.7 Establishing and maintaining responsibility for written policy and procedures governing medical care provided in the emergency service or department.²⁷⁸

10.1.3 CREDENTIALING

The Medical Staff is fully responsible to the Board for the credentialing process, which includes a series of activities designed to collect relevant data that will serve as a basis for decisions regarding appointments and reappointments to the Medical Staff, as well as delineation of clinical privileges. The Medical Staff shall perform the following functions to ensure an effective credentialing process:

²⁶⁹ MS.1.20, MS.1.30

²⁷⁰ MS.2.20, LD.1.10, LD.3.60

²⁷¹ The Joint Commission Comprehensive Accreditation Manual for Hospitals, Glossary

²⁷² LD.3.10

²⁷³ LD.4.50

²⁷⁴ LD.2.50

²⁷⁵ LD.3.10; MS.1.10

²⁷⁶ LD.3.10, LD.3.70

²⁷⁷ LD.5.10

²⁷⁸ MS.03.01.01

- 10.1.3.1 Establish specifically defined mechanisms for the process of appointment and reappointment to Medical Staff membership, and for granting delineated clinical privileges to qualified applicants.²⁷⁹
- 10.1.3.2 Establish professional criteria for membership and for clinical privileges.²⁸⁰
- 10.1.3.3 Conduct an evaluation of the qualifications and competence of individuals applying for Medical Staff membership or clinical privileges.²⁸¹
- 10.1.3.4 Submit recommendations to the Board regarding the qualifications of an applicant for appointment, reappointment or clinical privileges.²⁸²
- 10.1.3.5 Establish a mechanism for fair hearing and appellate review.²⁸³
- 10.1.3.6 Establish a mechanism to ensure that the scope of practice of individuals with clinical privileges is limited to the clinical privileges granted.²⁸⁴

10.1.4 QUALITY ASSESSMENT/PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

The Board requires that the Medical Staff is accountable to the Board for the quality of care provided to patients.²⁸⁵ All Medical Staff members and all others with delineated clinical privileges shall be subject to periodic review and appraisal as part of the Hospital's quality assessment and performance improvement activities.²⁸⁶ All organized services related to patient care shall be evaluated.²⁸⁷ The Hospital's quality assessment and performance improvement activities shall be described in detail in the Performance Improvement Plan. Through the activities of the Medical Staff Departments, the Medical Staff Quality Coordinating Council Committee, and representation of the Medical Staff on Hospital performance improvement committees and teams, the Medical Staff shall perform the roles in quality assessment and performance improvement that are listed below.²⁸⁸ The Medical Staff shall ensure that the findings, conclusions, recommendations, and actions taken to improve organization performance are communicated to appropriate Medical Staff members and the Board of Trustees.²⁸⁹

- 10.1.4.1 The Medical Staff shall participate with the Board and Administration in the performance of executive responsibilities related to the Hospital quality assessment and performance improvement program. The Board, the Medical Staff, and Administration shall be responsible and accountable for ensuring the following:²⁹⁰

- 10.1.4.1.1 That an ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained.

²⁷⁹ MS.1.20

²⁸⁰ MS.1.40, MS.4.10, MS.4.20, MS.4.40

²⁸¹ MS.4.20

²⁸² MS.1.20, MS.4.10, MS.4.20

²⁸³ MS.4.50

²⁸⁴ MS.4.40

²⁸⁵ 42 C.F.R. §482.12(a)(5)

²⁸⁶ MS.1.20, MS.3.10, MS.4.20, MS.4.40; 42 C.F.R. §482.22(a)(1)

²⁸⁷ 42 C.F.R. §482.21(a)(1)

²⁸⁸ 42 C.F.R. §482.22(a)(1), 42 C.F.R. §482.22(c)(3), Survey Procedures

²⁸⁹ MS.3.20

²⁹⁰ 42 C.F.R. §482.21 (effective March 25, 2003)

- 10.1.4.1.2 That the Hospital-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety; and that all improvement actions are evaluated.
- 10.1.4.1.3 That clear expectations for safety are established.
- 10.1.4.1.4 That adequate resources are allocated for measuring, assessing, improving, and sustaining the Hospital's performance and reducing risk to patients.
- 10.1.4.1.5 That the determination of the number of distinct improvement projects is conducted annually.
- 10.1.4.2 Medical Staff Leadership Role in Performance Improvement: The Medical Staff shall perform a leadership role in the Hospital's quality assessment, performance improvement, and patient safety activities when the performance of a process is dependent primarily on the activities of one or more individuals with clinical privileges.²⁹¹ Such activities shall include, but are not limited to a review of the following:
- 10.1.4.2.1 Use of patient safety data, proactive risk assessment and risk reduction activities, and implementation of procedures to respond to patient safety alerts and comply with patient safety goals;²⁹²
- 10.1.4.2.2 Root cause analysis, investigation and response to any unanticipated adverse events;²⁹³
- 10.1.4.2.3 Medical assessment and treatment of patients, including a review of all medical and surgical services for the appropriateness of diagnosis and treatment;²⁹⁴
- 10.1.4.2.4 Review and analysis of performance based on the results of core measures;²⁹⁵
- 10.1.4.2.5 Use of information about adverse privileging decisions for any Practitioner privileged through the medical staff process;²⁹⁶
- 10.1.4.2.6 Use of medications, including the review of any significant adverse drug reactions or medication errors, and the use of experimental drugs and procedures;²⁹⁷
- 10.1.4.2.7 Use of blood and blood components, including the review of any significant transfusions reactions;²⁹⁸
- 10.1.4.2.8 Use of operative and other procedures, including tissue review and the review of any major discrepancy between pre-operative and post-operative (including pathological) diagnoses;²⁹⁹

²⁹¹ MS.3.10

²⁹² LD.4.40, MS.3.10

²⁹³ LD.4.40, MS.3.10

²⁹⁴ MS.3.10, PI.1.10; 42 C.F.R. §482.21(a)(3)

²⁹⁵ Hospital Quality Alliance

²⁹⁶ MS.3.10

²⁹⁷ MS.3.10, PI.1.10; 42 C.F.R. §482.21; 42 C.F.R. §482.23(c)(4); 42 C.F.R. §482.25(b)(6)

²⁹⁸ MS.3.10, PI.1.10; 42 C.F.R. §482.21

²⁹⁹ MS.3.10, PI.1.10; 42 C.F.R. §482.21

- 10.1.4.2.9 Review of appropriateness, medical necessity, and efficiency of clinical practice patterns, including the review of surgical appropriateness, readmissions, appropriateness of discharge, and resource/utilization review;³⁰⁰
- 10.1.4.2.10 Significant departures from established patterns of clinical practice, including review of any sentinel events, risk management reports and patient or staff complaints involving the Medical Staff; and,³⁰¹
- 10.1.4.2.11 Use of developed criteria for autopsies.³⁰²
- 10.1.4.3 Medical Staff Participant Role in Performance Improvement: The Medical Staff shall participate in the measurement, assessment, and improvement of other patient care processes.³⁰³ Such activities shall include, but are not limited to a review of the following:
 - 10.1.4.3.1 Analyzing and improving patient satisfaction;³⁰⁴
 - 10.1.4.3.2 Education of patients and families;³⁰⁵
 - 10.1.4.3.3 Coordination of care with other practitioners and hospital personnel, as relevant to the care of an individual patient; and,³⁰⁶
 - 10.1.4.3.4 Accurate, timely, and legible completion of patients' medical records, including a review of medical record delinquency rates;³⁰⁷
 - 10.1.4.3.5 The quality of history and physical exams;³⁰⁸
 - 10.1.4.3.6 Surveillance of nosocomial infections.³⁰⁹
- 10.1.4.4 Medical Staff Peer Review: Findings relevant to an individual are used in an ongoing evaluation of the individual's competence.³¹⁰ When the findings of quality assessment or performance improvement activities are relevant to an individual's performance and the individual is a Medical Staff member or holds clinical privileges, the Medical Staff is responsible for determining the use of the findings in peer review or the ongoing evaluations of the individual's competence. In accordance with these Bylaws, clinical privileges are renewed or revised appropriately.³¹¹

10.1.5 CONTINUING AND GRADUATE MEDICAL EDUCATION

Since the Medical Staff recognizes continuing education as an adjunct to maintaining clinical skills and current competence, all individuals with clinical privileges shall participate in continuing education.³¹² In supporting high quality patient care, the Hospital and the Medical

