MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS OF ST. MARY’S HOSPITAL

MEDICAL STAFF BYLAWS

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APPENDIX A
ARTICLE 1

GENERAL

1.A. DEFINITIONS

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

(1) “ALLIED HEALTH PROFESSIONALS” (“AHPs”) means individuals other than Medical Staff members who are authorized by law and by the Hospital to provide patient care services.

(2) “BOARD” means the Board of Directors of the Hospital, which has the overall responsibility for the Hospital, or its designated committee.

(3) “CHIEF EXECUTIVE OFFICER” (“CEO”) means the individual appointed by the Board to act on its behalf in the overall management of the Hospital.

(4) “CHIEF MEDICAL OFFICER” (“CMO”) means the individual appointed to act as the chief medical officer of the Hospital. The Chief Medical Officer shall work in cooperation with the President of the Medical Staff.

(5) “CLINICAL PRIVILEGES” means the authorization granted by the Board to render specific patient care services, for which the Medical Staff leaders and Board have developed eligibility and other credentialing criteria and focused and ongoing professional practice evaluation standards.

(6) “DAYS” means calendar days.


(8) “HOSPITAL” means St. Mary’s Hospital.

(9) “MEDICAL EXECUTIVE COMMITTEE” or “MEC” means the Executive Committee of the Medical Staff.

(10) “MEDICAL STAFF” means all physicians, dentists, and podiatrists who have been appointed to the Medical Staff by the Board.

(11) “MEDICAL STAFF LEADER” means any Medical Staff Officer, department chief, and committee chair.

(12) “MEMBER” means any physician, dentist, and podiatrist who has been granted Medical Staff appointment and clinical privileges by the Board to practice at the Hospital.
(13) “NOTICE” means written communication by regular U.S. mail, e-mail, facsimile, Hospital mail, or hand delivery.

(14) “PATIENT CONTACT” includes any admission, consultation, procedure (inpatient or outpatient), or response to emergency call performed in the Hospital. It shall not include referrals for diagnostic or laboratory tests or x-rays.

(15) “PHYSICIAN” includes both doctors of medicine ("M.D.s") and doctors of osteopathy ("D.O.s").

(16) “PODIATRIST” means a doctor of podiatric medicine ("D.P.M.").

(17) “SPECIAL NOTICE” means hand delivery, certified mail (return receipt requested), or overnight delivery service providing receipt.

(18) “UNASSIGNED PATIENT” means any individual who comes to the Hospital for evaluation and/or treatment and either does not have an established relationship with a member of the Medical Staff or has no relationship with a member of the Medical Staff whose expertise is relevant to the patient’s presenting medical needs. (If patients’ established attending physician or designated alternate is unavailable to attend the patients, the patients will be considered “unassigned” for their immediate needs, but the reason for the attending physician’s unavailability must be evaluated by the Chief Medical Officer and, if necessary, the MEC.)

1.B. TIME LIMITS

Time limits referred to in these Bylaws are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

1.C. DELEGATION OF FUNCTIONS

(1) When a function is to be carried out by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to one or more designees.

(2) When a Medical Staff member is unavailable to perform a necessary function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

1.D. MEDICAL STAFF DUES

(1) Annual Medical Staff dues shall be as recommended by the MEC and may vary by category.
(2) Any Medical Staff member who attains the age of 65 may opt to not pay dues. However, upon doing so, such member shall not be eligible to vote, hold office, or accept Medical Staff committee assignments.

(3) Dues shall be payable every two years, at the time of reappointment. Failure to pay dues shall result in ineligibility to apply for Medical Staff reappointment.

(4) Signatories to the Hospital’s Medical Staff account shall be the Medical Staff Secretary-Treasurer and the Hospital’s Chief Financial Officer.
ARTICLE 2

CATEGORIES OF THE MEDICAL STAFF

2.A. ACTIVE STAFF

2.A.1. Qualifications:

The Active Staff shall consist of physicians, dentists, and podiatrists who:

(a) satisfy the qualifications for appointment to the Medical Staff as set forth in the Credentials Policy;

(b) regularly exercise clinical privileges at the Hospital on an inpatient and/or outpatient basis; and

(c) have indicated or demonstrated a willingness to assume all the responsibilities of membership on the Active Staff as outlined in Section 2.A.3.

