# Holy Cross Hospital

## MEDICAL STAFF BYLAWS

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*This Table of Contents is provided for reference purposes only.
BYLAWS OF
HOLY CROSS HOSPITAL MEDICAL STAFF

PREAMBLE

Recognizing that The Medical Staff of Holy Cross Hospital, ("Medical Staff") is deeply concerned with the quality of medical care in Holy Cross Hospital ("Hospital") and that the best interests of the patients are protected by an ongoing concern for the quality of medical care subject to the ultimate authority of the Hospital Board of Directors ("Board"), the physicians, dentists, psychologists and podiatrists practicing at the Hospital thereby organize themselves in conformity with these Bylaws, and Rules and Regulations herein stated, as may be amended from time to time. Any amendment to these Bylaws, and Rules and Regulations must be approved by the Board of Directors prior to becoming effective. Neither body may unilaterally amend the Medical Staff Bylaws or Rules and Regulations.

The purpose of these Bylaws is to assist in the orderly governance of the affairs of the Medical Staff and accordingly, these Bylaws are not intended to unreasonably affect the Member's exercise of professional judgement in the care and treatment of patients.

It is the policy of this Hospital and Medical Staff that all individuals within its facilities be treated courteously, respectfully, and with dignity. To that end, the Board requires that all individuals conduct themselves in a professional and cooperative manner in the Hospital. If a physician fails to conduct himself or herself in this manner, the matter shall be addressed in accordance with Medical Staff Rules & Regulations.

All statements and proceedings contained in these Bylaws and the proceedings and objectives outlined herein are informative only and represent that which is believed to be the highest performance and the maximum in hospital care, service or procedures relating to any particular set of circumstances. It is recognized that any specific procedure or service is always subject to modification, depending on the circumstances of a particular case. Under no circumstances should these Bylaws be interpreted as the standard or as any indication of standards specifying the duties or outlining the requirements of the Hospital personnel and the Medical Staff in the care and treatment of patients.
ARTICLE I
DEFINITIONS

The term “Medical Staff” means those medical professionals who are granted privileges who are: physicians, dentists, podiatrists and psychologists (limited to doctoral level clinical practitioners) who are fully licensed to independently practice medicine, dentistry, podiatry or psychology in all phases of each profession. “Medical Staff” is sometimes simply referred to as “Staff.”

The term BOARD OF DIRECTORS or BOARD means the governing body of the Hospital.

The term “Medical Executive Committee” means the Executive Committee of the Medical Staff.

The term "Medical Staff Leader" can mean either President, President-Elect, Secretary/Treasurer, Immediate Past President, Department Chief, and other standing members of the MEC.

The term CHIEF EXECUTIVE OFFICER or CEO means the highest ranking executive position of the Hospital.

The term “Administration” means the Chief Executive Officer and the Vice Presidents of Holy Cross Hospital.

The term “written notice” shall mean notice delivered by Certified Mail, Return Receipt Requested.

The term “Hospital” shall mean Holy Cross Hospital, Inc.

The term “Rules and Regulations” means the Rules and Regulations of the Medical Staff and of Medical Staff departments, adopted in accordance with these Bylaws.

The term “Member” shall mean when capitalized, a member of the Medical Staff.

The term “clinical privileges” or “privileges” shall mean authorization granted by the Board of Directors to a Member, to an APP (acting under the supervision of a designated Supervising Member), or to a House Physician, or temporary authorization granted to a Practitioner in accordance with these Bylaws, to provide specific form(s) of direct patient care to patients in the Hospital within well-defined limits.

The term “Adversely Affect” in the context of a Member’s Medical Staff privileges, shall mean reducing, restricting in any manner, suspending, revoking or failing to renew clinical privileges or membership at the Hospital.

The term “Patient” shall refer to anyone seeking healthcare within Holy Cross Health Ministries.
The term “Patient” also refers to “Residents” receiving Skilled Care/Long Term Care. Within Skilled/Long Term Care all references to Patient shall be considered to be replaced with Resident.

The term patient “contact” shall refer to any combination services at Holy Cross Hospital (located at 4725 North Federal Highway, Fort Lauderdale, FL 33308) including admissions, emergency room encounters, rendering of inpatient or hospital outpatient care as an attending, consultant or cross-covering physician, ambulatory or outpatient surgical cases, or invasive procedures. Medical Office H&P’s for admission and pre-operative medical clearance H&P’s shall not be considered a contact. Multiple visits to a patient during the same hospitalization counts as one contact. Contacts shall consist of a face to face physician/patient documented encounter.

Communication: Valid communication to Medical Staff include, but are not limited to, direct vote, letter correspondence, electronic communications (eg. email or text).
ARTICLE II

PURPOSE

The purpose of this organization shall be to:

1. Make a continuing effort to provide all patients admitted to the Hospital, admitted to Skilled Nursing/Long Term Care, or treated in the outpatient facilities, with the best possible care;

2. Promote a high level of professional medical performance by all Members authorized to practice in the Hospital, through the appropriate Delineation of the Clinical Privileges that each Member may exercise in the Hospital, and through an ongoing review and evaluation of each Member's performance in the Hospital;

3. Provide an appropriate educational setting that will encourage continuous advancement in professional knowledge and skill;

4. Initiate and maintain Rules and Regulations for the governing of the Medical Staff and Allied Health Providers;

5. Provide a mechanism for communication and collaboration between the Medical Staff, Administration and the Board;

6. Assist in the development and support of the Hospital and its facilities, and further the approved Mission and Philosophy of the Hospital;

7. This organization is formed exclusively for educational purposes in accordance with Section 501C(3) of the Internal Revenue Code of 1954. Any provision of these Bylaws in conflict with Section 501C(3) shall be ineffective and void.
ARTICLE III

MEDICAL STAFF MEMBERSHIP

Section 1 - General Qualifications for Membership

A. An applicant for membership shall be

(1) A graduate of an approved professional school recognized by the State Board, with the degree of Doctor of Medicine, Doctor of Osteopathy, Doctor of Dental Surgery or Dental Medicine, Doctor of Podiatric Medicine, or Doctor of Psychology.

(2) Be legally licensed to practice their profession in the State of Florida, of known competence and unquestionable moral integrity.

(3) For the duration of the Physician’s appointment, unless a member of the Honorary Medical Staff, the Physician shall be actively engaged in the practice of medicine, osteopathy, dentistry, psychology or podiatry, according to criteria established by the Credentials & Qualifications Committee.

(4) Applicants must also have such other qualifications as established by these Bylaws, by the Credentials & Qualifications Committee, applicable Departmental Committees, and by applicable law.

B. Recommendations for appointment, reappointment and clinical privileges shall include evaluation of: (1) patient care; (2) medical/clinical knowledge; (3) practice-based learning and improvement; (4) interpersonal and communication skills; and (5) professionalism; and practice, consistent with applicable accreditation and regulatory standards.

C. Sex, race, creed, religion and/or national origin are not considered when making decisions regarding the granting or denying of clinical privileges.

D. No applicant for privileges shall be entitled to membership on the Medical Staff or to the exercise of particular clinical privileges in the Hospital merely by virtue of the fact that the applicant is duly licensed to practice medicine, dentistry, psychology or podiatry in this State, or that the applicant is a member of any professional organization, or that the applicant had in the past, or presently has, such privileges at another hospital.

E. The current health status of the applicant shall allow for the exercise of the clinical privileges for which the applicant has applied. If requested, appropriate supporting information related to health status shall be submitted by the applicant.
F. Applicants shall have submitted a complete and approved pre-application and application, the failure of which to do so shall constitute the applicant's automatic withdrawal of the pre-application or application, as applicable, within the timeframe outlined in the Bylaws.

Section 2 - Extent of Privileges

A. Every practitioner practicing in this Hospital by virtue of Medical Staff membership or otherwise shall, in connection with such practice, be entitled to exercise only those clinical privileges granted by the Board except as hereinafter provided.

B. The Medical Staff may, from time to time, recommend to the Board that the membership of the Medical Staff be limited in number. In making such a recommendation to the Board, the Medical Staff shall without limitation take into consideration whether or not the Hospital facilities are such that it is desirable or mandatory that the membership of the Medical Staff be so limited in order that maximum quality of medical and hospital care is provided to Hospital patients consistent with the availability of such facilities. Toward that end, the Medical Staff may recommend that new applications for Medical staff membership be declined for a period of time, that the number of new applications to be considered be limited, that applications be considered only for Medical Staff positions in certain departments, or make any other recommendation regarding new applications.

C. Except for dentists, podiatrists or psychologists (see Paragraph H.1, 2, 3), applicants appointed to a department shall be certified, eligible for certification or in the process of being certified as defined by the American Board of Medical Specialties or the American Osteopathic Association Bureau of Osteopathic Specialists for the best interest of patient care, its quality and uniformity of its delivery.

D. Except as defined in Article III, Section 2(E), only Staff Members who are Board Certified in their primary specialty may practice their sub-specialty, without the need of sub-specialty board certification, as provided for in Article III, Section 2.

E. Any member who fulfills the following criteria may be exempted from Article III, Section 2(D) as follows:

1. Must meet all requirements and fulfill all procedures for appointment in Article V, Sections I and II;

2. At least 10 years of medical practice;

3. Active membership in a national specialty or sub-specialty society;

4. History of having received distinguished honors from a specialty or sub-specialty society;
(5) A documented history of clinical excellence and continuing medical education teaching;

(6) At least three (3) letters of reference, one of which comes from a nationally recognized leader in the field, who will certify to the distinguished expertise of the candidate; and,

(7) Equivalent to United States sub-specialty training.

Without exception, decisions made under this Paragraph E shall not be appealable nor shall they set any precedent.

F. Acceptance of membership on the Medical Staff shall constitute the Member's agreement to abide by the Bylaws and Rules and Regulations of the Medical Staff and the Bylaws of the Hospital, as amended from time-to-time, and the Principles of Medical Ethics adopted by the American Medical Association, the Code of Ethics of the American Dental Association, the Code of Ethics of the American Osteopathic Association, the Code of Ethics of the American Podiatry Association or the Code of Ethics of the American Psychological Association, whichever is applicable, and Ethical and Religious Directives for Catholic Healthcare Services as promulgated by the National Conference of Catholic Bishops.

G. Each Member of the Medical Staff shall participate in Medical Staff and Departmental activities (including attending department or committee meetings), cooperating with the Administration and the Board and with each other, to further the shared purpose described above.

H. Podiatric privileges shall be determined on the basis of submitted qualifications. Qualifications for Podiatry privileges shall require completion of at least two (2) years of an approved Podiatric residency program (APMA/CPME). Applicants must be Board Qualified or Board Certified by the American Board of Podiatry Surgery (ABPS) in Foot and Ankle Surgery, or the American Board of Ambulatory Foot Surgery (ABAFS) in Foot Surgery. Applicant must demonstrate current competence and continuing experience in the procedures requested, and document same with operative reports.

I. Dental privileges shall be determined on the basis of submitted qualifications, which shall include current licensure (D.D.S. or D.M.D.), relevant verified training/experience, demonstration of clinical current competence and the ability to perform the privileges requested.

J. Psychology privileges shall be determined on the basis of submitted qualifications, which shall include current licensure (PY), relevant verified training/experience, demonstration of current clinical competence and the ability to perform the privileges requested.
Section 3 - Duration of Appointment

A. All initial appointments and re-appointments shall be granted by the Board of Directors for a period not to exceed two years. Initial appointments are granted on a "provisional" basis.
ARTICLE IV
CATEGORIES OF THE MEDICAL STAFF

Section 1 - Divisions of the Medical Staff

A. The Medical Staff shall be divided into Honorary, Active, Provisional, Courtesy, Associate, Senior Active, Affiliate, and Locum Tenens categories. At each time of reappointment, the member’s staff category shall be determined.

B. Except for Honorary, Associate and Affiliate Staff, Members must be located sufficiently near to the Hospital to provide continuous care to their patients, which requires the Member, within 30 minutes in response to a call, to be able to arrive physically at the Hospital or satisfactorily arrange to provide such care.

Section 2 - Honorary Medical Staff

The Honorary Medical Staff (Honorary Staff) shall consist of Members who do not actively admit, treat or consult patients. They may be Members who have retired from active Hospital practice or physicians who are of outstanding reputation, not necessarily residing in the community. Honorary Medical Staff members shall not be eligible to admit patients or consult, to vote, to hold office or to serve on a Standing Medical Staff Committee. Honorary Staff members are not subject to reappointment.

Section 3 - Active Medical Staff

The Active Medical Staff (Active Staff) shall consist of Members who have 12 or more contacts during the prior appointment term. Members of the Active Staff shall be appointed to a specific Medical Staff Department. All Active Medical Staff Members shall be required to attend Medical Staff meetings as provided in Article XIV. Active Medical Staff members shall be eligible to vote, hold office and serve on Medical Staff Committees. Any member of the Active Medical Staff that retires or ceases active practice must notify the Medical Staff Services Office within 30 days and their membership category will automatically be reassigned and such member will be removed from the Active Staff.

Section 4 - Provisional Medical Staff

The Provisional Medical Staff shall consist of all those physicians newly accepted for appointment to the Medical Staff or those requesting change of staff status from Associate and shall be considered probationary. Those Members will not be eligible to vote or hold office. They will be assigned to a specific department. They may be assigned to serve on committees except Medical Executive Committee, Credentials & Qualifications Committee, Medical Staff Peer Improvement Committee and Holy Cross Hospital Joint Performance Improvement Committee. The minimum term of Provisional status is one year, maximum term is two years.

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After a minimum of one year, the Member can request elevation to either Active or Courtesy Staff.

The Member must have a minimum of 12 patient contacts performed at Holy Cross Hospital, with outcomes, in order to be elevated to Active Staff. The minimum number of contacts for elevation to the Courtesy Staff is between five and 11.

If at the end of the maximum probationary period (two years) the Provisional Staff Member is deemed ineligible for elevation, the Medical Executive Committee shall recommend to the Board that membership on the Provisional Staff be terminated. The affected Member shall then be entitled to all of the review procedures set forth in Article IX of these Bylaws.