³⁰⁰ MS.3.10; 42 C.F.R. §482.21; 42 C.F.R. §482.30

³⁰¹ MS.3.10; 42 C.F.R. §482.21

³⁰² MS.3.10

³⁰³ MS.3.20

³⁰⁴ MS.2.10

³⁰⁵ MS.3.20

³⁰⁶ MS.3.20

³⁰⁷ MS.3.20; IM3.10; 42 C.F.R. §482.21

³⁰⁸ MS.2.10;

³⁰⁹ IC.2.10; 42 C.F.R. §482.21(a)(2); 42 C.F.R. §482.42(b)(1 – 2)

³¹⁰ MS.3.20

³¹¹ MS.3.20; 42 C.F.R. §482.22(a)(1)

³¹² MS.5.10

Staff shall support the affiliated professional graduate medical education program by developing and upholding rules and regulations and policies to provide for supervision by members of the Medical Staff of house staff members in carrying out their patient care responsibilities.³¹³

Since the Medical Staff recognizes continuing education as an adjunct to maintaining clinical skills and current competence, all individuals with clinical privileges shall participate in continuing education.³¹⁴ In supporting high quality patient care, the Hospital and the Medical Staff shall sponsor educational activities that are consonant with the Hospital's mission, the patient population served, and the patient care services provided, within the limitations of applicable Federal laws and Hospital policy.³¹⁵ The Medical Staff shall develop educational programs for Medical Staff members and others with clinical privileges related at least in part to:

10.1.5.1 The type and nature of care offered by the hospital; and,³¹⁶

10.1.5.2 The findings of performance improvement activities.³¹⁷

Additionally, the Medical Staff shall support affiliated professional graduate medical education programs by developing and upholding rules and regulations and policies to provide for supervision by members of the Medical Staff of house staff members in carrying out their patient care responsibilities.³¹⁸

10.1.6 BYLAWS REVIEW AND REVISION

The Medical Staff shall provide a mechanism for adopting and amending the Medical Staff Bylaws, Rules and Regulations, and policies and for reviewing and revising the Medical Staff Bylaws, Rules and Regulations, and policies as necessary to:

10.1.6.1 Remain consistent with the Bylaws of the Board of Trustees;³¹⁹

10.1.6.2 Remain in compliance with all applicable Federal and State laws and regulations, and applicable accreditation standards;³²⁰

10.1.6.3 Remain current with the Medical Staff's organization, structure, functions, responsibilities and accountabilities;³²¹ and,

10.1.6.4 Remain consistent with Hospital policies.³²²

10.1.7 NOMINATING

The Medical Staff shall provide a mechanism for selecting qualified officers to give leadership to the Medical Staff organization.³²³

10.2 PRINCIPLES GOVERNING COMMITTEES

The key functions of the Medical Staff shall be performed ongoing through the activities of the Departments and committees of the Medical Staff. Specific key functions of the Medical Staff shall be performed through Medical Staff standing committees as outlined in the Medical Staff Rules and Regulations. The Medical Executive Committee may recommend to the Board the addition, deletion or

³¹³ MS.2.30

³¹⁴ MS.12.01.01

³¹⁵ MS.12.01.01, HCA, Ethics & Compliance Policy LL.010

³¹⁶ MS.12.01.01

³¹⁷ MS.12.01.01

³¹⁸ MS.04.01.01

³¹⁹ MS.1.20

³²⁰ LD.1.30

³²¹ MS.1.10, MS.1.20

³²² LD.1.20

³²³ MS.1.20

modification of any standing committee of the Medical Staff with the exception of the Medical Executive Committee. Such recommendations will be enacted following approval by the Board. In addition to the standing committees, the Medical Executive Committee or the Chief of Staff may designate a subcommittee of any standing committee or a special committee. The composition, duties and authority, and procedures for meetings and reporting of any subcommittee or special committee shall be specified in written policies or plans that are approved by the Medical Executive Committee. The continued need for a subcommittee or special committee shall be evaluated when the policy or plan that specifies the function of the committee is due for appraisal, which shall be at least every three years. If continued need for the subcommittee or special committee is no longer present, the subcommittee or special committee may be abolished upon approval of the Medical Executive Committee.

10.3 DESIGNATION

The committees of the Medical Staff as defined by the Bylaws are the Medical Executive Committee, the Credentials Committee, the Quality Coordinating Council Committee, the Bylaws Committee, and the Nominating Committee. All other standing committees are defined in the Medical Staff Rules and Regulations as stated in Section 10.2 of these bylaws.

10.4 OPERATIONAL MATTERS RELATING TO COMMITTEES

10.4.1 REPRESENTATION ON HOSPITAL COMMITTEES

In addition to the provisions of this Article, the leaders of the Medical Staff may collaborate with other Hospital leaders in planning for the performance of certain interdisciplinary functions through the establishment of Hospital committees. When a Hospital committee shall be involved in deliberations affecting the discharge of Medical Staff responsibilities, the Hospital committee shall include Medical Staff representation and participation.³²⁴ Medical Staff representatives for a Hospital committee shall be appointed by the Chief of Staff with input from the Chief Executive Officer or Chief Medical Officer.

10.4.2 EX OFFICIO MEMBERS

The Chief Executive Officer and Chief Medical Officer shall be an ex-officio member of all Medical Staff committees.³²⁵ The Chief Executive Officer may designate another senior administrative member to attend any meeting in his/her place. At the prerogative of the Board of Trustees, Board member(s) may be appointed by the Board of Trustees to serve as representative(s) of the Board of Trustees on any Medical Staff committee or Hospital committee as an ex-officio member. Other ex-officio members of specific standing committees shall be defined in the committee composition for each committee.

10.4.3 APPOINTMENT OF CHAIRPERSON AND MEMBERS

Within two months prior to the end of each Medical Staff year, the Medical Executive Committee shall appoint Medical Staff members to Medical Staff standing committee positions due to be vacated at the start of the next Medical Staff year. Terms of appointment shall commence at the start of the next Medical Staff year. Appointment of the chairpersons and any appointed members of the Medical Executive Committee, Credentials Committee, Quality Coordinating Council Committee and any other committee performing a professional review activity shall be subject to ratification by the Board per Article Eight, Section 8.3.3 of these Bylaws. The Chief Executive Officer, in consultation and with the approval of the Chief of Staff, shall make administrative staff appointments to a Medical Staff committee. Unless otherwise specified, administrative staff members serving on a Medical Staff committee shall not have the right to vote.

³²⁴ MS.1.10, MS.1.20, MS.1.30, MS.1.40, MS.4.50

³²⁵ MS.1.40

10.4.4 TERM, PRIOR REMOVAL AND VACANCIES

Unless otherwise provided for in the Medical Staff Bylaws all Committee Chairpersons shall be appointed by the Chief of Staff for a term of two (2) years. All chairperson(s) shall be appointed based on the criteria set for the in the Medical Staff Bylaws. Such appointments shall become effective when approved by the Board of Trustees. After serving an initial term, a chairperson may be reappointed by the Board upon recommendation from the Chief of Staff, in consultation with the Chief Executive Officer.

Members of each Medical Staff Committee shall be appointed biennially by the Chief of Staff, in consultation with the Chief Executive Officer, not more than thirty (30) days after the annual meeting of the Medical Staff, and there shall be no limitation in the number of terms they may serve.

If a chairperson or member of a committee fails to maintain Medical Staff membership in good standing or fails to attend, participate or perform the duties of the committee position, the Chief of Staff, the Medical Executive Committee, or the Board may remove that member from the committee position. As a condition of serving on a committee, and by virtue of having accepted the appointment, each member agrees to participate on the committee and further agrees not to divulge any of the peer review or other confidential proceedings of the committee. Failure to abide by the confidentiality requirements for such proceedings shall subject the member to removal from the committee and possible corrective actions, as warranted. Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made.

10.4.5 NOTICE

Notice of a committee meeting may be given in the same manner as notice for Medical Staff meetings, but in addition, notice for a committee meeting may be given orally and may be given not less than three (3) days before the meeting.

10.4.6 MEETINGS

The frequency of meeting shall be defined in writing for each committee, and shall be appropriate to the duties and functions of the committee.

10.4.7 QUORUM

Half the voting members of a committee present in person, or by interactive telecommunications shall constitute a quorum.