Reappointment Considerations:

All members of the Medical Staff are responsible for demonstrating their current clinical competence for the privileges they request and their ability to provide safe, appropriate care. Members who are clinically active at St. Mary's Hospital are subject to the Hospital's ongoing and focused professional practice evaluations, the results of which assist the Medical Staff Leaders and the Board in determining competence at the time of reappointment.

For members who are not clinically active, the professional practice evaluation data is limited and additional information is necessary to facilitate the reappointment process. Therefore, any Active Staff member who has fewer than 24 patient contacts during his/her two-year appointment term must present the following information in order to be eligible to request reappointment to the Active Staff:

(i) two evaluations from other physicians who are personally knowledgeable about the member’s qualifications and competence, who are not members of the same group practice, and at least one of whom is clinically active at St. Mary’s Hospital. These physicians must complete the Confidential Physician Evaluation Form provided by the Hospital; and

(ii) such additional quality data and other information as may be requested by the Medical Staff Leaders or Hospital to assist in an appropriate assessment of current clinical competence and overall qualifications for reappointment and clinical privileges (including, but not limited to, information from another hospital, ambulatory surgery center or clinic, managed care organization(s) in which the individual participates, and/or the individual’s private office).
The member seeking reappointment to the Active Staff bears the responsibility and burden of ensuring that this information is provided to the Medical Staff Leaders and the Hospital in a timely manner. If this information is not provided in a timely manner, the member’s reappointment application shall be considered incomplete and shall not be processed. In that event, the member’s appointment and privileges will expire at the end of his/her appointment term.

2.A.2. Prerogatives:

Active Staff members may:

(a) admit and treat patients within the limits of their clinical privileges, except as may be otherwise provided in these Bylaws or the Bylaws-related documents, or as limited by the Board;

(b) vote in all general and special meetings of the Medical Staff, and applicable department and committee meetings; and

(c) hold office, serve as department chiefs, and serve on Medical Staff committees and as chairs of such committees.

2.A.3. Responsibilities:

Active Staff members must assume all the responsibilities of membership on the Active Staff, including:

(a) serving on committees, as may be requested by the President of the Medical Staff;

(b) providing specialty coverage for the Emergency Department;

(c) providing care for unassigned patients;

(d) participating in the evaluation of new members of the Medical Staff;

(e) participating in the professional practice evaluation and performance improvement processes (including constructive participation in the development of clinical practice protocols pertinent to their medical specialties);

(f) accepting inpatient consultations during those periods when the member is on call for the Emergency Department, as requested;

(g) paying application fees, dues, and assessments; and

(h) performing reasonable additional duties as may be assigned by the Medical Staff Leaders.
Members of the Active Staff who (i) attain the age of 60, (ii) attain the age of 55 and have provided at least 10 years of service call at the Hospital, or (iii) have provided at least 20 years of service call at the Hospital are no longer obligated to participate in the emergency service call roster. These individuals may continue to provide these services on a voluntary basis. Any individual who satisfies the above criteria and wishes to be removed from the call roster must provide at least 30 days’ advance written notice to the relevant department chief and to the Medical Staff Office.

2.B. CONSULTING STAFF

2.B.1. Qualifications:

The Consulting Staff shall consist of those physicians, dentists, and podiatrists who:

(a) are of demonstrated professional ability and expertise who provide a service not otherwise available on the Active Staff;

(b) are not required to satisfy the office and residence location requirements set forth in Section 2.A.1 of the Credentials Policy; and

(c) at each reappointment time, provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual’s office practice, information from managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians).

2.B.2. Prerogatives and Responsibilities:

Consulting Staff members:

(a) may independently admit and/or treat up to five patients per year at the Hospital;

(b) may also evaluate and treat patients in conjunction with another physician on the Medical Staff, as permitted by the policies and rules and regulations of the Medical Staff and Hospital;

(c) may not hold office or serve as department chiefs or committee chairs;

(d) may attend meetings of the Medical Staff (without vote) and applicable department meetings (without vote) and may be invited to serve on committees (with vote);

(e) are excused from emergency call;
(f) shall accept consultations when requested, including those involving unassigned patients;

(g) shall cooperate in the professional practice evaluation and performance improvement processes; and

(h) shall pay application fees, dues, and assessments.

2.C. AFFILIATE STAFF

2.C.1. Qualifications:

(a) The Affiliate Staff shall consist of those physicians, dentists, and podiatrists who desire to be associated with, but who do not intend to establish a practice at, this Hospital. It is a membership-only category, with no clinical privileges being granted. The primary purpose of the Affiliate Staff is to promote professional and educational opportunities, including continuing medical education, and to permit these individuals to access Hospital services for their patients by referral of patients to Active Staff members for admission and care.