Section 5 - Courtesy Staff

The Courtesy Medical Staff shall consist of members having 0 to 5 patient contacts during their prior two-year appointment term. No member of the Courtesy Staff shall be entitled to any voting privilege or to hold office on the Medical Staff or on any standing committee. If there are less than 5 patient contacts within the two-year appointment term of Courtesy staff, the physician has the option of becoming an Associate member of the Medical Staff or resigning from the Medical Staff. The Medical Executive Committee from time to time may modify the rights and responsibilities of Courtesy Staff members.

Section 6 - Associate Staff

The Associate Medical Staff will be members on Courtesy or Provisional Staff who have zero to four patient contacts during the prior two-year appointment term. These members shall not be eligible to have any in-patient contacts as described in Article I, but may practice the scope of out-patient practice as approved by the Board of Directors.

The reappointment process for Associate members shall be in the same manner as required for all other members with the exception of privileges being offered. These members are not subject to FPPE or OPPE. No member of the Associate staff shall be entitled to any voting privilege or to hold office on the Medical Staff or on any standing committee.

If prior to or at the time of reappointment, an Associate Staff member wishes to regain privileges, can request an elevation to the Courtesy Staff from the Credentials & Qualifications Committee. The Credentials & Qualifications Committee will ask the physician for a case log of 50 cases from another hospital they are on staff at or from their office based practice within the immediate prior six months. If approved for elevation, the physician must then have 5 patient contacts within the first year of that appointment to the Courtesy Staff. These contacts will be monitored by a Focused Professional Practice Evaluation as outlined in the Medical Staff Rules and Regulations. If the physician does not have five (5) patient contacts within the timeframe allotted, then said physician can not request elevation of privileges. Associate staff members who request to regain privileges and are unsuccessful waive their right to appeal.
Section 7 - Senior Active Staff

Any Active Staff Member who has been on the Active Staff for twenty (20) years and has reached the age of 55, or has been on the Active Staff for fifteen (15) years and has reached the age of 60, or has been on the Active Staff for ten (10) years and has reached the age of 65, may request Senior Active Staff membership. These members shall have all the rights of any Active Staff Member, including the right to vote. They shall not be required to serve on any committees unless they so desire and will not be required to attend meetings. Any member of the Senior Active Medical Staff that retires or ceases active practice must notify the Medical Staff Services Office within 30 days and their membership category will automatically be reassigned and such member will be removed from the Senior Active Staff.

Section 8 - Locum Tenens Staff

A. For the limited purpose of providing for situations in which Members are temporarily absent or unable to care for their patients, there is hereby created a category of staff membership to be known as the Locum Tenens Staff. A physician, who is licensed in the State of Florida, who is Board Certified and who is otherwise eligible for appointment to the Active Medical Staff pursuant to the usual credential procedures as otherwise provided in these Bylaws, may be appointed to the Locum Tenens Staff. Upon the recommendation of the Medical Executive Committee and approval of the Board, a qualified appointee shall be a member of the Locum Tenens Staff and may attend and admit patients on a temporary basis, when appointed for that limited time and purpose. The term of said appointment is subject to the approval of the Chief Executive Officer of the Hospital or designee, President of the Medical Staff and the Department Chief involved. Locum Tenens appointments will be for a maximum of 120 days. Any physician, who has been appointed to the Locum Tenens Staff for any term may be eligible for additional temporary appointments upon updating of credentials, provided all other requirements for appointment are satisfied as provided herein.

B. The staff privileges exercised by the appointee to the Locum Tenens Staff during each term of appointment are limited as provided by the appointee’s clinical department, the Board and these Bylaws. These members shall not have the rights of Active Staff members, may not vote, hold office or serve on any committees.

Section 9 - Affiliate Staff

Affiliate Staff shall consist of those physicians, dentists, psychologists and podiatrists who shall have affiliate privileges only, as described below. The application process for Affiliate Staff membership shall be in the same manner as required for all other applicants.

A. Affiliate Staff Categories:

   (1) Medical Doctor First Assistant in the Operating Room
The Medical Doctor First Assistant provides aid in exposure, homeostasis, and other technical functions, thereby helping the surgeon carry out a safe operation with optimal results for the patient. The role will vary considerably with the surgical operation and specialty area. It is the responsibility of the surgeon to designate an individual who is most appropriate for the purpose of serving as a medical doctor first assistant. The medical doctor first assistant must make a formal application for appointment to the hospital, which includes Application for medical staff membership and application for specialty specific privileges for physicians. The member may not admit or discharge a patient from the Hospital.

(2) Consultant

Consultants shall be physicians who are Board Certified in the specialties of Pediatric Cardiology, Pediatric Neurology, Pediatric Ophthalmology and Maternal and Fetal Medicine. The Medical Executive Committee may add additional specialties to this list, from time to time, as it deems necessary and appropriate, based on the hospital’s needs, and only if such additional specialties are approved by the relevant Department Chief and the Credentials and Qualifications Committee.

These specialized physicians may maintain Consultant Privileges, regardless of the number of patient contacts, and shall in all other respects be treated the same as members of the courtesy staff. Members holding Consultant Privileges shall not admit or discharge a patient from the hospital and may only consult at the request of an Active staff member, and shall not have any rights to vote, serve on any medical staff committees or hold any medical staff office. Members holding Consultant Privileges shall be subject to and governed by the Medical Staff Bylaws and Rules and Regulations.

A physician who is on the Consultant Staff may apply to Active Staff status at reappointment if they had 12 or more contacts in the prior appointment term.

(3) Psychologist

Psychologists shall be assigned to the Department of Medicine, Subsection of Psychiatry. These members shall not admit or discharge a patient from the Hospital, vote, or hold office. They may be assigned to serve on committees.
ARTICLE V
PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

Section 1 - Application for Appointment

A. All application requests for appointment to the Medical Staff and requests for clinical privileges will be forwarded to the Medical Staff Office. Upon receipt of a request, the Medical Staff Office will provide the potential member with a pre-application form and an accompanying letter describing the documents that must accompany the completed form.

B. Upon receipt of a completed pre-application form, the Medical Staff Services Office will provide the potential member with a full application package if it is determined that the Hospital provides the services requested and the applicant meets the specific department eligibility. This will include a letter setting forth basic threshold criteria, privilege delineation overview, and privilege request form(s), including criteria for privileges and a detailed list of requirements for completion of the application. The potential member will also be provided with a copy of the Medical Staff Bylaws, Rules and Regulations.

The applicant must sign a medical staff application, and in so doing agrees to provide the Medical Staff Services Office with at least the following relevant information:

1. education, training and past and present affiliations;
2. voluntary or involuntary relinquishment of medical staff membership;
3. voluntary or involuntary limitation, reduction, suspension or loss of clinical privileges at another hospital;
4. previously successful or currently pending challenges to any licensure or DEA registration, or the voluntary relinquishment of such licensure or registration;
5. any involvement in liability claims; voluntary or involuntary cancellation of professional liability insurance;
6. Medicare/Medicaid sanctions, including both current and pending investigations and challenges;
7. any removal from a managed care organization's panel for quality of care reasons or unprofessional conduct;
8. One Hundred clinical case logs from a hospital within the immediate prior 24 months or the most recent 100 cases within the immediate prior 24 months. ICD codes are not acceptable to use on the case logs;
at the discretion of the relevant department chief and in conjunction with the Credentials & Qualifications Committee, clinical case logs and outcome data from an AHCA accredited center maybe considered to fulfill criteria of #8 above;

Dermatologists and psychologists can fulfill criteria #8 by submitting a case log with a minimum of 100 cases within the past 24 months from an office based practice. Additional sub-specialties may be added from time to time to this list based on hospital need for patient care in these areas, only if approved by the relevant department chief and the Credentials & Qualifications Committee; and,

If an applicant wishes to join the medical staff in category “Associate”, criteria #8 is waived.

C. By applying for appointment to the Medical Staff, each applicant consents to appear for interviews as requested in regard to the application, authorizes members of the medical staffs of other hospitals with which the applicant has been associated and with others who may have information bearing on competence, character and ethical qualifications. Applicant consents to the inspection of all records and documents, to release such information that may be material to the evaluation of professional qualifications and competence to carry out the clinical privileges requested, as well as the applicant’s moral and ethical qualifications for staff membership and releases from any liability all individuals and organizations who provide the information to the Hospital or the Medical Staff in good faith and without malice concerning the applicant’s competence, ethics, character and other qualifications for staff appointment and clinical privileges, including otherwise privileged or confidential information.

D. Americans with Disabilities Act - The Medical Staff of Holy Cross Hospital, consistent with the Hospital’s Core Values, acknowledges the special needs of the handicapped or disabled. Accordingly, in connection with the credentialing and re-credentialing of physicians, the Medical Staff will take such action(s) as may be required by applicable state or federal law and accreditation standards.

Section 2 - Procedure for Appointment

A. The applicant must provide the following information necessary to complete the application:

1. A legible, complete and signed application form and request for privileges;
2. A copy of current state license and DEA certificate;
3. A copy of certificate of professional liability insurance showing the applicant as being the insured party or a signed and notarized financial responsibility form;
4. Copies of certificates or letters confirming completion of an approved residency program;
(5) Copies of certificates or letters from appropriate specialty board(s) stating board status – i.e. board qualification, board certification, or re-certification; and

(6) Names and addressed of three professional references who have recently worked with the applicant and directly observed his or her professional performance over the past 24 months. At least one reference must be an individual practicing in a field similar to that of the applicant. If you are completing your residency or fellowship training program, your Program Director must be included as one of the references.

B. An applicant for appointment bears the burden of establishing and resolving any reasonable doubts about the applicant’s qualifications. Failure to meet this burden shall result in denial of the application. However, in order for the Medical Executive Committee to make a recommendation to the Board, either favorable or unfavorable, the Medical Staff must have in its possession adequate information for a conscientious evaluation of the applicant’s current licensure, relevant training, experience, current clinical competence and the ability to perform privileges requested. This information will be measured against the unique professional standards of this Hospital. Accordingly, the Medical Staff will not take action on an application that is not “complete.”

C. An application is considered complete when the applicant submits all the required documentation and the Medical Staff Services Office has received all primary source verification and references. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time. An incomplete application will not be processed.

D. If the Medical Staff Services Office does not receive all of the above information within 45 days of receipt of the application, the hospital will consider the application incomplete, and the Medical Staff Services Office will suspend further processing.

E. After receiving a complete application, the Medical Staff Services Office will then post the applicant’s name, photograph, specialty and board status in the designated area to permit medical staff members to provide additional information regarding the applicant to the Credentials & Qualifications Committee.

F. The Medical Staff Services Office will then verify all of the information submitted on the application form. All applicants will have their license(s), education, training, and current competence and all other pertinent information verified from the primary sources. Upon completion of verification of all information, the appropriate Departments shall be notified that the application is ready for review.

G. The completed application shall be presented to the appropriate Section Chief if applicable, and/or Department Chief, who will review the application to ensure that it fulfills the established standards for membership and clinical privileges, based on current licensure; relevant training and experience; current competence; and ability to perform
the privileges requested. Additional department-specific criteria may also apply. The recommendation of the Department Chief will be forwarded to the Chairman of the Credentials & Qualifications Committee within 15 days of receipt of the application.

H. The Credentials & Qualifications Committee shall investigate the character, credentials, qualifications and moral and ethical standing of the applicant and shall investigate whether the applicant meets requirements for staff membership established by these Bylaws. The Credentials & Qualifications Committee shall conduct a clinical interview for each new applicant, except those applicants eligible for the expedited credentialing process, within 30 days of receipt of the Department Chief recommendation.

I. Recommendations shall be made in writing by the Credentials & Qualifications Committee to the Medical Executive Committee as to the acceptance, deferment or rejection of the applicant.

J. The Medical Executive Committee, at its next meeting, (within 30 days of the Credentials & Qualifications Committee recommendation) shall recommend to the Board that the applicant be approved or rejected or be deferred for further consideration. All recommendations for appointment must also specifically recommend the clinical privileges to be granted which may be qualified by a probationary condition relating to such privileges. When the recommendation of the Medical Executive Committee is to admit the applicant to the Medical Staff, the President of the Medical Staff shall promptly forward it together with the supporting documentation to the Board. If the recommendation of the Medical Executive Committee is to defer the application for further consideration, it must be followed within thirty (30) days with a subsequent recommendation for appointment or rejection for Medical Staff membership. In the event the Medical Executive Committee’s recommendation is for rejection of the application, this recommendation shall be forwarded to the Board, but the Board shall not take any action thereon until the applicant has exercised or has been deemed to have waived his right to a fair hearing as provided in Article X of these Bylaws.

K. Unless the Medical Executive Committee determines otherwise, any application for privileges which has been denied shall not be subject to resubmission for one (1) year. In addition, any Member whose application has been denied twice shall not be eligible for resubmission for five (5) years.

L. All appointments are granted by the Board of Directors.

Section 3 - Procedure for Reappointment - General

A. Reappointments to the Medical Staff shall occur biennially. Members whose appointments are scheduled to expire shall submit a completed and signed reappointment application which includes all requested information and attachments no later than 90 days prior to the expiration date. Those Members on the Hospital’s Medical Staff as of January 1, 1996 who are not Board Eligible, Board Certified, or in the process of being certified are nevertheless eligible for reappointment. Written notice providing the
deadline for application for reappointment and outlining the penalties for failure to timely submit such application will be sent to each member no less than ten (10) days prior to the expiration of such deadline. Those individuals not returning a completed application within the prescribed time period, following appropriate notification by certified mail informing the individual of his or her non-compliance, shall be deemed to have resigned Medical Staff membership and privileges.

B. Such reapplication shall be on a form approved by the Medical Executive Committee and the Board and shall require detailed information including changes in the Member’s qualifications since the last review and documentation on requests for change of status or additional privileges.