10.4.8 MANNER OF ACTING

The act of a majority of the voting members of a committee present at a meeting at which a quorum is present shall be the act of the committee. No action of a committee shall be valid unless taken at a meeting at which a quorum is present; however, any action which may be taken at a meeting may be taken without a meeting if consent in writing, setting forth the action, is signed by a majority of the members of the committee entitled to vote.

10.4.9 ACTION THROUGH SUBCOMMITTEES

Unless specifically delegated in a subcommittee's written scope of authority, a subcommittee shall not take any action that requires the vote of the committee to which it reports. The subcommittee shall submit recommendations, to be acted on by the committee.

10.4.10 MINUTES

Each committee and subcommittee shall record minutes of each meeting in a format specified in Hospital policy and recorded in English. The minutes shall record the date and time of the meeting, the names of those attending the meeting, the items of business brought before the committee or subcommittee, and the committee's or subcommittee's conclusions, recommendations, actions and plans for follow-up. A copy of all meeting minutes, and all reports, records or other materials of each committee shall be kept and maintained in the

Hospital for at least the current year plus three (3) years,³²⁶ after which they may be placed in archive storage, for perpetuity.

10.4.11 PROCEDURES

Each committee may formally or informally adopt its own rules of procedure, which shall not be inconsistent with the terms of its creation or these Bylaws.

10.4.12 REPORTS

Each standing and special committee of the Medical Staff shall periodically report its activities, findings, conclusions, recommendations, actions, and results of actions to the Medical Executive Committee. Each subcommittee shall periodically report its activities to the committee of which it is a part.

10.4.13 COMMITTEES, DEPARTMENTS WITH PEER REVIEW RESPONSIBILITIES

Peer review is the concurrent or retrospective review of an individual's professional qualifications professional competence, or professional conduct, including through clinical professional review activities. Peer review or professional review activity is conducted to determine whether an individual may have Medical Staff membership or clinical privileges, to determine the scope and conditions of such membership or privileges, or to change or modify such membership or privileges.³²⁷

10.4.13.1 Purpose of Peer Review: The purpose of the Hospital's peer review processes, programs, and proceedings are to encourage candid discussions in a private and confidential setting among Practitioners, other individuals with clinical privileges and other health care personnel to accomplish the following objectives:

10.4.13.1.1 To improve the quality of health care provided to patients;

10.4.13.1.2 To reduce morbidity and mortality at the Hospital;

10.4.13.1.3 To improve the credentialing process in an effort to monitor the competence, professional conduct and patient care activities of Practitioners, other individuals with clinical privileges, and other health care professionals who provide care to patients at the Hospital; and,

10.4.13.1.4 To maintain confidentiality of information generated during the course of peer review processes, programs and proceedings.

10.4.13.2 Peer Review Information: All peer review information shall be kept private and confidential. A Practitioner, other individual with clinical privileges, or other Hospital staff member who participates or has participated in a peer review process at the Hospital shall treat all peer review information as private, confidential and privileged and shall not disclose peer review information obtained, generated or compiled during a peer review process in which he/she participates unless specifically and expressly authorized by the Hospital to do so or as required by law.

10.4.13.3 Hospital Committees or Functions: A peer review process includes any process, program or proceeding involving any or all of the following Hospital committees or functions: patient safety, performance improvement, utilization management, credentialing, infection control, review of use of operative and invasive procedures, review of medical

³²⁶ HCA, Ethics & Compliance Policy EC.014, Record Series Code ADM-90-09

³²⁷ 42 USC §11135; 42 C.F.R. §482.21(c), Guidance to Surveyors, 42 C.F.R. §482.22(a)(1)

records, review of use of medications, review of use of blood and blood components, clinical risk management, quality assessment, any other review or investigation of professional performance or conduct, and fair hearings conducted pursuant to the Medical Staff Fair Hearing Plan.

- 10.4.13.4 Circumstances for Peer Review: The primary purpose of peer review activities shall be to improve an individual's performance. Peer review analysis shall be conducted whenever data comparisons indicate that the level of an individual's performance patterns or trends vary substantially from the expected.³²⁸ Peer review shall also be conducted for unanticipated adverse events when root cause analysis indicates human factors related to an individual's performance are possibly significant to the cause of the event.³²⁹ Peer review may be conducted for other reasons including, but not limited to, situations involving an individual case that may fall outside the standard of care, or failure to comply with Hospital policies and procedures, or in any other circumstance deemed necessary by the Chief of Staff, Chief Executive Officer, Medical Executive Committee, or any other committee authorized to review or evaluate an individual's performance, or the Board of Trustees. An external reviewer or review panel may be used when the Medical Staff lacks necessary expertise, or when there is a question of conflict of interest, or when additional review is needed to confirm peer review results, or in any other circumstance in which external review is deemed necessary by the Chief of Staff, Chief Executive Officer, Medical Executive Committee, or any other committee authorized to review or evaluate an individual's performance, or the Board of Trustees.³³⁰
- 10.4.13.5 Peer Review Panel: Professional review shall be conducted by a professional review body (e.g., a committee with a designated peer review function or an ad hoc peer review panel), any person acting as a member or staff to a professional review body, or any person under contract with a professional review body.³³¹ Ad hoc peer review panels may be selected for specific focused review by the Chief of Staff, CEO, Medical Executive Committee, any other Medical Staff committee authorized to review or evaluate care, or the Board of Trustees.³³²
- 10.4.13.6 Timeframes for Review: Focused peer review activities shall be conducted and the results reports within a timeframe of 120 days. In circumstances requiring ongoing review before a determination can be made, an interim report may be submitted within the defined timeframe if the final report will not be completed within the defined timeframe.³³³
- 10.4.13.7 Participation in Review: The individual whose performance or conduct is being reviewed shall have an opportunity to participate in the peer review process, either through attendance at a meeting in which the peer review results are discussed, in interviews with peer reviewers, or any other form of communication or correspondence with peer reviewers or the peer review panel. If the individual has been offered an opportunity to participate but the individual decides not to participate, the review may be

³²⁸ PI.2.20

³²⁹ PI.2.20

³³⁰ MS.4.90

³³¹ HCQIA, §11111(a)(1)(A-C)

³³² MS.4.90

³³³ MS.4.90

concluded and final results reported without the participation of the individual.³³⁴

10.4.13.8 Records and Minutes: The records and minutes of Medical Staff meetings and other Hospital committees and functions engaged in peer review shall be considered confidential. The commencement and completion of a peer review process will be documented; peer review processes that are continuous and ongoing will be identified. Peer review records and information will be identified with a conspicuous notation or stamp, for example: CONFIDENTIAL PEER REVIEW INFORMATION. The names of individuals who present or provide information during a peer review process should be documented.

10.4.13.9 Credentialing Records: The credentialing record or file of each Practitioner or other individual with clinical privileges shall be subject to the peer review privilege and maintained separately and identified as peer review information.

10.4.13.10 Custody: Peer review information, including Medical Staff records, shall be maintained under the custody of the Chief of Staff and the Chief Executive Officer.

10.4.13.10.1 A Practitioner or other individual with clinical privileges shall be permitted access to further information in the credentials and peer review file only if, following a written request by the individual, the Chief Executive Officer, in consultation with the Chief of Staff and legal counsel, finds that the individual has a compelling need for such information and grants written permission. A Practitioner or other individual with clinical privileges shall be permitted access to further information in that credentials file only if, following a written request by the individual, the Medical Executive Committee and the Board find that the individual has a compelling need for such information and grants written permission. Factors to be considered include the reasons for which access is requested; whether the release of information might have an adverse effect on the Hospital, the Medical Staff, the individual or other persons; whether the information could be obtained in a less intrusive manner; whether the information was provided to the Hospital in specific reliance upon continued confidentiality; whether a harmful precedent might be established by the release; and such other factors as might be considered appropriate. The Medical Executive Committee or the Board may enforce restrictions or conditions if access is permitted.

10.4.13.11 Medical Staff Officers: Members of the Board, licensing agencies, accreditation and regulatory authorities, the Chief Executive Officer, counsel to the Hospital, authorized Hospital staff members participating in utilization management functions or in performance improvement activities, may be afforded limited access to Medical Staff files and records, as appropriate. Medical Staff committee members who are members of the Medical Staff may have access to the records of committees on which they serve and to the applicable credentials, peer review, utilization management, and performance improvement files of individuals whose qualifications or performance the committee is

³³⁴ MS.4.90

reviewing as part of its responsibilities and official functions. The Board and the Chief Executive Officer and their properly designated representatives shall have access to Medical Staff records to the extent necessary to perform their responsibilities and official functions.