(b) Individuals requesting appointment to the Affiliate Staff must submit an application as prescribed by the Credentials Policy. They shall not, however, be required to satisfy the qualifications set forth in Section 2.A.1(b), (c), (d), (k), (l), (m), (n), (o), (p), and (q) of the Credentials Policy.

2.C.2. Prerogatives and Responsibilities:

(a) Members of the Affiliate Staff:

(1) may attend meetings of the Medical Staff and applicable departments (all without vote);

(2) shall generally have no staff committee responsibilities, but may be assigned to committees (with vote);

(3) may attend educational activities of the Medical Staff and the Hospital;

(4) may refer patients to members of the Active Staff for admission and/or care;

(5) may review the medical records and test results (via paper or electronic access) for any patients who are referred;

(6) are encouraged to communicate with the Hospitalists and/or other Active Staff members about the care of any patients referred, and are encouraged to visit any patients who are hospitalized;
(7) may not: admit patients, attend patients, exercise any clinical privileges, write orders or progress notes, perform consultations, assist in surgery, make notations in the medical record, or otherwise participate in the provision or management of clinical care to patients at the Hospital;

(8) may refer patients to the Hospital’s diagnostic facilities subject to the rules and policies of the Hospital and the clinical departments; and

(9) are not required to pay any application fees, dues, or assessments.

(b) The grant of Affiliate Staff appointment is a courtesy only, which may be terminated by the Board upon recommendation of the MEC, with no right to a hearing or appeal.

2.D. EMERITUS STAFF

2.D.1. Qualifications:

(a) Medical Staff members who have retired from clinical practice shall be automatically advanced to the Emeritus Staff.

(b) Once an individual is appointed to the Emeritus Staff, that status is ongoing. As such, there is no need for the individual to submit a reappointment application/reappointment processing.

2.D.2. Prerogatives and Responsibilities:

Emeritus Staff members:

(a) are not eligible to admit patients or to exercise clinical privileges at the Hospital;

(b) may attend Medical Staff and department meetings (without vote);

(c) may be appointed to committees (with vote);

(d) are entitled to attend educational programs of the Medical Staff and Hospital;

(e) may not vote (except on any committee to which they may be appointed), hold office, or serve as a department chief or committee chair; and

(f) are not required to pay any application fees, dues, or assessments.
2.E. ACADEMIC AFFILIATE STAFF

2.E.1. Qualifications:

(a) The Academic Affiliate Staff shall consist of physicians, dentists, and podiatrists who are on the faculty of a medical school accredited by the Liaison Committee on Medical Education (the “Medical School”) and who are appointed by the Medical School to assist in teaching services to undergraduate medical students of the Medical School.

(b) Individuals requesting appointment to the Academic Affiliate Staff must submit an application as prescribed by the Credentials Policy. They shall not, however, be required to satisfy the qualifications set forth in Section 2.A.1(c), (d), (k), (l) or (n) of the Credentials Policy.

(c) An individual’s membership on the Academic Affiliate Staff shall automatically terminate in the event such individual ceases to be a faculty member at the Medical School.

(d) Membership of all Academic Affiliate Staff members will automatically terminate in the event the program affiliation agreement between the Medical School with which such Academic Affiliate Staff members serve as faculty and the Hospital expires or is terminated for any reason.

2.E.2. Prerogatives and Responsibilities:

Members of the Academic Affiliate Staff:

(a) may attend meetings of the Medical Staff and applicable departments by invitation only (all without vote);

(b) shall generally have no staff committee responsibilities, but may be assigned to committees (with vote);

(c) may not hold office or serve as department chiefs or committee chairs;

(d) may, with the consent of the patients and the relevant attending physicians, and subject to all the terms and conditions of the applicable program affiliation agreements, round on patients, obtain medical histories, perform physical examinations, review medical records of patients, and observe procedures including surgery, in each instance for the purpose of teaching students;

(e) may, and are actively encouraged to, provide verbal feedback to the relevant attending physicians (and may only provide verbal feedback to patients with the express prior consent of the relevant attending physicians on a case-by-case basis) regarding clinical issues that are pertinent to the patients involved in the teaching services they provide;
(f) may not: admit patients, serve as an attending physician, exercise any clinical privileges, write orders or progress notes, perform consultations, assist in surgery, make notations in the medical record, or otherwise participate in the provision or management of clinical care to patients; and