C. The reappointment application shall include, among other things, the following:

(1) Active license in good standing in the State of Florida;

(2) Current health status as it pertains to the ability to perform any of the mental and physical functions related to the specific clinical privileges requested;

(3) Name and address and staff category at any other healthcare facility where the Member has privileges;

(4) Membership, award or other recognition conferred by any other professional societies or organizations;

(5) Sanctions of any kind imposed or pending by any other healthcare facility or licensing authority;

(6) Professional liability insurance coverage, or documentation of compliance with Florida Statute 458.320; and

(7) Such other specifics about this Member’s professional ethics, qualifications, and competence that may bear on the Member’s ability to provide quality patient care in the Hospital.

D. A Member may request a change in status or privileges at any time throughout the year.

E. The completed reapplication form and all necessary documentation shall be returned to the Medical Staff Services Office and forwarded to the respective Department Chief for review and recommendation. The Department Chief will make recommendations on behalf of the department as to whether or not the Member shall be reappointed and on specific privileges requested. In making such recommendations, the Department Chief shall consider the Member’s clinical competence, current licensure, involvement in professional liability actions and member’s ethics and conduct, mental and physical status, attendance at Medical Staff meetings. The results of the Hospital’s performance improvement, ongoing professional practice evaluations, and other peer review activities,
any focused professional practice evaluations and any other reasonable indicators of 
continuing qualifications. The evaluation shall also include the Member’s adherence to 
the Bylaws and Rules and Regulations of the Medical Staff and pertinent department, and 
the policies of the Medical Staff and Hospital.

F. The National Practitioner Data Bank will be contacted for any information it may have on 
each Member being considered for reappointment. Information obtained from the NPDB 
will be considered in the reappointment recommendation.

G. The Credentials & Qualifications Committee shall review and make its recommendation 
regarding reappointment and shall forward it to the Medical Executive Committee at least 
30 days prior to the expiration of the appointment. The Medical Executive Committee 
forwards its recommendations to the Board for final action.

H. Circumstances that may result in a Member not being recommended for reappointment or 
a change in Member’s Medical Staff category (as outlined in Article IV) specifically 
include, without limitation, the following:

1. Failure to adhere to the standards of quality of care at the Hospital as determined 
   by the Medical Staff through its Medical Staff Peer Improvement Program;

2. Non-attendance at committee or required department meetings. (Staff members 
   must attend a majority of meetings unless excused due to illness, patient 
   responsibilities, scheduled vacations, family emergencies or other good cause);

3. Failure to utilize the Hospital according to standards for admissions/consultations 
   to be established by the Medical Executive Committee upon the recommendation 
   of the Member’s department;

4. Delinquency in maintaining medical records on a current basis;

5. Failure to adhere to standards of professional ethics;

6. Failure to comply with these Bylaws;

7. Failure to have a minimum number of patient contacts (i.e., admissions, consults, 
   encounters, procedures) over the prior 24-month period at Holy Cross Hospital. 
   In order to remain on the Active Staff, or to be elevated from Provisional Staff to 
   Active Staff, a minimum of 12 such contacts at Holy Cross Hospital are required. 
   Members having 11 or less such contacts shall be reassigned to the Courtesy Staff 
   and will be required to provide documentation from the member’s primary hospital, 
   with outcomes, for review by the Chief of the Department, in order to 
   establish current clinical competency; and

8. Failure to pay dues.
Section 4 - Conditional Reappointment

A. Recommendations for reappointment and renewed privileges may be contingent upon an individual’s compliance with certain specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring). Unless the conditions involve a restriction, as alluded to above, the imposition of such conditions does not entitle an individual to request a hearing.

B. In addition, reappointments 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 reappointment for a period of less than two years does not, in and of itself, entitle an individual to a hearing.

Section 5 - Leaves of Absence

Requests for Leaves of Absence shall be in writing to the Credentials & Qualifications Committee. Leaves of Absence will be granted for a period of up to one year, and may be extended for one additional year if requested in writing (two-year maximum). A Leave of Absence does not automatically extend the duration of a member’s appointment and privileges. Therefore, the reappointment process will take place on schedule, regardless of the Leave of Absence. Members while on Leave of Absence will be expected to pay annual medical staff dues. A physician must request reinstatement of privileges in writing to the Credentials & Qualifications Committee. The Credentials & Qualifications Committee recommendations will be forwarded to the Medical Executive Committee and Board respectively. If a request to reinstate privileges is not received at the conclusion of the Leave of Absence, the Member shall be removed from the Medical Staff. Members removed from the Medical Staff may reapply for staff privileges in the usual manner.

Section 6 - Resignation

A resignation of any practitioner shall not be final until said resignation is submitted in writing, unless otherwise provided for in these Bylaws, and is accepted and approved by the Board of Directors. The Board may defer action until a practitioner has fulfilled all of his patient and medical record responsibilities. Acceptance of any resignation is subject to the requirements of the Florida Statutes and the National Practitioners’ Data Bank. Any practitioner whose resignation is final and who wishes to be reinstated must reapply as a new applicant.

Section 7 - Appeals

A. In any case where the reappointment of a Member is not made, the Chief Executive Officer, or his designee, shall so notify the Member concerned in writing and the Member will be given the opportunity to appeal as set forth in Article X of these Bylaws.

In the event of denial of privileges, or a change in the status of privileges, the Board may not take final action until the rights of the Member adversely affected to appellate review
as set forth in Article X of these Bylaws have been fully utilized or waived; provided, however, that when the denial of, or change in Staff privileges results from a failure to maintain medical records on a timely basis, the Member has only those rights as provided in Article X, Section 7 of these Bylaws.
ARTICLE VI

CLINICAL PRIVILEGES

Section 1 - Basic Privileges/Extended Privileges

A. Basic Privileges

Application for appointment to the Medical Staff shall include a request for specific privileges. The basic privileges in the surgical departments and non-surgical departments (including Family Medicine) will be awarded on the basis of the evaluation of the applicant's training and demonstrated ability as determined by the Credentials & Qualifications Committee in accordance with Article V and Article VI of these Bylaws, and commensurate with the basic privileges of the other members of the department. The granting of delineated clinical privileges is subject to approval by the Board of Directors.

B. Extended Privileges

(1) Members qualified by training and experience who engage in more advanced work must apply for such additional privileges to the Credentials & Qualifications Committee, which shall consult with the Chief of the Department in which these additional privileges are requested. All requests for extended privileges must be approved by the Medical Executive Committee and the Board.

(2) Each Department shall be responsible for the monitoring and improving of professional care in the department as determined by periodic review of completed records and other pertinent information.

Section 2 - Temporary Privileges

A. Eligibility to Request Temporary Clinical Privileges

(1) Non-Applicants. Temporary privileges may also be granted to non-applicants by the Chief Executive Officer, upon recommendation of the President of the Medical Staff, when there is an important patient care, treatment, or service need. Specifically, temporary privileges may be granted for situations such as the following:

(i) the care of a specific patient; or

(ii) when necessary to prevent a lack or lapse of services in a needed specialty area.

The following factors will be considered and verified prior to the granting of temporary privileges in these situations: current licensure, current competence,
current professional liability coverage acceptable to the Hospital, results of a query to the National Practitioner Data Bank, and results of any criminal background check. The grant of clinical privileges in these situations will not exceed 60 days. In exceptional situations, this period of time may be extended in the discretion of the Chief Executive Officer and the President of the Medical Staff.

(2) Compliance with Bylaws and Policies. Prior to any temporary privileges being granted, the individual must agree in writing to be bound by the Bylaws, rules and regulations, policies, procedures and protocols of the Medical Staff and the Hospital.

B. Supervision Requirements

In exercising temporary privileges, the individual shall act under the supervision of the Department Chief or physician(s) designated by the Medical Executive Committee. Special requirements of supervision and reporting may be imposed on any individual granted temporary clinical privileges.

C. Termination of Temporary Clinical Privileges

(1) The Chief Executive Officer may, at any time after consulting with the President of the Medical Staff, the Chairpersons of the Credentials & Qualifications Committee or the Department Chief, terminate temporary admitting privileges. Clinical privileges shall be terminated when the individual’s inpatients are discharged.

(2) If the care or safety of patients might be endangered by continued treatment by the individual granted temporary privileges, the Chief Executive Officer, the Department Chief, or the President of the Medical Staff may immediately terminate all temporary privileges. The Department Chief or the President of the Medical Staff shall assign to another member of the Medical Staff responsibility for the care of such individual’s patients until they are discharged. Whenever possible, consideration shall be given to the wishes of the patient in the selection of a substitute physician.

(3) The granting of temporary privileges is a courtesy and may be terminated for any reason.

(4) Neither the denial nor termination of temporary privileges shall entitle the individual to a hearing or appeal.

Section 3 - Emergency Privileges

A. Regardless of departmental or staff status, in case of emergency, the Member attending the patient shall be expected to take all actions reasonably necessary to save the life of the
patient, including the calling of such consultations as may be appropriate. For the
purpose of this section, an emergency is defined as the unexpected condition in which, in
the opinion of that Member, the life of the patient is in immediate danger and in which
delay in administering treatment would increase the danger.

B. The Chief Executive Officer of the Hospital or designee will, after consultation with the
President of the Medical Staff, have the authority to grant one-case privileges to a
physician, dentist or podiatrist within their specialty who is not a member of the Medical
Staff. In the exercise of such privileges, the physician shall be under the direct
supervision of the President of the Medical Staff. Privileges shall not be extended to the
treatment of more than a single patient (including re-admissions) except where the
privileges are granted because an emergency situation exists that would justify extended
privileges.

C. The Medical Staff shall develop a policy to grant temporary/emergency privileges to
appropriate individuals in case of a disaster.

Section 4 - Disaster Privileges

A. When the disaster plan has been implemented and the immediate needs of patients in the
facility cannot be met, the Chief Executive Officer or the President of the Medical Staff
may use a modified credentialing process to grant disaster privileges to eligible volunteer
licensed independent practitioners ("volunteers"). Safeguards must be in place to verify
that volunteers are competent to provide safe and adequate care.

B. Disaster privileges are granted on a case-by-case basis after verification of identity and
licensure.

(1) A volunteer's identity may be verified through a valid government-issued photo
identification (i.e., driver's license or passport).

(2) A volunteer's license may be verified in any of the following ways: (i) current
hospital picture ID card that clearly identifies the individual's professional
designation; (ii) current license to practice; (iii) primary source verification of the
license; (iv) identification indicating that the individual has been granted authority
to render patient care in disaster circumstances or is a member of a Disaster
Medical Assistance Team, the Medical Resource Corps, the Emergency System
for Advance Registration of Volunteer Health Professionals, or other recognized
state or federal organizations or groups; or (v) identification by a current Hospital
employee or Medical Staff member who possesses personal knowledge regarding
the individual's ability to act as a volunteer during a disaster.

C. Primary source verification of licensure occurs as soon as the disaster is under control or
within 72 hours from the time the volunteer licensed independent practitioner presents
themselves to the hospital, whichever comes first.
D. In extraordinary circumstances when primary source verification cannot be completed within 72 hours, it should be completed as soon as possible. In these situations, there must be documentation of the following: (a) the reason primary source verification could not be performed in the required time frame; (b) evidence of the volunteer’s demonstrated ability to continue to provide adequate care; and (c) an attempt to obtain primary source verification as soon as possible. If a volunteer has not provided care, then primary source verification is not required.

E. The Medical Staff will oversee the care provided by volunteer licensed independent practitioners. This oversight shall be conducted through direct observation, mentoring, clinical record review, or other appropriate mechanism developed by the Medical Staff and Hospital.
ARTICLE VII

ACTIVE MILITARY DUTY

All obligations upon a Medical Staff Member described in these Medical Staff Bylaws shall be suspended indefinitely during any period of active military duty without penalty. Appointments that expire while on active military duty will be executed in a timely fashion upon return.
ARTICLE VIII

PHYSICIAN HEALTH

A. A process to identify and manage matters of individual physician health will be implemented that is separate from the medical staff disciplinary function. The primary goal is to insure patient safety and protect them from harm, followed by physician well-being. This process will help the Medical Staff recognize degrees of cognitive impairment and encourage more reporting and self-reporting. Therapeutic help is the first line of defence, along with strict confidentiality.

B. The Medical Staff President will delegate a group of physicians to address issues of physician health, confidentiality, authority and legal protection. The group’s duties will also include development and presentation of education to the Medical Staff on recognition issues and a referral process.

C. Physicians that have an impairment of physical or mental function that voluntarily seek assistance should meet with the Chief of his/her Department. The Chief shall promptly discuss with the practitioner the nature and cause of the perceived impairment. An impairment of physical or mental function may result from many factors, including, but not limited to, mental illness or substance abuse or dependency. If warranted, the Chief shall refer the matter to the Medical Executive Committee to determine the need for remedial action.

Remedies will depend upon the nature of the impairment, the nature of the practitioner’s responsibilities, the practitioner’s acknowledgment of the impairment and other relevant circumstance. Such remedies may include, without limitation, a leave of absence from the medical staff in order for the practitioner to seek the necessary medical or psychiatric care and assistance through existing programs for impaired physicians or through other outside agencies (such as Physicians Recovery Network) authorized to participate and monitor such activities. In addition to the foregoing, such remedies may include, without limitation, reduction of the practitioner’s clinical privileges or voluntary resignation from the medical staff.

In the event that the affected practitioner fails to follow the recommendation of the Department Chief under the preceding paragraphs to address the perceived impairment, or if, for any other reason, the Department Chief deems it necessary, proceedings may be commenced under and in accordance with Article IX of these bylaws with respect to Medical Staff members, without limitation, the precautionary suspension or restriction of clinical privileges.

D. Physicians that suspect impairment of physical or mental function of another physician shall meet with the suspected physician’s Department Chief and disclose the suspected impairment. That physician will be held under the aforementioned confidentiality. The Chief shall follow all aforementioned procedures as noted in the Bylaws.
E. Not withstanding any of the preceding actions, physicians and Medical Staff Leadership are expected to comply with the Board of Medicine, Statutes 456.072 and 458.331 (1)(e) as regard to reporting requirements under the Failure to Practice Act in regards to this matter.