10.4.13.12 Outside Requests for Information: The Medical Staff Office and the Chief of Staff (or his designee) may release information contained in Medical Staff files in response to a proper request from another hospital or health care facility or institution, provided that the request includes a representation that the information shall be kept confidential. The request must include information that the Practitioner or other individual with clinical privileges is a member of the requesting facility's medical staff or has been granted privileges at the requesting facility, or is an applicant for medical staff membership or clinical privileges at that facility, and must include a release for such records signed by the individual involved. No information shall be released until a copy of a signed authorization and release from liability has been received. Disclosure shall generally be limited to the specific information requested.

10.4.13.13 Reporting Obligations: If a Practitioner or other individual with clinical privileges has been the subject of disciplinary action at the Hospital and information concerning the action must be reported to the state professional licensing or regulatory authorities, appropriate information from Medical Staff files may be released for reporting and compliance purposes. This information shall only be released upon approval of hospital legal counsel.

10.4.13.14 Surveyor Review: Hospital surveyors from licensing and regulatory agencies and authorities and accreditation bodies may be given access to Medical Staff records on the Hospital premises in the presence of Medical Staff personnel in accordance with law or accreditation requirements, provided that (a) no originals or copies may be removed from the premises, except pursuant to court or administrative order or subpoena or other legal requirements, (b) access is provided only with the concurrence of the Chief Executive Officer (or his/her designee) and the Chief of Staff (or his/her designee), and (c) the surveyor demonstrates the following to the satisfaction of the Chief Executive Officer or Chief of Staff:

10.4.13.14.1 Specific statutory, regulatory or other appropriate authority to review the requested materials;

10.4.13.14.2 The materials sought are directly pertinent to the matter being surveyed, investigated or evaluated;

10.4.13.14.3 The materials sought are the most direct and least intrusive means to accomplish the purpose;

10.4.13.14.4 Sufficient specificity of documents has been given to allow for the production of individual documents without undue burden to the Hospital;

10.4.13.14.5 If requests are made for documents with identifiers, the need for such identifiers is given and is determined to be appropriate, and information will be kept confidential to the maximum extent permitted by law.

10.4.13.15 Subpoenas: All subpoenas of Medical Staff records shall be referred to the Chief Executive Officer, with communication to the Risk Manager and the Chief of Staff.

10.4.13.16 Legal Counsel: Legal counsel to the Hospital may have access to information in Medical Staff records related to peer review proceedings, litigation, potential litigation or threatened litigation.

10.4.13.17 Other Requests: All other requests by persons or organizations for information contained in Medical Staff records shall be forwarded to the Chief Executive Officer for evaluation with communication to the Chief of Staff.

10.4.13.18 Peer Review Meetings: All peer review functions shall be performed only at meetings held on the campus of the Hospital.

10.5 MEDICAL EXECUTIVE COMMITTEE

10.5.1 COMPOSITION

The Medical Executive Committee shall consist of a majority of voting, fully licensed physician members of the Medical Staff actively practicing in the Hospital. The membership shall include the Chief of Staff, the Chief of Staff-Elect, the Immediate Past Chief of Staff, the Secretary/Treasurer, the Chairperson and Vice Chairperson of each Medical Staff Department, representation from hospital-based physician groups, representatives of the standing committees, other members of the Medical Staff designated by the Committee, the Chief Medical Officer and the Chief Executive Officer. The Chief Executive Officer shall be ex-officio member without a vote. No Medical Staff member actively practicing in the Hospital is ineligible for membership on the Medical Executive Committee solely because of his/her professional discipline, specialty, or practice as a hospital-based physician. The Chief of Staff shall service as chairperson of the committee.

10.5.2 DUTIES AND AUTHORITY

The Medical Executive Committee is empowered to represent and act for the Medical Staff in the interval between Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws.³³⁵ The Medical Staff has delegated to the Medical Executive Committee the authority to adopt, on behalf of the voting members of the Medical Staff, any Rules and Regulations and Medical Staff Policies to address the details for describing, implementing, enforcing or otherwise operationalizing the provisions contained within these Bylaws.³³⁶ The Medical Executive Committee shall perform or direct the performance of the duties relative to the key functions of Governance and Planning, as described in these Bylaws in Sections 10.1.1 and 10.1.2, and oversee the performance of other key functions. The following duties shall be performed by the Medical Executive Committee:

10.5.2.1 Providing for current Medical Staff Bylaws, rules and regulations, and Medical Staff policies, subject to the approval of the Board.

10.5.2.2 Providing liaison and communication with all levels of Hospital governance and administration with regard to policy decisions affecting patient care services.

10.5.2.3 Collaborate with other leaders of the organization in Hospital planning.

10.5.2.4 Review the qualifications, evidence of current competence, and the recommendations of a Department Chairperson and the Credentials Committee for each individual applying for Medical Staff membership or clinical privileges, and make recommendations for appointment,

³³⁵ MS.02.01.01

³³⁶ MS.01.01.01

reappointment, staff category, assignment to Departments, clinical privileges, and any disciplinary actions.

10.5.2.5 Organizing the Medical Staff's quality assessment and performance improvement activities and establishing a mechanism designed to conduct, evaluate, and revise such activities.³³⁷

10.5.2.6 Conduct and supervise Medical Staff peer review activities.

10.5.2.7 Receive and act on reports and recommendations from Medical Staff committees, Departments, and assigned activity groups, specifically as related to Medical Staff quality assessment and performance improvement activities.³³⁸

10.5.2.8 Make recommendations directly to the Board with regard to all of the following:³³⁹

10.5.2.8.1 The Medical Staff structure;³⁴⁰

10.5.2.8.2 The mechanism used to review credentials and to delineate individual clinical privileges;³⁴¹

10.5.2.8.3 Recommendations of individuals for Medical Staff membership;³⁴²

10.5.2.8.4 Recommendations for delineated clinical privileges for each eligible individual;³⁴³

10.5.2.8.5 The participation of the Medical Staff in organization quality assessment, performance improvement, and patient safety activities;³⁴⁴

10.5.2.8.6 Reports regarding the Medical Staff's evaluation of the quality of patient care services provided by the Medical Staff and the Hospital;³⁴⁵

10.5.2.8.7 The mechanism by which Medical Staff membership may be terminated; and,³⁴⁶

10.5.2.8.8 The mechanism for fair hearing procedures.³⁴⁷

10.5.2.9 Report at each Medical Staff meeting with regard to the actions taken by the Medical Executive Committee on behalf of the Medical Staff.

10.5.3 MEETINGS AND REPORTING

The Medical Executive Committee shall meet at least ten (10) times annually, and shall report the activities of the Medical Staff and the Medical Executive Committee to the Board.³⁴⁸

³³⁷ MS.1.20, MS.1.40, MS.3.10, MS.3.20, MS.4.50

³³⁸ MS.1.40

³³⁹ MS.1.40

³⁴⁰ MS.1.40

³⁴¹ MS.1.40

³⁴² MS.1.40

³⁴³ MS.1.40

³⁴⁴ MS.3.10, MS.3.20

³⁴⁵ 42 C.F.R. §482.12(a)(5); 42 C.F.R. §482.22.(b)

³⁴⁶ MS.1.40

³⁴⁷ MS.4.50

³⁴⁸ MS.1.40

10.6 CREDENTIALS COMMITTEE

10.6.1 COMPOSITION

The Credentials Committee shall consist of the Chairman, appointed by the Chief of Staff, the Chairmen of the Departments of Medicine and Surgery or their appointee and four members appointed by the Chief of Staff from the Active Staff so as to insure adequate representation of the various departments or major specialties. Members should be appointed on the basis of their objectivity and experience on other Committees. Chief Operating Officer, Chief Nursing Officer, the Chief Medical Officer and a representative from the Medical Staff Office shall participate without vote.

10.6.2 DUTIES AND AUTHORITY

The Credentials Committee shall perform the key function of Credentialing, as described in these Bylaws in Section 10.1.3, under the oversight and direction of the Medical Executive Committee. The Credentials Committee shall review all applications for appointment, reappointment, and the granting, renewal or revision of clinical privileges and make recommendations as to whether the applicants meet the Medical Staff's criteria for membership and/or clinical privileges. In addition, the following specific functions shall be performed by the Credentials Committee:

- 10.6.2.1 Oversee a mechanism to ensure that all Medical Staff members and individuals with clinical privileges maintain required credentials ongoing;³⁴⁹
- 10.6.2.2 Through making recommendations related to granting clinical privileges, ensure that the same level of quality of care is provided by all individuals with delineated clinical privileges, within Medical Staff Departments, across Departments, and between members and non-members of the Medical Staff who have delineated clinical privileges;³⁵⁰
- 10.6.2.3 Oversee a mechanism to ensure that the scope of practice of individuals with clinical privileges is limited to the clinical privileges granted;³⁵¹
- 10.6.2.4 Make recommendations to the Medical Executive Committee with regard to any revisions in the process for appointment, reappointment or delineation of clinical privileges.