(g) shall pay application fees, dues, and assessments as shall be recommended by the Medical Executive Committee pursuant to Section 1.D.1.
ARTICLE 3

OFFICERS

3.A. DESIGNATION

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

3.B. ELIGIBILITY CRITERIA

Only those members of the Active Staff who satisfy the following criteria initially and continuously shall be eligible to serve as an officer of the Medical Staff, unless a waiver is granted by the Board in unusual circumstances after considering the recommendations of the MEC. They must:

(1) be appointed in good standing to the Active Staff;

(2) have no past or pending adverse recommendations concerning Medical Staff appointment or clinical privileges, and have never been removed from a committee for inappropriate conduct or activities;

(3) not presently be serving as a Medical Staff officer, department chief, or Board member at any other hospital, and shall not so serve during their term of office;

(4) be willing to faithfully discharge the duties and responsibilities of the position;

(5) have experience in a leadership position, or other involvement in performance improvement functions, for at least two years;

(6) attend continuing education relating to Medical Staff leadership and/or credentialing/peer review functions prior to or during the term of the office;

(7) have demonstrated an ability to work well with others; and

(8) not have any financial relationship (i.e., an ownership or investment interest in or compensation arrangement) with an entity that competes with the Hospital or any affiliate, in the discretion of the Hospital after consulting with the MEC. This does not apply to services provided within a practitioner’s office and billed under the same provider number used by the practitioner.
3.C. DUTIES

3.C.1. President of the Medical Staff:

The President of the Medical Staff shall:

(a) act in coordination and cooperation with the CMO, Hospital management, and nursing and other patient care services in matters of mutual concern involving the care of patients in the Hospital;

(b) represent and communicate the views, policies, and needs of the Medical Staff, and report on the activities of the Medical Staff to the CEO and the Board;

(c) receive and interpret the policies of the Board on the performance and maintenance of quality with respect to the Medical Staff’s delegated responsibility to provide medical care;

(d) be accountable to the Board, as the representative of the Medical Staff, for the quality and efficiency of clinical services and professional performance within the Hospital and for the effectiveness of the patient care audit and other quality assessment functions delegated to the staff;

(e) call, preside at, and be responsible for the agenda of all meetings of the Medical Staff and the MEC;

(f) appoint all committee chairs and committee members, in consultation with the MEC;

(g) chair the MEC (with vote, as necessary) and be a member of all other Medical Staff committees (ex officio, without vote);

(h) serve as an ex officio member of the Board;

(i) promote adherence to the Bylaws, policies, Rules and Regulations of the Medical Staff and to the Policies and Procedures of the Hospital;

(j) be responsible for meeting the Medical Staff’s requirements for accreditation in conjunction with the department chiefs, and report on accreditation status matters to the MEC, the Medical Staff and the Board;

(k) recommend Medical Staff representatives to Hospital committees;

(l) be responsible for the educational activities of the Medical Staff;

(m) perform all functions authorized in all applicable policies, including the collegial intervention steps outlined in the Credentials Policy; and
serve as the spokesperson for the Medical Staff in its external professional and public relations.

3.C.2. President-Elect:

The President-Elect shall:

(a) assume all duties of the President of the Medical Staff and act with full authority as President of the Medical Staff in his or her temporary absence or unavailability for any reason;

(b) serve on the Credentials Committee and the MEC;

(c) assume all such additional duties as are assigned to him or her by the President of the Medical Staff or the MEC; and

(d) become President of the Medical Staff upon completion of his/her term.

3.C.3. Immediate Past President:

The Immediate Past President shall:

(a) chair the Bylaws Committee and serve on the MEC; and

(b) assume all such additional duties as are assigned to him or her by the President of the Medical Staff or the MEC.