F. The Medical Staff and Hospital leaders will design and establish a process to protect patients from harm, which provides education about physician health, addresses prevention of physical, psychiatric, or emotional illness, and facilitates confidential diagnosis, treatment and rehabilitation of physicians who suffer from potentially impairing conditions.
ARTICLE IX

PEER REVIEW PROCEDURES FOR ISSUES
INVOLVING MEDICAL STAFF MEMBERS

Section 1 - Collegial Intervention

A. These Bylaws encourage the use of progressive steps by Medical Staff leaders and Hospital management, beginning with collegial and educational efforts, to address questions relating to a Member’s clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the Members to resolve questions that have been raised.

B. Collegial intervention is a part of ongoing and focused professional practice evaluation, performance improvement, and peer review.

C. Collegial intervention efforts involve reviewing and following up on questions raised about the clinical practice and/or conduct of a Member and pursuing counseling, education, and related steps, such as the following:

(1) advising colleagues of all applicable policies, such as policies regarding appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;

(2) proctoring, monitoring, consultation, and letters of guidance; and

(3) 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.

D. The relevant Medical Staff leader(s) will determine whether it is appropriate to include documentation of collegial intervention efforts in an individual’s confidential file. If documentation of collegial efforts is included in an individual’s file, the individual will have an opportunity to review it and respond in writing. The response will be maintained in that individual’s file along with the original documentation.

E. Collegial intervention efforts are encouraged, but are not mandatory, and will be within the discretion of the appropriate Medical Staff leaders and Hospital management.

F. The relevant Medical Staff leader(s), in conjunction with the Chief Executive Officer, shall determine whether to direct that a matter be handled in accordance with another policy (e.g., code of conduct policy; practitioner health policy; peer review policy). Medical Staff leaders may also direct these matters to the Medical Executive Committee for further action.
Section 2 - Investigations

A. Criteria for Initiation

Any person may provide information to the MEC about the conduct, performance or competence of Members of the Medical Staff. If the MEC reasonably believes that conduct by a Medical Staff Member or other healthcare professional who delivers healthcare services at the Hospital may constitute one or more grounds for investigation as provided in this Subsection, or where collegial efforts have not resolved an issue, the Medical Staff Peer Improvement Committee (“MSPIC”) shall review the matter and advise the MEC whether grounds for an investigation exist. In no event, however, shall purely economic or financial aspects of a Member’s activity in the Hospital form the basis of an investigation. The MSPIC shall promptly report its findings to the MEC, which has the ultimate authority in such matters. The following shall constitute the grounds for such investigation:

1. Incompetence;

2. Being found to be a habitual user of intoxicants or drugs to the extent that he or she is deemed dangerous to himself, herself or others;

3. Mental or physical impairment which may adversely affect patient care;

4. Failure to comply with the policies, procedures or directives of the risk management program or any quality assurance committees of any licensed facility;

5. Conduct which is disruptive to the operation of the Hospital; or

6. Whenever required by applicable law.

Any request for an investigation of such member may be initiated by the President of the Medical Staff, CEO, a department chief or the MEC.

B. Initiation

A request for an investigation must be in writing, submitted to the MEC, identify the person initiating the investigation and be supported by reference to specific activities or conduct alleged. If the MEC initiates the request, it shall make an appropriate recordation of the general reasons. The MEC shall promptly advise the CEO of all requests for investigations and shall keep him or her appraised of the status of all investigations.
C. Investigation Procedure

If the MEC concludes an investigation is warranted, it shall promptly direct, in writing, that an investigation be undertaken by the MSPIC. The MSPIC shall proceed with the investigation in a reasonably prompt manner and shall forward a written report of the investigation to the MEC within thirty (30) days after receiving the MEC’s directions, unless an extension of time is granted by the President of the Medical Staff in his or her sole determination for good cause. No member of the MEC shall serve on the MSPIC. The MSPIC report to the MEC may include specific findings and recommendations. At the time the MEC requests the MSPIC to investigate, the Member shall be notified by the MEC in writing within thirty (30) days of the commencement of the investigation that an investigation is being conducted, and shall be invited to appear before the MSPIC before the MSPIC reports its findings to the and to provide the MSPIC information in a manner and upon such terms as the MSPIC deems to be relevant to the investigation. Except for meeting with the affected Member, the MSPIC may, but is not obligated to, conduct interviews with persons involved and obtain expert review of conduct as the MSPIC determines to be reasonably necessary for the investigation. Such investigation shall not constitute a “hearing” as that term is used in Article X, nor shall the procedural rules with respect to hearings or appeals apply. Despite the status of any investigation, at all times the MEC shall retain authority and discretion to make whatever findings, conclusions, and recommendations that may be reasonably warranted by the circumstances, including precautionary suspension or restriction, termination of the investigative process, or other action, as provided for in these Bylaws.

D. MEC Recommendation

At the MEC’s next regularly scheduled meeting or within 15 days after receiving the report of the MSPIC investigation, whichever is later, the MEC shall make a recommendation based on the findings and recommendations of the MSPIC, which may include, without limitation:

(1) adopting the MSPIC report and recommendations;

(2) determining no action be taken and, if the MEC determines there was no reasonable, credible evidence for the complaint in the first instance, removing any adverse information from the Member’s file;

(3) deferring action for a reasonable time where circumstances warrant;

(4) issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude department heads from issuing informal written or oral warnings outside of the formal investigation. In the event such letters are issued, pursuant to this subsection or otherwise, the affected Member may make a written response which shall be placed in the Member’s file;
(5) recommending the imposition of terms of probation or special limitation, restriction or conditions upon continued Medical Staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admissions, retrospective case review, mandatory consultation, direct supervision, monitoring or proctorship;

(6) recommending reduction, modification, suspension or revocation of clinical privileges;

(7) recommending suspension, revocation or probation of Medical Staff membership;

(8) remanding the matter back to the MSPIC for further investigation and/or reconsideration of the MSPIC recommendation for specific reasons; and

(9) taking or recommending other actions deemed appropriate under the circumstances.

The Member shall be advised of the MEC’s recommendation and supporting reasons by Special Notice. The term “special notice,” as used in these bylaws means written notification sent by certified or registered mail, return receipt requested.

E. Subsequent Action

(1) A recommendation by the MEC that would entitle the individual to request a hearing shall be transmitted to the CEO, Board of Directors and the Member, and the Member shall be provided the notice specified in Article X, Section 3 of these Bylaws. When the Board approves the recommendation of the MEC, it shall become final action unless the Member timely requests a hearing as required by Article X, Section 3 of these Bylaws, in which case the final decision shall be determined as set forth in Article X, Section 9.

(2) If the Medical Executive Committee makes a recommendation that does not entitle the individual to request a hearing, it shall take effect immediately as specified in Article X, Section 2 (B).

F. Mental and Physical Examinations

If at any time during an investigation a question arises concerning the physical, emotional or mental capabilities of a Member, the Member shall submit to an independent examination performed by a professional in the appropriate field, chosen by the Medical Executive Committee; however, the examination shall not be performed by a Member of the Holy Cross Hospital Medical Staff. Member agrees to abide by the results of such examination. The cost of the examination, including drug and alcohol testing, will be borne by the Member.
Section 3 – Precautionary Suspension or Restriction

A. Criteria for Initiation

A precautionary suspension or restriction of clinical privileges, including but not limited to the privilege to admit patients and provide any form of patient service, may be imposed if the failure to take such action is reasonably likely to result in an imminent danger to the health or safety of any individual in the Hospital. In such event, the CEO or designee, the President of the Medical Staff, the Medical Executive Committee, or the Chief of the Department in which the Member holds privileges, may (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. 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. A 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 will not imply any final finding of responsibility for the situation that caused the suspension or restriction. A precautionary suspension or restriction shall become effective immediately upon imposition, shall immediately be reported in writing to the CEO and the President of the Medical Staff, and shall remain in effect unless it is modified by the CEO or Medical Executive Committee. The individual in question shall be provided a brief written description of the reason(s) for the precautionary suspension or restriction, including the names and medical record numbers of the patient(s) involved (if any), within three days of the imposition of the suspension or restriction.

B. MEC Action

The Medical Executive Committee shall review the matter resulting in a precautionary suspension or restriction within a reasonable time under the circumstances, not to exceed 14 days. 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 smooth operation of the Hospital, depending on the circumstances. 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 shall also determine whether the precautionary suspension shall be lifted or converted as stipulated in Article IX, Section 2, B of the Bylaws. If the precautionary suspension is lifted there is no right to a hearing.

C. Care of Patients

Immediately upon the imposition of a precautionary suspension or restriction, the President of the Medical Staff shall assign to another individual with appropriate clinical
privileges responsibility for care of the suspended individual’s hospitalized patients, or to aid in implementing the precautionary restriction, as appropriate. The assignment shall be effective until the patients are discharged. The wishes of the patient shall be considered in the selection of a covering physician. All Members of the Medical Staff have a duty to cooperate with the President of the Medical Staff, the department chief, the Medical Executive Committee, and the CEO in enforcing the precautionary suspensions or restrictions.

Section 4 - Automatic Suspension or Limitations

In the following instances, the Member’s privileges or membership shall be automatically suspended or limited as described, which action shall be final without a right to a fair hearing appeal, except for the issue of whether the circumstances justifying automatic suspension or limitation have occurred, which determination shall be made by the MEC at an informal meeting requested for that purpose by the affected Member within ten (10) working days of the suspension. Within ten (10) working days of receiving a written request for review from a Member whose privileges have been automatically suspended, the MEC shall convene to review and consider the facts, and make such recommendations as it may deem appropriate following the procedures generally set forth herein. The Member’s failure to timely request a meeting with the MEC shall be deemed to constitute a waiver of the right to challenge the automatic suspension.

A. Licensure

(1) Revocation and Suspension. Whenever a Member’s license or other legal credential authorizing practice in this State is revoked or suspended, Medical Staff membership and clinical privileges shall be automatically revoked as of the date such action becomes effective.

(2) Restriction. Whenever a Member’s license or other legal credential authorizing practice in this State is limited or restricted by the applicable licensing or certifying authority, any clinical privileges which the Member has been granted at the Hospital which are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

(3) Probation. Whenever a Member is placed on probation by the applicable licensing or certifying authority, his or her membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

B. Controlled Substances

(1) Whenever a Member’s DEA registration or certificate is revoked, limited, or suspended, the Member shall automatically and correspondingly be divested of
the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.

(2) Whenever a Member’s DEA registration or certificate is subject to probation, the Member’s right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

C. Loss of Medicare/Medicaid Participation

Whenever a Member’s participation in Medicare or Medicaid is revoked or suspended, Medical Staff membership and clinical privileges shall be automatically revoked as of the date such action becomes effective.

D. Medical Records

Members of the Medical Staff are required to complete medical records within such reasonable time as may be prescribed by the MEC, but in no event more restrictive than applicable law. A limited suspension in the form of withdrawal of admitting and other related privileges until medical records are completed may be imposed by the CEO, or designee, or the President of the Medical Staff, after Special Notice to a Member of such delinquency for failure to complete medical records within such a period. For the purpose of this Section, “related privileges” means scheduling surgery or assisting in surgeries at the Hospital, unless a consultative relationship has already been established with patient currently in-house as of the time of the suspension; admit patients to the Hospital, whether through the Emergency Department or private practice; attend to patients, except for patients in-house at the time of suspension of privileges, perform deliveries or C-sections, perform any and all other services previously approved through the credentialing process at the Hospital. This temporary loss of privileges does not relieve the physician of duties and responsibilities associated with being on-call for the Emergency Department that was scheduled prior to the suspension. Bona fide vacation or illness may constitute an excuse subject to approval by the MEC. The suspension shall continue until lifted by the CEO (or designee) or President of the Medical Staff, and shall be lifted after the Member has established to the reasonable satisfaction of the CEO, or designee, or President of the Medical Staff, as applicable, that such delinquency has been cured.
ARTICLE X

HEARINGS AND APPELLATE REVIEWS

Section 1 - General Provisions

A. Exhaustion of Remedies

If adverse action described in Article IX or Article X herein is taken or recommended by the MEC, the applicant or Member must exhaust the remedies afforded by these Bylaws before resorting to legal action, and these Bylaws shall be admissible and enforceable in such legal proceeding.

B. Application of Article

For purposes of this Article, the term “Member” may include “applicant,” as it may be applicable under the circumstances.

Section 2 - Grounds For/Not For Hearing

A. An individual is entitled to request a hearing whenever the Medical Executive Committee makes one of the following recommendations:

(1) Denial of Medical Staff membership;
(2) Denial of requested advancement in staff membership status, or category;
(3) Denial of Medical Staff reappointment;
(4) Suspension of Medical Staff membership for more than 30 days;
(5) Revocation of Medical Staff membership;
(6) Denial of requested clinical privileges;
(7) Termination of clinical privileges;
(8) Suspension of clinical privileges for more than 30 days;
(9) Mandatory concurring consultation requirement (i.e., the consultant must approve the course of treatment in advance); or
(10) Denial of reinstatement from a leave of absence if the reasons relate to professional competence or conduct.

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B. None of the following actions shall constitute grounds for a hearing, and they shall take effect without a hearing or appeal, provided that the individual shall be entitled to submit a written explanation to be placed into his or her file:

(1) issuance of a letter of guidance, counsel, warning, or reprimand;

(2) imposition of conditions, monitoring, or a general consultation requirement (i.e., the individual must obtain a consult but need not get prior approval for the treatment);

(3) termination of temporary privileges;

(4) automatic relinquishment of appointment or privileges;

(5) imposition of a requirement for continuing education;

(6) precautionary suspension or restriction;

(7) denial of a request for leave of absence, for an extension of a leave or for reinstatement from a leave if the reasons do not relate to professional competence or conduct;

(8) determination that an application is incomplete;

(9) determination that an application will not be processed due to a misstatement or omission;

(10) determination of ineligibility based on a failure to meet threshold eligibility criteria, a lack of need or resources, or because of an exclusive contract; or

(11) Discovery of such misrepresentation, misstatement or omission on the appointment or reappointment application leading to the denial or termination of your privileges.