10.6.3 MEETINGS AND REPORTING

The Credentials Committee shall meet at least ten (10) times annually, and shall report their recommendations and activities to the Medical Executive Committee.³⁵²

10.7 QUALITY COORDINATING COUNCIL COMMITTEE COMPOSITION

The Quality Coordinating Council Committee shall be composed of voting members of the Medical Executive Committee who shall be Active Staff members in good standing. In addition to the Chief Nursing Officer, and the Chief Medical Officer, the ex-officio members without vote shall also include the Director of Quality Management and the Risk Manager. The Committee shall also have the option of calling upon any member of the Medical Staff or other individual with clinical privileges to serve on the committee on an ad hoc basis to

³⁴⁹ MS.1.40, MS.4.10, MS.4.20, MS.4.40

³⁵⁰ LD.3.20; MS.1.10

³⁵¹ MS.4.40

³⁵² MS.1.40

provide clinical review and recommendations to the committee, their appointment subject to the approval of the Chief of Staff acting on behalf of the Medical Executive Committee and the Board in this singular capacity. Ad hoc members of the committee shall be bound by the confidentiality requirements of the committee and shall be provided indemnification while serving on the committee, subject to the provisions of Article 8, Section 8.3.3. Ad hoc members of the committee shall not have voting rights on the committee.

10.7.1 DUTIES AND AUTHORITY

The Quality Coordinating Council Committee shall perform the key function of Quality Assessment/Performance Improvement, as described in these Bylaws in Section 10.1.4, under the oversight and direction of the Medical Executive Committee. The Quality Coordinating Council Committee shall plan, implement, coordinate and promote ongoing Medical Staff leadership and participation in the Hospital's performance improvement program through the activities of the Medical Staff Departments, committees with a quality review function, and other assigned activity groups, as described in the Performance Improvement Plan. Additionally, the Quality Coordinating Council Committee shall ensure that when the findings of the quality assessment process (either aggregate data or single events) are relevant to an individual's performance, the committee shall conduct peer review or an ongoing evaluation of the individual's competence and make recommendations accordingly.³⁵³ In addition, the Quality Coordinating Council Committee shall perform the following specific functions:

10.7.1.1 Participate in an annual evaluation of the Hospital's Performance Improvement program and in the development or revisions to the Performance Improvement Plan, including making recommendations for the establishment of priorities for the program.³⁵⁴

10.7.1.2 Ensure that Medical Staff quality assessment and performance improvement activities address applicable review requirements found in regulatory and accreditation laws, regulations, and standards. Also ensure that the activities address the scope of patient care provided and are effective by reviewing the reports of the Medical Staff Departments and any other Medical Staff or Hospital quality review groups and making recommendations to the Medical Executive Committee.

10.7.2 MEETINGS AND REPORTING

The Quality Coordinating Council Committee shall meet at least quarterly, and shall report their recommendations and activities to the Medical Executive Committee.³⁵⁵

10.8 GRADUATE MEDICAL EDUCATION COMMITTEE

10.8.1 COMPOSITION

The Graduate Medical Education Committee shall be composed of voting members who shall be active staff members in good standing. The voting membership shall include two active staff members from each Department. In addition to the Chief Executive Officer and the Chief Medical Officer the ex-officio members without vote shall also include the Medical Staff Services Coordinator and the Education Coordinator.

10.8.2 DUTIES AND AUTHORITY

The Graduate Medical Education Committee shall perform the key function of Continuing and Graduate Medical Education, as described in these Bylaws in Section 10.1.5, under the oversight and direction of the Medical Executive Committee. The Graduate Medical Education Committee shall plan, implement, coordinate and promote ongoing clinical and scientific

³⁵³ MS.3.20; 42 C.F.R. §482.22(a)(1)

³⁵⁴ LD.4.50

³⁵⁵ MS.1.40

education programs for Medical Staff members and other individuals with clinical privileges. In addition, the committee shall perform the following specific duties:

- 10.8.2.1 Establish liaison with the quality assessment and performance improvement program to identify the need for education based on the findings from the program;³⁵⁶
- 10.8.2.2 Assist in prioritizing plans for hospital-sponsored education;³⁵⁷
- 10.8.2.3 Ensure provision of any required Medical Staff education, including:
 - 10.8.2.3.1 Education about illness and health issues specific to physicians and other individuals with clinical privileges;³⁵⁸
 - 10.8.2.3.2 Education about unprofessional or inappropriate conduct and its potential impact on patient safety;
 - 10.8.2.3.3 Central line-associated bloodstream infections and the importance of prevention;³⁵⁹
 - 10.8.2.3.4 Health care-associated infections, multidrug-resistant organisms, and prevention strategies;³⁶⁰
 - 10.8.2.3.5 Surgical site infections and the importance of prevention;³⁶¹
 - 10.8.2.3.6 Education about assessing and managing patients with pain.³⁶²
 - 10.8.2.3.7 At a minimum, education about the influenza vaccine; non-vaccine control and prevention measures; and the diagnosis, transmission, and impact of influenza;³⁶³
 - 10.8.2.3.8 Education that concerns about the safety or quality of care provided in the organization may be reported to The Joint Commission;³⁶⁴
 - 10.8.2.3.9 Education regarding a practitioner's role(s) in emergency response and to whom he or she reports during an emergency;³⁶⁵
 - 10.8.2.3.10 Education for licensed independent practitioners who perform waived testing;³⁶⁶
 - 10.8.2.3.11 Education regarding minimizing, eliminating and reporting environmental risks;³⁶⁷

³⁵⁶ MS.12.01.01

³⁵⁷ MS.12.01.01

³⁵⁸ MS.11.01.01

³⁵⁹ NPSG.07.04.01

³⁶⁰ NPSG.07.03.01

³⁶¹ NPSG.07.05.01

³⁶² MS.03.01.03

³⁶³ IC.02.04.01

³⁶⁴ APR.09.02.01

³⁶⁵ EM.02.02.07

³⁶⁶ WT.03.01.01

³⁶⁷ EC.03.01.01

10.8.2.3.12 Alternative procedures to follow when electronic information systems are unavailable;³⁶⁸

10.8.2.4 Select appropriate teaching methods and knowledgeable faculty for each education program;

10.8.2.5 Promote and document attendance at each program, and assess the effectiveness of each program;

10.8.2.6 Make recommendations regarding the library needs of the Medical Staff;

10.8.2.7 Make recommendations regarding the financial needs of the continuing education program;

10.8.2.8 Provide liaison and oversee the affiliation with any graduate medical education programs, including overseeing the safety and quality of care provided by program participants, and related educational and supervisory needs.³⁶⁹

10.8.3 MEETINGS AND REPORTING

The Graduate Medical Education Committee shall meet at least quarterly, and shall report their recommendations and activities to the Medical Executive Committee.³⁷⁰ The Graduate Medical Education Committee shall communicate periodically with the Medical Executive Committee and the Board about the educational needs and performance of the participants in professional graduate education programs.³⁷¹

10.9 BYLAWS COMMITTEE

10.9.1 COMPOSITION

The Bylaws Committee shall be composed of voting members who shall be Active Staff members in good standing. The voting membership shall include the Immediate Past Chief of Staff who shall chair the committee, and two Active Staff member(s) from each Department. In addition to the Chief Medical Officer and Chief Executive Officer or his designee, the ex-officio members without vote shall also include the Medical Staff Office representative.

10.9.2 DUTIES AND AUTHORITY

The Bylaws Committee shall perform the key function of Bylaws Review and Revision, as described in these Bylaws in Section 10.1.6, under the oversight and direction of the Medical Executive Committee. The Bylaws Committee shall review these Bylaws and the Rules and Regulations and recommend any needed additions, revisions, modifications, amendments or deletions.