C. Moreover, notwithstanding any provision of these Bylaws to the contrary, any investigation or recommendation must be taken:

(1) In the reasonable belief that the action was in the furtherance of quality health care;

(2) After a reasonable effort to obtain the facts of the matter;

(3) After adequate notice and hearing procedures are afforded to the member involved or after such other procedures as are fair and to the member under the circumstances. Each Member agrees that the notice and hearing procedures specified in these Bylaws are fair; and
(4) In the reasonable belief that the action or recommendation was warranted by the facts known after such reasonable effort to obtain the facts.

Section 3 - Notice and Requests for Hearing

A. Notice of Action or Proposed Action

In all cases in which action has been taken or a recommendation made, said person or body taking such action or making such recommendation shall give the Member prompt special notice of its recommendation or action and of the right to request a hearing, which notice shall include:

(1) The reasons for the proposed action. In the event that the said action involves an automatic suspension, revocation or reduction of privileges, the Member shall further be informed of the action that is proposed to continue.

(2) That the Member has the right to request a hearing on the proposed action.

(3) The time limit within which a hearing must be requested which shall in no case be less than thirty (30) days from the date of the notice.

(4) That if a hearing is timely requested, the Member shall be entitled to at least thirty (30) days advance notice without demand of the place, time and date of the hearing and a list of witnesses, expected to testify on behalf of the professional review body.

(5) That if a hearing is timely requested, the hearing will be held, at the option of the MEC or Board, as applicable, before:

a. An arbitrator mutually acceptable to the physician and the health care entity, or

b. The MEC as hearing review panel, as more particularly described in these Bylaws.

(6) That the right to a hearing may be forfeited if the Member fails without good cause to appear at the hearing.

(7) That at the hearing the Member shall have the right:

a. To representation by an attorney or other person of the member’s choice; provided, however, that the hearing is intended to constitute the resolution of an intraprofessional matter. As such, the purpose of having such representation is so that the Member can be appropriately advised, and not so that the proceedings become essentially a trial;
b. To have a record made of the proceedings, copies of which may be obtained by the Member upon payment of reasonable charges associated with the preparation thereof;

c. To call, examine, and cross-examine witnesses;

d. To present evidence determined to be relevant by the arbitrator or MEC, regardless of its admissibility in a court of law; and

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

(8) That upon completion of the hearing, the Member shall have the right:

a. To receive the written recommendation of the arbitrator or MEC, including a statement of the basis for the recommendation, and

b. To receive a written decision of the health care entity, including a statement of the basis for the decision.

B. Request for Hearing

The Member shall have thirty (30) days following receipt of notice of such action to request a hearing. The request shall be in writing addressed to the MEC with a copy to the Board of Directors. In the event the Member does not request a hearing within the time and in the manner prescribed, the Member shall be deemed to have waived any right to a hearing and to have accepted the recommendation or action involved. A request shall be effective upon the earlier of hand delivery to the President of the Medical Staff or Special Notice.

Section 4 - Time and Place for Hearing

Upon receipt of a request for hearing, the MEC shall schedule a hearing and, no less than thirty (30) calendar days prior to the hearing, give Special Notice to the Member of the time, place, and date of the hearing. Unless extended by the MEC for good cause, the date of the commencement of the hearing shall be not less than thirty (30) days, nor more than ninety (90) days, from the date of the notice of hearing provided, however, that when the request is received from a Member who is under suspension the hearing shall be held as soon as the arrangements may reasonably be made, within the time frames set forth herein.

Section 5 - Notice of Recommended Action

Together with the notice of hearing, the MEC shall state clearly and concisely in writing the general reasons for the adverse action taken or recommended, including the acts or omissions with which the Member is charged, and shall include a list of witnesses, if any, expected to testify on behalf of the MEC, and a list of any patient records in question.

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Section 6 - Arbitrator or Hearing Review Panel

When a hearing is requested, the MEC shall, at its option:

A. Appoint a Hearing Panel in accordance with the following guidelines:
   
   (1) The Hearing Panel shall consist of at least seven members, one of whom shall be designated as chair, as determined by the Hearing Panel.
   
   (2) The Hearing Panel may include any combination of any member of the Medical Staff, provided the member has not actively participated in the matter at any previous level.
   
   (3) Knowledge of the underlying peer review matter, in and of itself, shall not preclude the individual from serving on the Panel.
   
   (4) Employment by, or other contractual arrangement with, the Hospital or an affiliate shall not preclude an individual from serving on the Panel.
   
   (5) The Panel shall not include any individual who is in direct economic competition with the individual requesting the hearing.
   
   (6) The Panel shall not include any individual who is professionally associated with or related to the individual requesting the hearing.
   
   (7) The Panel shall not include any individual who is demonstrated to have an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter.

B. Appoint an arbitrator mutually acceptable to the member and the MEC, or

C. Appoint a hearing officer, who may be an attorney, and who is not in direct economic competition with the Member involved.

The decision of the appointed arbitrator, or hearing review panel shall be final subject to the right to appeal specified in these Bylaws.

Section 7 - Failure to Appear or Proceed

Failure without good cause of the Member to personally attend and proceed at such a hearing in an efficient and orderly manner shall be deemed to constitute voluntary acceptance of the recommendations or actions involved.
Section 8 - Postponements and Extensions

Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted in these Bylaws may be permitted by the hearing review panel, or its chairman acting upon its behalf, the hearing officer or arbitrator upon a showing of good cause.

Section 9 - Hearing Procedure

A. Prehearing Procedure

(1) The MEC the Member shall, within ten (10) working days of the hearing or such other time as is set by the hearing review panel or arbitrator, exchange written lists of the names and addresses of the individuals, so far as is then reasonably known or anticipated, who are anticipated to give testimony or evidence in support of that party at the hearing, together with a summary of the anticipated testimony of each such witness. The hearing officer, hearing review panel or arbitrator shall also require both sides to exchange documents and document lists which are relevant to the issues to be presented at the hearing.

(2) It shall be the duty of the member and the MEC, or its designee, to exercise reasonable diligence in notifying the hearing review panel or arbitrator of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as reasonably possible, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any prehearing decisions must be succinctly made at the hearing.

B. Representation

Both the Member and the MEC shall be entitled to independent representation by an attorney or other person of their own choice and at their own expense. Notwithstanding the foregoing, since the purpose of the hearing is to resolve matters on an intraprofessional basis, direct participation of the Member is essential, and participation of a Member’s legal representative shall not substitute for the Member’s participation in the Hearing.

C. Hearing Review Panel, Arbitrator

The hearing review panel, or arbitrator must not act as a prosecuting officer or as an advocate. The hearing officer, panel, or arbitrator shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The hearing review panel or arbitrator shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure, or the admissibility of evidence. If the hearing review panel or arbitrator determines that either side in a hearing is not proceeding in an
efficient and expeditious manner, it may take such discretionary action as it deems warranted by the circumstances.

D. MSPIC Representative

A person or persons designated by the MSPIC shall be responsible to present evidence in support of its recommendation to the MEC at the hearing.

E. Record of the Hearing

At the request of either the Member or the MEC, a shorthand or court reporter shall be present to make a record of the hearing proceedings, and the prehearing proceedings. The cost of attendance of the reporter shall be borne by the Hospital, but the cost of the transcript, if any, shall be borne by the party requesting it. The hearing officer, panel or arbitrator may, but shall not be required to order that oral evidence shall be taken only on oath administered by any person lawfully authorized to administer such oath.

F. Rights of the Parties

Within reasonable limitations, both sides at the hearing may make argument, call and examine witnesses for relevant testimony, introduce relevant exhibits or other documents, or cross-examine or impeach witness who shall have testified orally on any matter relevant to the issues, and otherwise rebut evidence and make a written statement at the close of the hearing. The Member may be called by the MEC, the MSPIC representative, the hearing review panel or arbitrator and examined as if under cross-examination.

G. Miscellaneous Rules

Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under this Article. Any relevant evidence, including hearsay shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The MEC, MSPIC representative, hearing review panel, or arbitrator may interrogate the witnesses or call additional witnesses if it deems such action appropriate. At its discretion, the hearing officer, panel or arbitrator may request or permit both sides to file written arguments.

H. Burdens of Presenting Evidence and Proof

At the hearing, unless otherwise determined for good cause, the MSPIC shall have the initial duty to present evidence in support of its action or recommendation. The Member shall be obligated to present evidence in response. Throughout the hearing, the MSPIC and MEC shall bear the burden of persuading the hearing review panel or arbitrator by a preponderance of the evidence, that its action or recommendation was not arbitrary or capricious.
I. Adjournment and Conclusion

The hearing review panel, or arbitrator may adjourn the hearing and reconvene the same without special notice at such times and intervals as may be reasonable and warranted, with due consideration for reaching an expeditious conclusion to the hearing. Upon conclusion of the presentation of oral and written evidence, and the receipt of closing written arguments, the hearing shall be closed.

J. Basis for Decision

The decision of the hearing review panel or arbitrator shall be based on the evidence introduced at the hearing, including all logical and reasonable inferences from the evidence and the testimony. The decision shall be final, subject to the Member's appellate rights.

K. Decision of the Hearing Review Panel or Arbitrator

Within thirty (30) days after final adjournment of the hearing, the hearing review panel or arbitrator shall render a decision which shall be accompanied by a report in writing and shall be delivered to the MEC. If the Member is currently under automatic suspension, however, the time for the decision and report shall be as set forth in these Bylaws. A copy of said decision shall also be forwarded to the CEO, the Board of Directors, and by special notice, to the Member. The report shall contain a concise statement of the reasons in support of the decision. The decision shall be considered final, subject only to such rights of appeal or review as described in these Bylaws. The notice to the Member shall advise him or her of his or her right to appeal.

Section 10 - Appeal

A. Time for Appeal

Within twenty (20) days after receipt of the decision of the hearing review panel or arbitrator, either the Member or the MEC may request an appellate review. A written request for such review shall be delivered to the President of the Medical Staff, the CEO, and the opposing party in the hearing. If a request for appellate review is not requested within such period, the decision shall become final and binding on the parties.

B. Grounds for Appeal

A written request for an appeal shall include an identification of the grounds for appeal, and a clear and concise statement of the facts in support of the appeal.
The grounds for appeal shall be:

(1) Substantial non-compliance with the procedures required by these Bylaws or applicable law which has created demonstrable prejudice; or

(2) The decision was arbitrary or capricious.

Appellate review is not intended as de novo review of the matter.

C. Time, Place, and Notice

If an appellate review is to be conducted, the Board of Directors shall serve as the Appeal Board pursuant to its policies and procedures, which shall be provided to the MEC.

Section 11 - Right to One Hearing

No member shall be entitled to more than one (1) evidentiary hearing and one appellate review on any matter which shall have been the subject of adverse action or recommendation.
ARTICLE XI

OFFICERS

Section 1 - Medical Staff Officers

The officers of the Medical Staff shall be the President, the President-Elect, the Immediate Past President and the Secretary/Treasurer. The President-Elect will be elected at every other Annual Medical Staff Meeting, during the second year of the current President’s term, and serve one year; (s)he will then automatically move to the office of President, and serve a two-year term; followed by a one year term as Immediate Past President. The Secretary/Treasurer will be elected at the Annual Medical Staff Meeting, at the beginning of the President’s second term of office, and serve two years.

A. Medical Staff Officers

(1) President
Term - Two years – February 1 – January 31, twenty-four (24 months later)

(2) President-Elect
Term - One year – February 1 – January 31

(3) Immediate Past President
One-Year Term – February 1 – January 31

(4) Secretary/Treasurer
Term – Two years – February 1 – January 31, twenty-four (24 months later)

Section 2 - Nominating Committee

The Nominating Committee for Medical Staff shall be Chiefs of Medicine, Surgery, Family Medicine, OB-GYN, and Pediatrics, plus two additional members at large who are not members of the Medical Executive Committee. The members at large shall be appointed by the President of the Medical Staff. The President of the Medical Staff shall appoint the Chairman of the Committee. This Committee shall submit a slate of candidates for the offices of President-Elect and Secretary/Treasurer no less than sixty (60) days prior to the Annual Meeting of the Medical Staff.

Any active member of the Medical Staff may submit a nomination for office if they have sufficient support, which would be considered 50 signatures from members eligible to vote for any given office. The Member may not support by signature more than one candidate for each office. If these criteria are met no less than 30-days prior to the Annual Meeting, the nominee will be placed on the ballot as well.
Section 3 - Vacancies

A vacancy in the office of President is filled by the President-Elect or the Immediate Past President. If the Immediate Past President, a Special Election will be held as soon as reasonably possible to elect a (new) President. In the event the President-Elect assumes the position of President due to a vacancy, the President-Elect will complete the President’s term and then complete their two year elected term of office.

A vacancy in the office of President-Elect is filled by special election within 120 days.

A vacancy in the office of Immediate Past President is filled by the most recent Past President available to serve.

Section 4 - Duties of Officers

A. President of the Medical Staff:

(1) shall appoint and remove members of all staff committees, except the Medical Executive Committee and the Medical Staff Peer Improvement Committee;

(2) shall appoint the Chairman of the Medical Staff Peer Improvement Committee;

(3) shall preside as Chairman at all meetings of the Medical Executive Committee and report at general meetings of the Medical Staff on the activities of the Medical Executive Committee;

(4) shall be a voting member of the Board as a representative of the Medical Staff;

(5) shall make certain that committees meet regularly, maintain accurate records of minutes of their proceedings, and furnish their recommendations to the Medical Executive Committee for final action;

(6) shall see that all Department Chiefs perform their proper duties under Article XII, Section 3;

(7) shall have the right to suspend or restrict all or any portion of the clinical privileges of a Member in accordance with the provisions of Article IX, Section 3;

(8) may initiate peer review investigations against any Member under Article IX, Section 2;

(9) shall appoint a Chairman of the Nominating Committee for Medical Staff Officers;

(10) may call special meetings of the Medical Staff as indicated under Article XIV, Section 2;
(11) shall preside at the Annual Meeting, or special meetings of the Medical Staff;

(12) shall bring before the Board all matters acted upon by the Medical Executive Committee which require the action of the Board, or which should be forwarded as a matter of information;

(13) shall be responsible to the Board for the professional functioning of the Medical Staff consistent with these Bylaws, Rules and Regulations and Hospital Policies; and,

(14) shall be an ex-officio, non-voting member of all Medical Staff Committees and can sit in all departmental meetings.

Section 5 - President-Elect

In the absence of the President, the President-Elect shall assume all the duties of the President and have all such authority. In addition, the President-Elect shall perform such duties as may be assigned by the President. The President-Elect shall be a member of the Medical Executive Committee, the Medical Staff Peer Improvement Committee and the Medical/Hospital Joint Performance Improvement Committee. The President-Elect shall be a voting member of the Board as a representative of the Medical Staff.

Section 6 - Secretary/Treasurer

The Secretary/Treasurer shall:

A. Maintain accurate and complete minutes of all meetings of the General Medical Staff;

B. Call meetings on order of the President;

C. Attend to all correspondence;

D. Perform other duties as assigned by the President. The Secretary/Treasurer shall be a voting, member of the Board as a representative of the Medical Staff.

In addition, the Secretary/Treasurer shall be accountable for all funds entrusted, subject to audit. The Secretary/Treasurer may disburse staff funds only with prior approval of the Medical Executive Committee unless the sum is $500.00 or less. The Secretary/Treasurer shall also be a member of the Medical Executive Committee.

Section 7 - Immediate Past President

In the absence of the President, in the alternate year without a President-Elect, the Immediate Past President shall assume all the duties of the President and all such authority. The Immediate Past President shall be a member of the Medical Executive Committee, the Medical Staff Peer
Improvement Committee and the Medical/Hospital Joint Performance Improvement Committee for one year in the alternate year without a President-Elect and shall be a voting member of the Board as a representative of the Medical Staff for two years.

Section 8 - Removal of Staff Officers

Any elected Medical Staff Officer may be removed from office, only upon the submission of a petition to the Medical Executive Committee signed by at least fifty (50) Active and Senior Active Medical Staff Members, which specifically delineates the reason(s) for removal from office.

The following criteria constitute appropriate reasons to consider removal of Medical Staff Officers:

A. Displays consistently poor judgement in medico-administrative matters.

B. Attends less than 50% without good cause when the Medical Executive Committee meets for business.

C. Displays disruptive behavior.

D. Disregards Medical Staff policies openly.

E. Ignores Medical Staff adopted bylaws and rules and regulations when conducting medical staff business.

F. Fails to maintain Active category status.

G. Is physically or mentally incapable of fulfilling the office.

This is not meant to be an inclusive list.

The Medical Executive Committee shall determine the clarity of the petition and, if satisfied, shall direct the President of the Medical Staff to issue a mail ballot returnable within twenty-one (21) days to the Active and Senior Active Medical Staff. If the officer to be removed is the President, the Medical Executive Committee shall so instruct the Immediate Past President to act as above. If more than two-thirds of the Active and Senior Active Medical Staff vote for removal, the Officer shall be removed. The President of the Medical Staff or the Immediate Past President shall then conduct an election to replace the deposed Officer as stipulated in Article XI, Section 3 (Vacancies).
ARTICLE XII
DEPARTMENTS

Section 1 – Organization of Departments

A. The Medical Staff shall be organized into component departments in the following fields: Anesthesiology, Emergency Medicine, Family Medicine, Medicine, Obstetrics and Gynecology, Pathology, Pediatrics, Radiology and Surgery.

B. Upon approval of the Medical Executive Committee and the Board, these departments may be further divided into sections according to specialties for the purposes of administrative efficiency and for the improvement of quality and the delivery of medical care. If approved by the Medical Executive Committee, sections may hold their own meetings. Accurate records or minutes of such department section meetings shall be maintained, and the department section shall follow the same attendance requirements as applicable to the department of which it is a section.

Section 2 — Qualifications, Selection and Tenure of Department Chiefs and Vice Chiefs

A. Each Department Chief and Vice Chief must be physicians actively engaged in the practice of medicine, osteopathy, dentistry or podiatry, and shall be a member of the Active Staff, qualified by training, experience and demonstrated ability for this position and shall not be a current officer of the Medical Staff.

B. Each Department Chief and Vice Chief shall be elected by the Active Staff membership of said department for a two-year term to begin on February 1st subject to approval of the Board. The Department Chiefs and Vice-Chiefs may be re-elected but may not serve for more than four consecutive years with the exception of the Departments of Anesthesia, Emergency Medicine, Pathology and Radiology, which shall not be subject to this restriction.

C. Removal of a Department Chief, or Vice Chief, during his term of office may be initiated by a two-thirds majority vote of the Active Medical Staff of the Department, subject to the approval of the Medical Executive Committee and Board. A Department Chief or Vice Chief can also be removed by a two-thirds vote of the Medical Executive Committee, which vote will also be approved by the Board.

The following criteria constitute appropriate reasons to consider removal of Department Chiefs and Vice Chiefs:

(1) Displays consistently poor judgement in medico-administrative matters.

(2) Attends less than 50% of scheduled meetings without good cause (either Departmental, MEC, or MSPI as applicable).
(3) Displays disruptive behavior.

(4) Disregards Medical Staff policies openly.

(5) Ignores Medical Staff adopted bylaws and rules and regulations when conducting medical staff business.

(6) Fails to maintain Active category status.

(7) Is physically or mentally incapable of fulfilling the office.

This is not meant to be an inclusive list.

D. With the exception of the Departments of Anesthesia, Emergency Medicine, Pathology and Radiology, election of Chiefs and Vice-Chiefs will be held at the last regularly scheduled department meeting of the year. The day after Labor Day, a notice will be sent to the Active members of the department notifying them of the election and requesting if they would like to have their name appear on the ballot for Chief or Vice-Chief. Active members will have 30 days to submit their name to appear on the ballot.

Section 3 - Functions of Department Chiefs

A. The duties of Chiefs of Departments are as follows:

(1) Each Department Chief shall be responsible for the clinical related activities in their respective Departments.

(2) Each Department Chief shall be responsible for the administratively related activities of the department, unless otherwise provided for by the hospital.

(3) Provide continuous surveillance of professional performance of its members.

(4) Be responsible for departmental implementation of actions taken by the Medical Executive Committee, and for the formulation of rules and regulations pertinent to the department.

(5) Develop and recommend criteria for clinical privileges in association with the department members.

(6) Recommend clinical privileges for each department member.

(7) Assess/recommend the selection and use of off-site sources.

(8) Provide leadership responsibilities to members.
(9) Under the circumstances set forth in Article IX, Section 3, a Chief of a Department may suspend or restrict all or any portion of the clinical privileges of a Member.

(10) Department Chiefs shall provide or arrange for all medical coverage for a Member’s inpatients if the Member’s privileges are suspended, revoked or not renewed, with the agreement of the patient or the patient’s representatives.

(11) When applicable, Department Chiefs shall appoint Section Chiefs to serve a two-year term that coincides with the Department Chief’s term of office, and shall delegate such duties to the Section Chiefs as deemed necessary to comply with these Bylaws and Rules and Regulations.

(12) Integrate the department or service into the primary functions of the organization.

(13) Coordinate and integrate interdepartmental and intradepartmental services.

(14) Develop and implement policies and procedures that guide and support the provision of care, treatment and services.

(15) Recommend a sufficient number of qualified and competent persons to provide care, treatment and service.

(16) Determine the qualifications and competence of department of service personnel who are not licensed independent practitioners and who provide patient care, treatment and services.

(17) Continual assessment and improvement of the quality of care, treatment and services.

(18) Maintain quality control programs, as appropriate within the department.

(19) Provide for orientation and continuing education for members in the department.

(20) Recommend space and other resources needed by the department.

Section 4 - Functions of a Department Vice Chief

The Department Vice Chief shall oversee the Department’s Peer Review functions and shall serve on the Medical Staff Peer Improvement Committee. A Department of fewer than 20 members may appoint a Coordinator of Peer Review other than the Vice Chief of the Department. The Department Vice Chief shall act as a Department representative to the Medical Executive Committee in the absence of the Chief of the Department. The Department Vice Chief provides Peer and Performance Improvement reports at the Department Meetings.
Section 5 - Functions of Departments

Each Department shall establish its own criteria consistent with these Bylaws, the policies of the Medical Staff and the Board for the granting of clinical privileges, and for the holding of office in the department.

Section 6 - Assignments to Departments

The Medical Executive Committee shall, after consideration of the recommendations of the departments as transmitted through the Credentials & Qualifications Committee, recommend initial departmental assignments for all Members.
ARTICLE XIII

COMMITTEES OF THE MEDICAL STAFF

Section 1 - Committees - Standing and Special

A. Committees of the Medical Staff shall be Standing and Special. The President of the Medical Staff shall appoint the Chairperson and Medical Staff Members of all Medical Staff committees with the exception of the Medical Staff Peer Improvement Committee and the Medical Executive Committee.

B. The Standing Committees shall be:

(1) Medical Executive Committee
(2) Medical Staff Peer Improvement Committee
(3) Credentials & Qualifications Committee
(4) Cancer Committee
(5) Health Information Management Committee
(6) Operating Room and Procedures Committee
(7) Pharmacy & Therapeutics Committee
(8) Infection Control Committee
(9) Critical Care Committee
(10) Emergency Management Committee
(11) Risk Management Committee of the Medical Staff
(12) Continuing Medical Education
(13) Bylaws Committee
(14) Utilization Review Committee

C. Frequency of Committee Meetings:

(1) The following Committees shall meet at least 10 times per year, and quorum will be defined as 50% of membership.
(a) Medical Executive Committee

(b) Credentials & Qualifications Committee

(2) The Medical Staff Peer Improvement Committee shall meet at least 6 times per year, and a quorum will be defined as 50% of membership.

(3) Holy Cross Hospital Joint Performance Improvement Committee shall meet at least 4 times per year, and a quorum will be defined as 50% of membership.

(4) Operating Room and Procedures Committee quorum definition as 50% of members. Meetings will be held at least quarterly.

(5) The following Committees shall meet at least three times per year. The members present shall constitute a quorum, provided at least three are present.

(a) Cancer Committee

(b) Critical Care Committee

(c) Health Information Management Committee

(d) Pharmacy & Therapeutics Committee

(e) Infection Control Committee

(6) The following Committees shall meet as necessary:

(a) Risk Management Committee - Medical Staff

(b) Emergency Management Committee

(c) Continuing Medical Education Committee

(d) Bylaws Committee

D. All Committees shall keep permanent records of all proceedings and actions.

E. Attendance at Meetings

Members are required to attend fifty percent (50%) of the scheduled meetings.

Section 2 - Medical Executive Committee

A. The Composition of the Medical Executive Committee shall be:
The President of the Medical Staff (who shall act as Chairman), President-Elect, Immediate Past President in the alternate year without a President-Elect, Secretary/Treasurer and the Chiefs of the Departments of Anesthesiology, Emergency Medicine, Family Medicine, Medicine, Obstetrics and Gynecology, Pathology, Pediatrics, Radiology and Surgery, and the Chairpersons of the Credentials & Qualifications Committee and Medical Staff Peer Improvement Committee, all of whom will be voting members. The Chief Executive Officer or designee of the Hospital shall represent Administration at the Medical Executive Committee. The Chief Executive Officer or designee and Chairman of the Medical Executive Committee shall agree on the composition of the Administrative Team which shall represent Administration on the Medical Executive Committee without vote. No person may serve in two Medical Executive Committee positions at the same time. The Medical Executive Committee is empowered to act for the medical staff in the intervals between medical staff meetings.

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

1. represent and act on behalf of the Medical Staff, recommending, when needed, to the Administration action on matters of medical administrative nature, long-range planning, and liaison between the Medical Staff, Administration, and the Board;

2. fulfill the Medical Staff's accountability to the Board for the medical care rendered to patients in the Hospital;

3. receive and act upon committee reports, including requests by the Medical Staff Peer Improvement Committee for adjudication or investigations and make recommendations to the Board pertaining to the mechanisms for fair hearing procedures;

4. coordinate the activities and general policies of the various departments and to implement those policies not otherwise the responsibility of the individual departments;

5. review the recommendations of the Credentials & Qualifications Committee regarding applicants for Medical Staff membership, assignment to departments and delineation of clinical privileges;

6. review annually and as necessary, pertinent information on the reappointment and reassignment of said privileges and to take reasonable steps to ensure the ethical conduct and competent clinical performance of the Medical Staff is under surveillance;

7. report its activities at each General Staff meeting;

8. assess Medical Staff dues as hereinafter described and as may be determined from time-to-time by the Medical Executive Committee;
(9) review the Bylaws (annually) and amend them as necessary in accordance with the provisions of Article XX of these Bylaws;

(10) recommend changes in the Medical Staff's structure to the Board;

(11) recommend to the Board the participation of the Medical Staff in organization performance improvement activities; and;

(12) review matters related to patient satisfaction, patient relations and community outreach programs and provides feedback and makes recommendations as appropriate.

Section 3 - Medical Staff Peer Improvement Committee

A. There is hereby created a Medical Staff Improvement Committee, which shall be entitled to all of the provisions concerning confidentiality and privileged communications as set forth in these Bylaws and prevailing law. The purpose of the Committee is to (1) oversee the effectiveness of the Departmental Peer Review functions, (2) provide assistance through education to Medical Staff members regarding quality issues and individual health related and behavioral issues that would affect patient safety, (3) to initiate Performance Improvement projects it deems beneficial through department peer review functions. The Medical Staff Peer Improvement Committee is empowered to delegate its authority to a non-member of the Committee for the purpose of obtaining information, facts or opinions in furtherance of the duties or the objectives of the Medical Staff Peer Improvement Committee. Any information, facts or opinions obtained in this manner should be deemed a part of the Medical Staff Peer Improvement Committee activities.