10.9.3 MEETINGS AND REPORTING

The Bylaws Committee shall meet at least annually, and shall report their recommendations and activities to the Medical Executive Committee.³⁷²

³⁶⁸ IM.01.01.03

³⁶⁹ MS.04.01.01

³⁷⁰ MS.02.01.01

³⁷¹ MS.04.01.01, LD.01.03.01

³⁷² MS.1.40

10.10 MEDICAL STAFF LEADERSHIP DEVELOPMENT & NOMINATING COMMITTEE

10.10.1 COMPOSITION

The Medical Staff Leadership Development & Nominating Committee shall be composed of voting members who shall be active staff members in good standing. The voting membership shall include the Chief of Staff who shall chair the meeting, the Immediate Past Chief of Staff, and one active staff Member from each Department. The Chief Executive Officer and the Chief Medical Officer shall serve as ex-officio members without vote. No candidate for election may serve as a Member of the Medical Staff Leadership Development & Nominating Committee.

10.10.2 DUTIES AND AUTHORITY

The Medical Staff Leadership Development & Nominating Committee shall perform the key function of Medical Staff Leadership Development & Nominating, as described in these Bylaws in Section 10.1.7, under the oversight and direction of the Medical Executive Committee. The Medical Staff Leadership Development & Nominating Committee shall define desired leadership characteristics, identify and recruit future potential medical staff leaders from among the Members of the Medical Staff, and shall advise the Chief Executive Officer, the Chief Medical Officer and the Medical Executive Committee of the education and development needs of potential medical staff leaders so as to be successful in future roles. The Medical Staff Leadership Development & Nominating Committee shall solicit and accept nominations for elected Medical Staff officer positions, consult with the nominees concerning their qualifications and willingness to serve, prepare ballots, and supervise the election of officers.

10.10.3 MEETINGS AND REPORTING

The Medical Staff Leadership Development & Nominating Committee shall meet at least once a year, and shall report their recommendations and activities to the Medical Executive Committee.³⁷³

11 ARTICLE ELEVEN: MEETINGS

11.1 MEDICAL STAFF YEAR

The Medical Staff year shall be the period from May 1 to April 30 of each year.

11.2 MEDICAL STAFF MEETINGS

11.2.1 REGULAR MEETINGS

The regular meeting of the Medical Staff shall be held annually before the end of the Medical Staff year, at a time and place designated by the Medical Executive Committee, for the purpose of receiving reports from officers and committees, electing officers, and transacting other such business as may properly come before the meeting of the Medical Staff.

11.2.2 SPECIAL MEETINGS

Special meetings of the Medical Staff may be called at the direction of the Chief of Staff and/or the request of the Medical Executive Committee or any ten members of the Active Staff by written request, to be held at such time and place as shall be designated in the notice of the meeting. No business shall be transacted at a special meeting, except as specified in the notice or as otherwise expressly provided in these Bylaws.

³⁷³ MS.02.01.01

11.3 DEPARTMENT MEETINGS

11.3.1 REGULAR MEETINGS

Regular meetings of each Department shall be held at least twice annually, or more frequently as necessary to perform the functions of Departments as specified in Article Nine of these Bylaws.

11.3.2 SPECIAL MEETINGS

Special meetings of a Department may be called at the direction of the Chairperson of the Department or any five members of the active staff of the Department by written request to the Department Chairperson, to be held at such time and place as shall be designated in the notice of the meeting. No business shall be transacted at a special meeting, except as specified in the notice or as otherwise expressly provided in these Bylaws.

11.4 ATTENDANCE REQUIREMENTS

11.4.1 GENERALLY

Active staff members of the Medical Staff shall be required to attend twenty-five percent (25%) of the meetings of the Department to which they are assigned, and the annual general staff meeting. Attendance shall be considered at the time of reappointment when evaluating whether a Member has met the obligations associated with Medical Staff membership.

11.4.2 SPECIAL APPEARANCES

A Medical Staff Member or other individual with clinical privileges may be required to attend a meeting of a Medical Staff Committee for purposes of conducting peer review. Following receipt of proper notice of such an attendance requirement, failure to attend may be grounds for suspension, termination, or other actions on Medical Staff membership or clinical privileges.

11.5 MEETING PROCEDURES

11.5.1 NOTICE OF MEETINGS

Notice of the date, time and place of the annual Medical Staff meeting shall be given not less than seven (7) days or more than thirty-one (31) days prior to a regular meeting, and not less than three (3) days prior to a special meeting of the general Medical Staff by written electronic notice or written notice by mail to each member of the active staff at his/her address as shown in Medical Staff records. The Medical Executive Committee or the Chief of Staff may send notice to members of other categories of the Medical Staff, the Chief Executive Officer, members of Administration and others. If mailed, notice shall be deemed to be delivered when deposited in the United States mail, postpaid.

Notice to a Medical Staff member or other individual with clinical privileges who is being required to attend a meeting for quality review purposes shall be considered proper and valid when a registered, return receipt letter is sent at least seven (7) days prior to the meeting.

11.6 QUORUM

11.6.1 GENERAL STAFF MEETINGS

At least ten percent (10%) of the Active Staff members present in person shall constitute a quorum once a quorum is established the business of the meeting may continue and all action taken shall be binding even though the number of voting staff may decrease as at a later time

in the Medical Staff meeting. If a quorum was not determined the meeting may be adjourned until a quorum can be established. Voting by proxy shall be permitted if the vote is given to the Department Chairman and/or Chief of Staff to read and counted at the meeting and recorded in the minutes.

11.6.2 DEPARTMENT

At least five of the Active Staff members present in person shall constitute a quorum, once a quorum is established the business of the meeting may continue and all action taken shall be binding. If a quorum was not determined the meeting may be adjourn until a quorum can be established. Voting by proxy shall be permitted if the vote is given to the Department Chairman and/or Chief of staff to read and counted at the meeting and recorded in the minutes.

11.7 MANNER OF ACTION

The act of a majority of the voting members present at a general Medical Staff meeting at which the quorum requirement is met shall be the act of the Medical Staff. The act of the majority of voting Department members present at a Medical Staff Department meeting at which the quorum requirement is met shall be the act of the Department.

11.8 VOTING RIGHTS

Only Active Staff members have the right to vote. A non-physician member of the Medical Staff may vote on credentialing matters (such as procedures for appointment, reappointment, granting clinical privileges and discipline) only when such matters involve practitioners who hold the same professional license as the non-physician.

11.9 RIGHTS OF EX-OFFICIO MEMBERS

Persons serving under these Bylaws as ex-officio members of a Medical Staff body shall have all rights and privileges of regular members except they shall not be counted in determining the existence of a quorum, and they shall not have voting rights unless expressly provided.

11.10 MINUTES

The Secretary/Treasurer shall prepare minutes of each meeting of the Medical Staff, which shall include a record of attendance and the vote taken on each matter. Minutes shall be signed by the Secretary/Treasurer, approved by the presiding officer, and maintained in a permanent file. Minutes shall be available for inspection by Medical Staff members for any proper purpose, subject to any policies concerning confidentiality of records and information. Each Department Chairperson shall ensure that minutes are prepared for their respective Department meetings.

11.11 PROCEDURAL RULES

The Chief of Staff, or in his/her absence, the Chief of Staff-Elect, shall preside at general Medical Staff meetings. Meetings shall be conducted in accordance with an acceptable form of parliamentary procedure, such as Robert's Rules of Order, as may be modified by the Medical Staff.

12 ARTICLE TWELVE: CONFIDENTIALITY, IMMUNITY AND RELEASE

12.1 AUTHORIZATIONS AND CONDITIONS

Any applicant for Medical Staff membership or clinical privileges and every member of the Medical Staff or individual with clinical privileges shall agree that the provisions of this Article shall specifically control with regard to his/her relationship to the Medical Staff, other members of Staff, members of the Board, and the Hospital. By submitting an application for membership or clinical privileges, by accepting appointment or reappointment to the Staff or clinical privileges, or by exercising clinical privileges including temporary privileges, each individual specifically agrees to be bound by these Bylaws, including the provisions of this Article during the processing of his/her application and at any time thereafter, and such provisions shall continue to apply during his/her term of membership or term of clinical privileges.