B. The composition of the Medical Staff Peer Improvement Committee shall be:

The Medical Staff Peer Improvement Committee shall have voting and non-voting, members. Any member of the committee listed below can not serve as Chairman of MSPI (this is to avoid any perceived conflict of interest). In the absence of the Chairman of MSPI, the President of the Medical Staff will act as Chair. Its voting composition shall be as follows:

The President of the Medical Staff shall appoint the Chairman
President of the Medical Staff as Vice Chairman;
President-Elect of the Medical Staff
Immediate Past President of Medical Staff in the alternate year without a President-Elect
Vice Chief, Department of Anesthesia
Vice Chief, Department of Emergency Medicine
Vice Chief, Department of Family Medicine
Vice Chief, Department of Medicine
Vice Chief, Department of Ob/Gyn
Vice Chief, Department of Pathology
Vice Chief, Department of Pediatrics
Vice Chief, Department of Radiology
Vice Chief, Department of Surgery
Hospitalist Representative
Designated Institutional Officer of the Residency Programs (non voting member)
Medical Director of Holy Cross Hospital Heart Lab
Continuing Medical Education Program Director
Case Manager/Physician Advisor
Infection Control Committee Chairperson
Physician Representative of Critical Care

The President of the Medical Staff shall appoint two at-large members from the Medical Staff.

No person may serve in two Medical Staff Peer Improvement Committee positions at the same time.

C. Duties:

The duties of the Medical Staff Peer Improvement Committee (MSPI) are to evaluate and improve the quality of health care rendered by Members of the Medical Staff or to determine that health services rendered were professionally indicated or were performed in compliance with applicable standard of care. Programming for Continuing Medical Education for each calendar year shall be presented to the Medical Staff Peer Improvement Committee for input, and programming shall be reflective of identified educational needs for the Medical Staff. The Medical Staff Peer Improvement Committee shall forward its peer review activities to the Performance Improvement Professional Affairs Committee of the Board for information and forward issues dealing with potential sanctions of Medical Staff members to the Medical Executive Committee for determination. The Continuing Medical Education Program Director shall advise the President of the Medical Staff of the agenda of each meeting in advance.

D. All Medical Staff committees related to patient care shall be represented on and report to the appropriate performance improvement Committee of the Board of Directors, in accordance with the hospital’s Performance Improvement Plan.

Section 4 – Holy Cross Hospital Joint Performance Improvement Committee

A. The Medical Staff and Administration hereby create a joint committee for the purpose of overseeing and directing the quality activities and performance improvement initiatives throughout the Holy Cross Hospital organization.

B. The Co-Chairs of the Holy Cross Hospital Joint Performance Improvement Committee shall be the Medical Staff Peer Improvement Committee Chair as appointed by the President of the Medical Staff and the Executive Director of Quality Improvement & Case Management. In the absence of MSPI staff co chair, the President may serve as co-chair representative from the Medical Staff. In the event of absence of both MSPI co-
chair and President (serving as medical co chair) the meeting shall be rescheduled to another date.

C. The composition of the Holy Cross Hospital Joint Performance Improvement Committee shall be:

Voting Members: (no voting member shall have more than one vote)
Executive Director of Performance Improvement & Case Management
Medical Staff co chair (appointed by the President of the Medical Staff)
Vice Chief - Department of Anesthesia
Vice Chief - Department of Emergency Medicine
Vice Chief - Department of Family Medicine
Vice Chief - Department of Medicine
Vice Chief - Department of Ob/Gyn
Vice Chief - Department of Pathology
Vice Chief - Department of Pediatrics
Vice Chief - Department of Radiology
Vice Chief - Department of Surgery

The Chief Executive Officer shall appoint not more than five members to the Committee and those members shall be voting members of the Committee.

Non-Voting Members:
Decision Support Representative
Performance Improvement & Case Management Representative
Executive Assistant Performance Improvement & Case Management

D. Duties:

The duties of the Holy Cross Hospital Joint Performance Improvement Committee are to officially charter all clinically related Performance Improvement Projects. To monitor progress and receive timely reports regarding the implementation and completion of chartered projects.

To receive and review Rapid Process Improvement Projects undertaken by Administration for the purpose of communicating important physician related information to the Medical Staff.

To receive and review analysis of quality data and information in an ongoing way.

Key clinical quality activities and projects shall be presented to the Medical Executive Committee in the regular report provided by the Co-chair of the Holy Cross Hospital Joint Performance Improvement Committee and Chair of the Medical Staff Peer Improvement Committee.
The Holy Cross Hospital Joint Performance Improvement Committee shall provide a review of activities to the Performance Improvement/Professional Affairs Committee to the Board.

Section 5 - Credentials & Qualifications Committee

A. The composition of the Credentials & Qualifications Committee shall be:

Members of the Active Staff so selected by the President of the Medical Staff as to ensure representation of the major clinical specialties.

B. The duties of the Credentials & Qualifications Committee shall be to:

(1) Review the credentials and qualifications of all applicants;

(2) Make recommendations for membership and delineation of clinical privileges in compliance with Articles III, V, and VI of these Bylaws;

(3) Review biannually, or upon request of the Medical Executive Committee, information forwarded to them as to the continuing evaluation of the competence of the staff membership and the reappointment and reassignment to departments and any changes in clinical privileges.

Section 6 - Cancer Committee

A. The composition of the Cancer Committee shall be:

Physicians and representatives from the following departments and sub-sections: Surgical, Medical Oncology, Radiation Oncology, Diagnostic Radiology, Pathology, Cancer Liaison, Ancillary Staff, Administration, Nursing, Social Services, Cancer Registry and Quality Assurance. It is expected that the physician representatives from the five major sites of Cancer seen at the institution will be included.

B. The duties of the Cancer Committee shall be to:

(1) Establish and evaluate annual goals and objectives for all clinical and educational activities related to cancer;

(2) The Committee must meet at least quarterly to meet the needs of the institution;

(3) Ensure that educational and consultative cancer conferences are available to the Medical Staff and Allied Health Professionals, and cover all major sites in related issues;

(4) Ensure an active support of care system is in place for patients, families and staff;
(5) Monitor quality management and improvement with completion of patient care
studies that focus on quality, access to care and outcomes;

(6) Perform quality control of registry data and supervise the Cancer Registry to
ensure accurate and timely abstract in staging the follow-up;

(7) Publish an annual report by November 1st of the following year;

(8) Ensure that the organization and management structure includes medical direction
and administrative management to ensure effectiveness of its cancer program
services;

(9) Ensure that a formal mechanism is in place to establish, manage, and evaluate
medical, scientific and ethical standards.

Section 7 - Health Information Management Committee

A. The composition of the Health Information Management Committee shall be:

At least five (5) members of the Active Medical Staff, a representative from
Administration and Nursing and the Director of Health Information Management. The
latter shall serve as secretary.

B. The duties of the Health Information Management Committee shall be to:

(1) Make a continuing effort to see that all medical records meet the highest standards
of patient care, usefulness and historical validity and the medical record reflects
realistic documentation of medical events.

(2) Conduct regularly scheduled reviews of selected charts so that they properly
describe the condition and progress of the patient, the therapy provided, the
results thereof, and that they are sufficiently clear and complete so as to meet the
criterion of medical comprehension of the case by any physician subsequently
reviewing the patient’s record.

(3) Have the authority, with approval of the Medical Executive Committee, to
establish such rules and regulations as may be needed to effectuate these
responsibilities.

(4) Advise staff members as to delinquent medical records and shall advise the CEO
or designee, and the President of the Medical Staff and the Medical Executive
Committee and other appropriate individuals regarding practitioners who fail to
correct deficiencies on published lists and shall notify physicians of their own
delinquencies by Certified Mail, Return Receipt Requested, or by hand delivery.
Section 8 - Pharmacy and Therapeutics Committee

A. The composition of the Pharmacy and Therapeutics Committee shall be:

Membership shall consist of at least five (5) representatives of the Medical Staff and one each from the Pharmaceutical Service, Nursing Service and Administration. The Hospital Pharmacist shall be a member of the Committee and act as Secretary.

B. The duties of the Pharmacy and Therapeutics Committee shall be:

(1) To be responsible for the development and surveillance of all drug, utilization policies and practices within the Hospital in order to assure optimum clinical results and a minimum potential for hazard;

(2) To assist in the formulation of broad professional policies regarding the evaluation, procurement, storage, distribution, use and safety procedures as related to drugs used in the Hospital.

Section 9 - Infection Control Committee

A. The composition of the Infection Control Committee shall be:

A representative of each of the clinical departments, as well as Pathology, Nursing Service, In-service Education, Bacteriology, Housekeeping and Hospital Administration.

B. The duties of the Infection Control Committee shall:

(1) Be responsible for prevention, investigation and control of all infection within the Hospital;

(2) Develop written policies and procedures, which define types of isolation, with copies readily available to appropriate personnel;

(3) Develop, evaluate and revise the procedures and techniques for meeting established sanitation and asepsis standards;

(4) Develop a system for reporting, evaluating and keeping records of infections among patients and personnel;

(5) Provide assistance in the development of an educational program for the Medical Staff, Hospital personnel, patients and visitors;

(6) Review periodically the use of antibiotics as they relate to patient care within the Hospital; (Control use of antibiotics when found to be effective.)

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(7) Maintain traffic control and visiting regulations in all areas, especially in the Operating Room, Nursery, Obstetrical Department and isolation rooms;

(8) Check sources of air pollution;

(9) Review all Patient Infection Reports and culture reports of specialized areas.

Section 10 - Critical Care Committee

A. The composition of the Critical Care Committee shall be:

One (1) representative from each of the following Medical Staff Departments: Medicine, Family Medicine, Surgery, and Anesthesiology, and from Administration and Nursing Service.

B. The Critical Care Committee shall be:

Responsible for the establishment of protocol and policies for resuscitation, education of the Medical Staff, Emergency Room physicians, and nursing staff and other appropriate Hospital personnel and evaluation of the program by periodic review of procedures, records and overall results.

Section 11 - Operating Room and Procedures Committee

A. The composition of the Operating Room and Procedures Committee shall be:

Voting Members: (no voting member shall have more than one vote)
The Chief of Surgery will Chair
The Executive Director of Surgical Services will be Vice-Chair

Medical Director of Surgical Services
Chief - Department of Anesthesia
Chief - Department of Ob/Gyn
A physician representative from Pathology
A physician representative from Radiology
Surgery Section Chiefs of: Cardiovascular/Thoracic Surgery, Colon/Rectal Surgery, General Surgery, Neurosurgery, Ophthalmology, Orthopedics, Otolaryngology, Plastics, Podiatry and Urology

Representatives from Administration and Surgical Operating Room Management will also be included as non-voting members.

B. The duties of the Operating Room and Procedures Committee shall be:
Provide input, advise and/or recommend on matters regarding scheduling, staffing, capital expenditures, standardization of supplies and/or instruments, peer sanctions of non-clinical associates, and other such issues as may be pertinent.

Section 12 - Departmental Peer Review Functions

A. Functions:

(1) The Chief of each Department is responsible for assuring the implementation of a process for monitoring and evaluating the quality and appropriateness of the care and treatment of patients and the clinical performance of all individuals with privileges in that department.

No Vice Chief or Peer Review Coordinator (M.D./D.O.) shall serve more than two consecutive two-year terms. The President of the Medical Staff, in consultation with the Chief and/or Vice Chief of a Department, may appoint a physician to serve in a peer review functional capacity which is not in his department so as to enhance the effectiveness of peer review. The Vice Chief is to serve as the Coordinator of the Department Peer Review functions. A Department of fewer than 20 members may appoint a Coordinator of Peer Review other than Vice Chief of the Department.

(2) Appointments will be made biannually. The Committee shall have further assistance from, and attendance by, members of the Health Information Management Departments.

B. The duties related to Departmental Peer Review shall be:

(1) Review those medical records not meeting the approved screening criteria;

(2) Review patient records for the purpose of evaluating clinical performance of the staff and to assure appropriate care and treatment of the patient. In addition, all requirements related to hospital admissions, length of stay, discharge practices, use of medical and hospital services and all related factors which may contribute to the effective utilization of hospital and physician services shall be reported and reviewed by the Medical Staff Peer Improvement Committee via the Physician Advisor;

(3) Clinical peer review will incorporate case management, which is a clinical system that focuses on the accountability for a continuum of patient care; and facilitates the achievement of quality and clinical outcomes;

(4) Document findings and conclusions of the monitoring, evaluating and problem-solving, activities and report every other month to the Chiefs of each department and the Medical Staff Peer Improvement Committee;
(5) Unresolved problems will be reviewed by each Chief of the Department with the responsible physician. The action taken by the Department shall be reported back to the Medical Staff Peer Improvement Committee;

(6) The Blood Utilization Review function, under the direction of the Department of Pathology is concerned with the ordering, distribution and administration patterns of blood and blood products, and in monitoring outcomes of transfusions. All blood and blood products (RBC, platelets, fresh frozen plasma, cryoprecipitate) are reviewed for physician compliance with medical staff approved criteria. The information gathered is reported to Medical Staff Services and will be considered in the reappointment recommendation.

Section 13 - Emergency Management Committee

A. The Emergency Management Committee is a Hospital Administrative Committee. The Chief or the Vice Chief of Emergency Medicine will serve on the Committee and be the liaison to the Medical Staff. During an emergency, the President of the Medical Staff or designee and the Chief Executive Officer or designee of the Hospital will work as a team to coordinate activities and directions.

Section 14 - Risk Management - Medical Staff Committee

A. The Medical Staff shall assist the Board in the implementation of its comprehensive risk management program by the creation of a Risk Management Committee, the purpose of which is to assist and advise the Hospital and which shall consist of the following voting members: the President of the Medical Staff, as Chairman, two (2) members of the Medical Staff Peer Improvement Committee (nominated and elected by the Committee), two (2) members of the Medical Executive Committee (nominated and elected by the Committee). The Hospital’s Chief Executive Officer or designee shall be an ex-officio, non-voting member of the Committee. Regular members of the Committee shall serve for biannual terms, each ending on January 1 of the year following election. This Committee shall assist the Hospital’s Risk Manager in fulfilling the purposes of FS 395.0197 and any other purpose permitted or required by law, particularly in relation to evaluation of adverse incidents involving members of the Medical Staff, continuing medical education, and the development of Risk Management policy.

B. Prior to the reporting of an adverse incident involving a member of the Medical Staff, the members of the aforementioned Risk Management Committee shall be notified, and a meeting will be convened within 48 hours.
Section 15 - Continuing Medical Education Committee

A. The composition of the Continuing Education Committee shall be:

The Continuing Medical Education Program Director shall serve as Chairman. Members will consist of physicians from various specialties who have an interest in developing continuing medical education.

B. The duties of the Continuing Medical Education Committee shall be:

Determine the educational needs of the Medical Staff and seek the presentation of programs that will fill those needs.

Section 16 – Utilization Review Committee

A. The composition of the Utilization Review Committee shall be physician members appointed by the President of the Medical Staff with input from the Medical Executive Committee.

The Committee Chairman shall be a physician appointed by the President of the Medical Staff.

The non-physician members shall be appointed by CEO or designee.

The duties of the Utilization Review Committee are to administer and review the functions outlined in the Utilization Review Plan.
ARTICLE XIV
MEDICAL STAFF MEETINGS

Section 1 - The Annual Staff Meeting

The annual meeting, ("Annual Meeting") of the Medical Staff shall occur during the last month of the calendar year. The precise date shall be determined by the President of the Staff, and shall be noticed no less than one month prior to the said date. Any matter to be brought before the Medical Staff for discussion or action must be presented in writing to the President of the Staff at least two weeks prior to the meeting for inclusion on the agenda. The agenda for the meeting shall include the election of officers for the ensuing year and such other matters as appropriate. Attendance at the Annual Staff Meeting is mandatory for all Active Staff members, unless a written request to be excused is accepted by the President of the Medical Staff.

Section 2 - Special Meetings

Special meetings of the Medical Staff may be called at any time by the President and shall be called at the request of the Board, the Medical Executive Committee or 10% of the Active and Senior Active Medical Staff and presented in writing to the Chief Executive Officer. At any special meeting, no business shall be transacted except that stated in the notice calling the meeting. Written notice of any special meeting shall be provided to each member of the Medical Staff no less than thirty (30) days prior to the date of the special meeting.

Section 3 - General Medical Staff Meetings

General meetings of the Medical Staff shall occur during the calendar year. The precise dates shall be determined by the President of the Staff, and shall be noticed no less than one month prior to the said date. Any matter to be brought before the Medical Staff for action must be presented in writing to the President of the Staff at least two weeks prior to the meeting for inclusion on the agenda. Attendance at the General Meetings is voluntary for all medical staff members.

Section 4 – Communication between amongst Medical Staff

Legitimate communications for exchange of information/data, educational purpose, voting regarding Medical Staff issues, may take the form of verbal approbation, email, text, or other form of electronic communication allowing, however, that count and subject matter is subject to scrutiny and documentation. Communications may be duplicative formats if deemed relevant.
ARTICLE XV

DEPARTMENTAL MEETINGS

Section 1 - Regular Meetings

Each department shall hold meetings at least quarterly, with attendance being voluntary at the discretion of the individual department. The number of meetings will be determined by each department. Results of Peer Review/Quality Review will be reported at regular department meetings.

Section 2 - Special Meetings

A special meeting of any department may be called by the Chief of the department, or upon written request of one-third of the membership of the department.

Section 3 - Notice of Meetings

Communications stating the place, hour and day of regular or special meetings shall be sent to each member of the department not less than ten (10) days before the time of such meeting. A meeting agenda will be sent out in advance of department meetings.

Section 4 - Minutes

Minutes of every regular or special meeting of a department shall be maintained and shall include a record of attendance of the Members and votes taken.

Section 5 - Quorum

The Medical Staff members of the department who are present shall constitute a quorum for any departmental meeting, and the action of those who are present shall constitute a valid action of the department.
ARTICLE XVI

RESPONSIBILITIES/IMMUNITY FROM LIABILITY

All applicants and Members agree by their submission of an application or by acceptance of clinical privileges, to be bound by the waivers, limitations and protections set forth in this Article, and shall not be construed to limit any other grant of immunity as provided by law.

A. Any act, communication, report, recommendation or disclosure, with respect to any such Member, performed or made in good faith and without malice and at the request of an authorized representative of this or any other healthcare facility, for the purpose of achieving and maintaining quality patient care in this or any other healthcare facility, shall be privileged.

B. Such privileges shall extend to members of the Hospital’s Medical Staff and its officers, its other practitioners, the Hospital and its Directors, and to third parties, and those who supply information, and any of the foregoing persons authorized to receive, release or act upon the same. For the purpose of this Article, the term “third parties” means both individuals and organizations from which information has been requested by an authorized representative of the Board or of the Medical Staff.

C. There shall be absolute immunity from civil liability arising from any such act, communication, report, recommendation or disclosure, even where the information involved would otherwise be deemed privileged.

D. Such immunity shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other healthcare institution’s activities related, but not limited to: 1) applications for appointment or clinical privileges; 2) periodic reappraisals for reappointment or clinical privileges; 3) peer review activities, including precautionary suspensions or restrictions; 4) hearings and appellate reviews; 5) medical care evaluations; 6) utilization reviews; 7) other hospital, departmental, service or community activities related to quality patient care and inter-professional conduct.

E. The acts, communications, reports, recommendations and disclosures referred to in this Article may relate to a practitioner’s professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly impact on patient care.

F. In furtherance of the foregoing, each Member shall, upon request of the Hospital, execute releases in favor of the individuals and organizations specified in Paragraph (2) above.
ARTICLE XVII
RULES AND REGULATIONS AND POLICIES

Section 1 - Adoption and Amendment of Rules and Regulations

The Medical Executive Committee shall adopt such rules and regulations as may be necessary for the proper conduct of Medical Staff activities. Such Rules and Regulations may be formulated or amended by a majority vote of the Medical Executive Committee. Notice of all proposed amendments shall be provided to each voting member of the Medical Staff at least ten days prior to the vote by the Medical Executive Committee. Any voting member may submit written comments on the amendments to the Medical Executive Committee.

Amendments to Medical Staff policies and Rules and Regulations may also be proposed by a petition signed by 50% plus 1 of the voting members of the Medical Staff. Notice of any such proposed amendment to these documents shall be provided to each voting member of the Medical Staff ten days in advance of forwarding the proposed recommendation to the Medical Executive Committee. Any such proposed amendments will be reviewed by the Medical Executive Committee, which may comment on the amendments before they are forwarded to the Board for its final action.

The Medical Executive Committee and the Board shall have the power to provisionally adopt urgent amendments to the Rules and Regulations that are needed in order to comply with a law or regulation, without providing prior notice of the proposed amendments to the Medical Staff. Notice of all provisionally adopted amendments shall be provided to each member of the Medical Staff as soon as possible. The Medical Staff shall have ten days to review and provide comments on the provisional amendments to the Medical Executive Committee. If there is no conflict between the Medical Staff and the Medical Executive Committee, the provisional amendments shall stand. If there is conflict over the provisional amendments, then the process for resolving conflicts shall be implemented.

Section 2 - Policies

In addition to the Medical Staff Bylaws, Rules and Regulations, there shall be policies applicable to all members of the Medical Staff and other individuals who have been granted clinical privileges. All Medical Staff policies shall be considered an integral part of the Medical Staff Bylaws, but may be adopted and amended by a majority vote of the Medical Executive Committee. No prior notice is required, but the Medical Executive Committee shall strive, unless there are extenuating circumstances, to provide reasonable notice and opportunity to the voting staff to comment.

Section 3 - Conflict Management Process

When there is a conflict between the Medical Staff and the Medical Executive Committee (as evidenced by a petition signed by 50% plus 1 of the voting staff) with regard to proposed
amendments to the Medical Staff Rules and Regulations or policies, a special meeting of the Medical Staff will be called. The agenda for that meeting will be limited to the amendment(s) or policy at issue. The purpose of the meeting is to strive to resolve the differences that exist with respect to Medical Staff Rules and Regulations or policies. If the differences cannot be resolved at the meeting, the Medical Executive Committee shall forward its recommendations, along with the proposed recommendations pertaining to the Medical Staff Rules and Regulations or policies offered by the petition, to the Board for final action. This conflict management section is limited to the matters noted above. It is not to be used to address any other issue, including, but not limited to, professional review actions concerning individual members of the Medical Staff.
ARTICLE XVIII

DUES

The Medical Staff may establish and collect annual dues from its Members. The Medical Executive Committee shall determine the amount of annual dues. Annual dues shall become due on January 1 of each year. Dues shall apply to all members of the Medical Staff. Physicians who are on a Leave of Absence are also required to pay dues. Only retired staff members are exempt. Members who have not paid their dues by the first of February shall be delinquent. Delinquent members shall be so notified by mail. If delinquent dues are not paid by the first of March, the Member shall be removed from the Medical Staff. Members removed from the Medical Staff may reapply for Staff privileges in the usual manner after delinquent dues have been paid.
ARTICLE XIX
CONFIDENTIALITY AND PEER REVIEW PROTECTION

A. Confidentiality

Actions taken and recommendations made pursuant to these Bylaws shall be strictly confidential. Individuals participating in, or subject to, credentialing and peer review activities shall make no disclosures of any such information (discussions or documentation) outside of peer review committee meetings, except:

(1) when the disclosures are to another authorized Member of the Medical Staff or authorized Hospital employee and are for the purpose of conducting legitimate credentialing and peer review activities;

(2) when the disclosures are authorized by a Medical Staff or Hospital policy;

(3) when the disclosures are authorized, in writing, by the Chief Executive Officer or by legal counsel to the Hospital.

Notwithstanding the above, the business of the medical staff excluding peer review, credentialing and certain possible specific issues, should be in the domain of record for members of the medical staff.

Any breach of confidentiality may result in a professional review action and/or appropriate legal action.

B. Peer Review Protection

All credentialing and peer review activities pursuant to these Bylaws and related Medical Staff documents shall be performed by “Peer Review Committees” in accordance with applicable state law. Peer review committees include, but are not limited to:

(1) all standing and ad hoc Medical Staff and Hospital committees;

(2) all departments and sections;

(3) hearing panels;

(4) the Board and its committees; and

(5) any individual acting for or on behalf of any such entity, including but not limited to department chiefs, section chiefs, committee chairpersons and members, officers of the Medical Staff, the VPMA, and experts or consultants retained to assist in peer review activities.
All reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and covered by the provisions of applicable state law. All peer review committees shall also be deemed to be “professional review bodies” as that term is defined in the Health Care Quality Improvement Act of 1986, 42 U.S.C. §11101 et seq.
ARTICLE XX

AMENDMENTS

These Bylaws may be amended in any of the following ways, with subsequent Board approval:

1. Amendments may be proposed by a petition signed by 50% plus 1 of the voting members of the Medical Staff, by the Bylaws Committee appointed by the President of the Medical Staff to conduct the annual review, or by the Medical Executive Committee. Amendments not proposed by the Medical Executive Committee shall first be reviewed by the Medical Executive Committee which may, at its discretion, provide a written report on them, either favorably or unfavorably.

2. The notice of the proposed amendments shall be given to members of the Active and Senior Active Medical staff together with a ballot to be signed and returned to the Medical Staff Office no later than thirty (30) days after the mailing of the proposed amendments. Said ballot may list the proposed amendments separately and may provide a method for voting favorably or unfavorably against each said proposed amendment separately. A majority of returned ballots shall be required for adoption of said amendments.

3. At any regular, special or annual meeting, written notice of the proposed amendments shall be mailed to all members of the Active and Senior Active Medical Staff not later than thirty (30) days prior to the Annual Staff meeting at which meeting said proposed amendments shall be accepted or rejected providing a quorum (25%) of Active and Senior Active members are present at said meeting. A majority of the said quorum approving said amendments shall be required for the adoption of said amendments.

The Medical Staff Bylaws shall be reviewed annually by a committee appointed by the President of the Medical Staff.
ARTICLE XXI

HISTORIES AND PHYSICALS

The patient receives a medical history and physical examination no more than 30 days prior to, or within 24 hours after, registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services.

For a medical history and physical examination that was completed within 30 days prior to registration or inpatient admission, an update documenting any changes in the patient’s condition is completed within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services.

A. History and Physical Exams for Non-Inpatient Services

A History and Physical will not be required for non-inpatient services except in the case of the necessity for extended recovery phase, overnight stay or ambulatory surgery requiring anesthesia care, or receives monitored anesthesia care, general anesthesia, regional anesthesia and/or moderate/or deep sedation as part of the procedure.

B. Content of the Record

a. The history shall include the complaint, history of present illness, past medical history, family and social history and review of systems.

b. The physical examination

c. Assessment

d. Plan of care/recommendation

C. An abbreviated History and Physical is acceptable in the outpatient areas of the hospital. The abbreviated History and Physical must include:

a. Chief complaint / present illness
b. Past history
c. Review of systems
d. Physical Examination including vital signs and heart and lung exam
e. Pre-procedure diagnoses
f. Plan
ARTICLE XXII

DISSOLUTION

In the event of dissolution, the residual assets of the organization will be turned over to one or more organizations which themselves are exempt as organizations as described in Sections 501C(3) and 170C(2) or the Internal Revenue Code of 1954, or corresponding sections of any prior or future law, or to the Federal, State or local government, located in Broward County, for medical, educational or other exclusive public purpose.

ADOPTED by the Active Medical Staff effective December 16, 2019.

ADOPTED by the Board of Directors effective January 27, 2020.

Jon Kojler, M.D.
President of the Medical Staff

John Cunha, D.O.
Secretary/Treasurer of the Medical Staff

Sr. JoAnne Courteen, R.S.M., Chair
Holy Cross Hospital Board of Directors