12.2 CONFIDENTIALITY OF INFORMATION

Any act, communication, report, recommendation or disclosure concerning any applicant for membership or clinical privileges given or made by anyone in good faith and without malice, with or without the request of any authorized representative of the Medical Staff, the Administration, the Board, the Hospital or any other healthcare facility or provider for the purposes of providing, achieving or maintaining quality patient care in the Hospital or at any other healthcare facility shall be confidential and protected from discovery to the fullest extent permitted by law. Such protection shall extend to members of the Medical Staff, the Chief Executive Officer, Administrative officials, Board members and their representatives and to third parties who furnish information to any of them to receive, release or act upon such information. Third parties shall include individuals, firms, corporations and other groups, entities, or associations from whom information has been requested or to whom information has been given by a member of the Medical Staff, authorized representatives of the Staff, the Administration or the Board.

12.3 BREACH OF CONFIDENTIALITY

Inasmuch as effective peer review, credentialing and quality assessment /performance improvement activities must be based on free and candid discussions, any breach of confidentiality of the discussions, deliberations, or records of any Medical Staff meeting, Department, or committee is outside appropriate standards of conduct for this Medical Staff and shall be deemed disruptive to the operation of the Hospital and as having an adverse impact on the quality of patient care. Such breach or threatened breach shall subject the individual responsible for a breach of confidentiality to disciplinary action under the Medical Staff Bylaws, Rules and Regulations, and applicable Hospital policies.

12.4 IMMUNITY FROM LIABILITY

There shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any act, communication, report, recommendation or disclosure performed, given or made, even if the information involved would otherwise be protected. No action, cause of action, damage, liability or expense shall arise or result from or be commenced with respect to any such act, communication, report, recommendation, or disclosure. Such immunity shall apply to all acts, communications, reports, recommendations and disclosures performed, given or made in connection with, or for, or on behalf of any activities of any other healthcare facility or provider including, without limitation, those relating to:

- 12.4.1 Applications for appointment to the Medical Staff or for clinical privileges;
- 12.4.2 Periodic appraisals or reviews for reappointment or for renewal or revisions to clinical privileges;
- 12.4.3 Corrective action or disciplinary action, including suspension or revocation of Medical Staff membership or clinical privileges;
- 12.4.4 Hearing and appellate review;
- 12.4.5 Medical care evaluations;
- 12.4.6 Peer review evaluations;
- 12.4.7 Utilization review and resource management; and,
- 12.4.8 Any other Hospital, departmental, service or committee activities related to quality patient care, professional conduct or professional relations. Such matters may concern, involve or relate to, without limitation, such person's professional qualifications, clinical competence, character, fitness to practice, physical and mental condition, ethical or moral standards or any other matter that may or might have an effect or bearing on patient care.

12.5 RELEASES

In furtherance of and in the interest of providing quality patient care, each applicant for Medical Staff membership or clinical privileges, and each Medical Staff member or individual with clinical privileges shall, by requesting or accepting membership or clinical privileges, release and discharge from loss, liability, cost, damage and expense, including attorney's fees, such persons who may be entitled to the benefit of the privileges and immunities provided in this Article, and shall, upon the request of the Hospital or any officer of the Staff, execute a written release in accordance with the tenor and import of this Article.

12.6 SEVERABILITY

In the event any provision of these Bylaws are found to be legally invalid or unenforceable for any reason, the remaining provisions of the Bylaws shall remain in full force and effect provided the fundamental rights and obligations remain reasonably unaffected.

12.7 NONEXCLUSIVITY

The privileges and immunities provided in this Article shall not be exclusive of any other rights to which those who may be entitled to the benefit of such privileges and immunities may be entitled under any statute, law, rule, regulation, bylaw, agreement, vote of members or otherwise, and shall inure to the benefit of the heirs and legal representatives of such persons.

13 ARTICLE THIRTEEN: ADOPTION AND AMENDMENT AND GENERAL PROVISIONS

13.1 MEDICAL STAFF AUTHORITY AND RESPONSIBILITY

The Board of Trustees shall require the Medical Staff to adopt and enforce Bylaws to carry out its medical staff functions.³⁷⁴ The Board of Trustees shall require that the Medical Staff Bylaws, Rules & Regulations, and policies comply with local, State and Federal law and regulations, and the requirements of the Medicare hospital Conditions of Participation, and applicable accreditation

³⁷⁴ 42 C.F.R. §482.12(a)(3), 42 C.F.R. §482.22(c)

standards.³⁷⁵ The Medical Staff Bylaws shall be adopted upon the approval of the Medical Staff and become effective upon approval by the Board. The Medical Staff Rules and Regulations shall be adopted upon the approval of the Medical Executive Committee, acting on behalf of the Medical Staff, and become effective upon approval by the Board. Neither the Board nor the Medical Staff may unilaterally amend the Medical Staff Bylaws or Rules and Regulations. Notwithstanding anything to the contrary contained herein, the Board shall maintain responsibility and authority over the operation of the Medical Staff and in the event the Medical Staff is unable or refuses to amend their Bylaws or Rules and Regulations to comply with local, State and Federal law and regulations, and the requirements of the Medicare hospital Conditions of Participation, and applicable accreditation standards, the Board retains the authority to unilaterally amend the Medical Staff Bylaws and Rules and Regulations to so comply after first exhausting reasonable efforts to obtain Medical Staff approval.³⁷⁶ The Medical Staff Bylaws, Rules and Regulations, and policies shall not conflict with the Bylaws of the Board of Trustees.³⁷⁷ The Medical Staff shall comply with and enforce the Medical Staff Bylaws, Rules and Regulations, and policies.³⁷⁸

13.2 EXCLUSIVE MECHANISM

The mechanism described herein shall be the sole method for initiation, adoption, amendment or repeal of the Medical Staff Bylaws.

13.3 METHODOLOGY

13.3.1 MEDICAL STAFF BYLAWS

Upon the request of the Medical Executive Committee, or the Chief of Staff, or the Bylaws Committee after approval by the Medical Executive Committee, or upon timely written petition signed by at least ten percent (10%) of the members of the Medical Staff in good standing who are entitled to vote, consideration shall be given to the adoption, amendment, or repeal of these Bylaws. Such action shall be taken at a regular meeting, special meeting, or by the response received by mailed written ballot of the Active Medical Staff, provided that written notice of the proposed change was sent to all members of the active staff no less than twenty (20) days prior to the meeting or response date, at which the Bylaws changes are to be voted upon and/or counted. The notices shall include the proposed change(s) of the Bylaws. If a meeting is held and a quorum is present as described in Article Eleven, Section 11.6.1, for the purpose of enacting a bylaw change, the change shall require an affirmative vote of greater than fifty percent (50%) of the members voting in person or who have submitted a written ballot returned to the Medical Staff Office either prior to the meeting or within five (5) days after the date of the meeting, or if not meeting is held, than an affirmative vote greater than fifty percent (50%) of those Active Medical Staff Members eligible to vote on such Bylaw change(s) who have responded by written ballot. Bylaws changes adopted by the Medical Staff shall become effective following approval by the Board, which approval shall not be unreasonably withheld. Following significant changes to the Bylaws, Rules and Regulations or Medical Staff policies, Medical Staff members shall be provided with a revised text.³⁷⁹

In the event of a documented need for an urgent amendment of the Medical Staff Bylaws to comply with law or regulation or accreditation standards, the Medical Executive Committee may provisionally adopt, and the Board of Trustees may provisionally approve the urgent amendment without prior notification of the voting members of the Medical Staff. In such cases, the voting members of the Medical Staff shall be immediately notified by the Medical

³⁷⁵ 42 C.F.R. §482.12(a)(3), Interpretive Guidelines

³⁷⁶ HCA, Model Governance Bylaws, 42 C.F.R. §482.12(a)(4), 42 C.F.R. §482.22(c)(1), MS.1.20, MS.1.30

³⁷⁷ MS.1.20

³⁷⁸ 42 C.F.R. §482.12(a)(3), 42 C.F.R. §482.22(c), MS.1.20

³⁷⁹ MS.1.20, MS.1.40, LD.3.60

Executive Committee of the urgent amendment within ten (10) days after the Board of Trustees has approved the amendment. The voting members of the Medical Staff shall have an additional twenty (20) days within which to retrospectively review the amendment and provide written comment to the Medical Executive Committee. If there are no comments opposing the provisional amendment, then the provisional amendment shall become final. If there are comments opposing the provisional amendment, then the Medical Staff process for conflict management shall be implemented, and a revised amendment shall be submitted to the Board of Trustees if necessary.³⁸⁰

Neither the Board nor the Medical Staff may unilaterally amend the Medical Staff Bylaws or Rules and Regulations, except as set forth below.³⁸¹ As required by the Medicare Conditions of Participation and other regulatory requirements, the Board shall maintain complete and ultimate responsibility and authority over the Hospital and Medical Staff.³⁸² In the event of a documented need for an urgent amendment of the Medical Staff Bylaws in which the Medical Staff and the Medical Executive Committee are incapable of, or refuse to amend the Medical Staff Bylaws to comply with local, State or Federal laws and regulations, or to address a documented concern that could adversely affect patient safety or quality of care, the Board shall exercise its authority in such a situation to unilaterally amend the Medical Staff Bylaws or Rules & Regulations as necessary to address an issue of quality, patient safety, liability, regulatory compliance, legal compliance after first exhausting reasonable efforts to gain the Medical Executive Committee's or Medical Staff's approval, including using the conflict management process as set out below in Section 13.5.9. In such a situation, the Board's amendment shall be final, and all voting members of the Medical Staff shall be notified of the amendment within ten (10) days of the amendment becoming final.

13.3.2 RULES & REGULATIONS AND MEDICAL STAFF POLICIES

To implement the Medical Staff Bylaws, the Medical Staff shall develop administrative procedures, which shall be described in documents that supplement the Bylaws, such as Rules and Regulations, and policies. If any administrative procedures contained in supplemental documents relate to credentialing, privileging, appointment, reappointment, corrective actions, fair hearing and appeal, the procedures shall be approved by both the Medical Staff and the Board of Trustees through the mechanisms described below. Administrative procedures eligible to be in supplemental documents shall meet the following criteria:³⁸³

- The administrative procedure is not a step in the process itself;
- The procedure does not have a major impact on the outcome of the process such as procedures that result in an evaluative conclusion or decision;
- The procedure is not so material to the appropriateness and fairness of the process that it needs to be in the Bylaws.

13.3.2.1 Medical Staff Rules and Regulations and Policies: Subject to approval by the Board, the Medical Executive Committee, acting on behalf of the Medical Staff, shall adopt such Rules and Regulations and Policies as may be necessary to implement these Bylaws. The Rules and Regulations and Policies shall relate to the proper conduct of Medical Staff organizational activities and shall embody the level of practice required of each Staff appointee and individuals with clinical privileges. Such Rules and Regulations and Policies shall not conflict with the Governance Bylaws of the Board of Trustees.

³⁸⁰ MS.01.01.01

³⁸¹ MS.01.01.03

³⁸² 42 C.F.R, §482.12

³⁸³ MS.1.20, EP 19, *Perspectives, December 2004*

13.4 TECHNICAL AND EDITORIAL AMENDMENTS

The Medical Executive Committee may correct typographical, spelling, grammatical or other obvious technical or editorial errors in the Bylaws and Rules and Regulations and Policies.

13.5 GENERAL PROVISIONS

13.5.1 SUCCESSOR IN INTEREST

These Bylaws and the membership accorded under these Bylaws will be binding upon the Medical Staff and the Board of any successor in interest in this Hospital except where hospital medical staffs are being combined. In the event that the staffs are being combined, the medical staffs shall work together to develop new bylaws which will govern the combined medical staffs, subject to the approval of the hospital's Board or its successor in interest. Until such time as the new bylaws are approved, the existing Bylaws of this Medical Staff shall remain in effect.

13.5.2 AFFILIATIONS

Affiliations between the Hospital and other hospitals, healthcare systems, or other entities shall not, in and of themselves, affect these Bylaws.

13.5.3 NO IMPLIED RIGHTS

Nothing contained herein is intended to confer any rights or benefits upon any individual or to confer any private right, remedy, or right of action upon any person, except as expressly set forth herein. These Bylaws and the Rules and Regulations are intended for internal Hospital use only and solely for the governance of the internal affairs of the Hospital. No person is authorized to rely on any provisions of these Bylaws or the Rules and Regulations except as specifically provided herein, and no person may personally enforce any provision hereof, except as specifically provided.

13.5.4 NOTICES

Any notices, demands, requests, reports or other communications required or permitted to be given hereunder shall be deemed to have been duly given if in writing and delivered personally or deposited in the United States first class mail, postpaid, to the person entitled to receive notice at his/her last known address, except as otherwise provided in these Bylaws or in the Rules and Regulations.

Notwithstanding anything herein to the contrary, it is understood that these Bylaws and the Rules and Regulations do not create, nor shall they be construed as creating, in fact or by implication or otherwise a contract of any nature between or among the Hospital or the Board or the Medical Staff and any Member of the Medical Staff or any person granted clinical privileges. Any clinical or other privileges are simply privileges which permit conditional use of the Hospital facilities, subject to the terms of these Bylaws and the Rules and Regulations.

13.5.5 CONFLICT OF INTEREST

Individuals shall disclose any conflict of interest, as defined by the Board, or potential conflict of interest in any transaction, occurrence or circumstance which exists or may arise with respect to his/her participation on any committee or in his/her activities in Medical Staff affairs, including in departmental activities and in the review of cases. Where such a conflict of interest exists or may arise, the individual shall not participate in the activity, or as appropriate, shall abstain from voting, unless the circumstances clearly warrant otherwise. This provision does not prohibit any person from voting for himself/herself nor from acting in matters where all others who may be significantly affected by the particular conflict of interest consent to such action.

13.5.6 NO AGENCY

Physicians, other practitioners, and other individuals with clinical privileges shall not, by virtue of these Bylaws or Medical Staff appointment, be authorized to act on behalf of, or

bind the Hospital, and shall not hold themselves out as agents, apparent agents or ostensible agents of the Hospital, except where specifically and expressly authorized in a separate written contract with the Hospital.

13.5.7 CONFLICT

In the event that these Bylaws, including provisions for Fair Hearing, shall conflict with the Rules and Regulations or the policies of the Medical Staff, the provisions of these Bylaws shall control.

13.5.8 CONFLICT MANAGEMENT/RESOLUTION

13.5.8.1 CONFLICTS BETWEEN THE BOARD AND THE MEDICAL EXECUTIVE COMMITTEE³⁸⁴

The Medical Staff, in partnership with the Board, will make best efforts to address and resolve all conflicting recommendations in the best interests of patients, the Hospital, and the members of the Medical Staff. When the Board plans to act or is considering acting in a manner contrary to a recommendation made by the Medical Executive Committee, the Medical Staff officers shall meet with the Board, or a designated committee of the Board and Administration, and seek to resolve the conflict through informal discussions. If these informal discussions fail to resolve the conflict, the Chief of Staff or the Chairperson of the Board may request initiation of a formal conflict resolution process. The formal conflict resolution process will begin with a meeting of the Joint Conference Committee within thirty (30) days of the initiation of the formal conflict resolution process.

To address Board-Medical Staff conflicts, the Joint Conference Committee shall be composed of:

- Three officers of the Medical Staff
- One other Medical Executive Committee member
- The Chairperson, Vice-Chairperson, and Secretary of the Board or other designees of the Board
- The Chief Executive Officer or designee

If the Joint Conference Committee cannot produce a resolution to the conflict that is acceptable to the Medical Executive Committee and the Board within 30 days of the initial meeting, the Medical Staff and the Board shall enter into mediation facilitated by an outside party. The Medical Executive Committee and Board shall together select the third-party mediator, the costs for which shall be shared equally by the Hospital and the Medical Staff. The Medical Executive Committee and the Board shall make best efforts to collaborate together and with the third-party mediator to resolve the conflict. The Board and the Medical Executive Committee shall each designate at least three people to participate in the mediation. Any resolution arrived at during such meeting shall be subject to the approval of the Medical Executive Committee and the Board, in accordance with the provisions of Medical Staff Bylaws and the Articles of Incorporation and Bylaws of the Hospital.

In addition to the formal conflict resolution process herein described, the Chairperson of the Board and the Chief of Staff may call for a meeting of the Joint Conference Committee at any time and for any reason to seek direct input from the Joint Conference Committee members, clarify any issue, or relay information directly to Medical Staff leaders, the Board, or Administration.

³⁸⁴ MS.01.01.01; LD.02.04.01

13.5.9 ENTIRE BYLAWS

These Bylaws are the entire Medical Staff Bylaws of the Hospital and supersede any and all prior Medical Staff Bylaws that, by adoption hereof, shall be automatically repealed.

14 CERTIFICATION OF ADOPTION AND APPROVAL

Approved and Adopted by the Medical Staff of Largo Medical Center on _____, 20__.

CHIEF OF STAFF

Approved and Adopted by the Board of Largo Medical Center on _____, 20__.

CHAIRPERSON OF THE BOARD