3.C.4. Secretary-Treasurer:

The Secretary-Treasurer shall:

(a) serve as a member of the MEC and the Bylaws Committee;

(b) serve on all other Medical Staff committees, ex officio, without vote;

(c) cause to be kept accurate and complete minutes of all MEC and Medical Staff meetings;

(d) call Medical Staff meetings on order of the President of the Medical Staff and record attendance;

(e) attend to all correspondence and perform such other duties as ordinarily pertain to the office of Secretary-Treasurer; and

(f) be responsible for the collection of, accounting for, and disbursements of any funds collected, donated, or otherwise assessed and present in the Medical Staff Fund and report to the Medical Staff.
3.D. NOMINATIONS

The President of the Medical Staff shall appoint a Nominating Committee consisting of at least three members of the Active Staff for all general and special elections. The Nominating Committee shall include at least one Past President of the Medical Staff. The Committee shall convene at least 45 days prior to the election and shall submit to the President of the Medical Staff the names of one or more qualified nominees for each office and for two at-large members of the MEC. Notice of the nominees shall be provided to each voting member of the Medical Staff and shall also be posted on the Medical Staff bulletin board at least 30 days prior to the election. Nominations may also be submitted in writing by petition signed by at least 10% of the Active Staff members at least 10 days prior to the election. In order for a nomination to be placed on the ballot, the candidate must meet the qualifications in Section 3.B, in the judgment of the Nominating Committee, and be willing to serve. Nominations from the floor shall not be accepted.

3.E. ELECTION

(1) Only Active Staff are eligible to vote. The vote shall be by written secret ballot at a general or special Medical Staff meeting. Those who receive a majority of the votes cast by the Active Staff members shall be elected. The election of each officer shall then become effective as soon as confirmed by the Board. Each officer shall then serve from the start of the next Medical Staff year for a term of two years or until a successor has been elected and that election has been confirmed by the Board.

(2) In the alternative, at the discretion of the MEC, the election shall be held solely by written ballot returned to the Medical Staff Office. Ballots may be returned in person, by mail, by facsimile, or by e-mail ballot. All ballots must be received in the Medical Staff Office by the day of the election. Those who received a majority of the votes cast by the Active Staff members shall be elected as soon as confirmed by the Board.

3.F. TERM OF OFFICE

Officers shall serve for a term of two years or until a successor is elected.

3.G. REMOVAL

(1) Removal of an elected officer and/or an MEC member may be effectuated by a two-thirds vote of the MEC, by a majority vote of all Active Staff members of the Medical Staff, or by the Board. Grounds for removal shall be:

   (a) failure to comply with applicable policies, Bylaws, or Rules and Regulations;

   (b) failure to continue to satisfy any of the criteria in Section 3.B of these Bylaws;

   (c) failure to perform the duties of the position held;
(d) conduct detrimental to the interests of the Hospital and/or its Medical Staff; or

(e) an infirmity that renders the individual incapable of fulfilling the duties of that office.

(2) At least 10 days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action is to be considered. The individual shall be afforded an opportunity to speak to the MEC, Active Staff members, or the Board, as applicable, prior to a vote on removal.

3.H. VACANCIES

A vacancy in the office of President of the Medical Staff shall be filled by the President-Elect, who shall serve until the end of the President of the Medical Staff’s unexpired term and the term as President to which he has already been elected. A vacancy in the office of President-Elect shall be filled by a special election conducted as soon after the vacancy occurs as practicable, following the procedure provided in Sections 3.D and 3.E. A vacancy in the office of Immediate Past President shall not be filled prior to the next annual meeting. A vacancy in the office of Secretary-Treasurer shall be filled by the MEC for a period extending to the end of the current Medical Staff year.
ARTICLE 4

STAFF DEPARTMENTS

4.A. ORGANIZATION

(1) The Medical Staff shall be organized into the departments as listed in the Organization Manual.

(2) Subject to the approval of the Board, the MEC may create new departments, eliminate departments, create sections within departments, or otherwise reorganize the department structure.

4.B. ASSIGNMENT TO DEPARTMENT

(1) Upon initial appointment to the Medical Staff, each member shall be assigned to a clinical department. Assignment to a particular department does not preclude an individual from seeking and being granted clinical privileges typically associated with another department.

(2) An individual may request a change in department assignment to reflect a change in the individual’s clinical practice.

4.C. FUNCTIONS OF DEPARTMENTS

The departments shall be organized for the purpose of implementing processes (i) to monitor and evaluate the quality and appropriateness of the care of patients served by the departments, and (ii) to monitor the practice of all those with clinical privileges in a given department. Each department shall also assure appropriate emergency call coverage, consistent with the provisions in these Bylaws and related documents.

4.D. QUALIFICATIONS OF DEPARTMENT CHIEFS

Each department chief shall:

(1) be an Active Staff member;

(2) be certified by an appropriate specialty board or possess comparable competence, as determined through the credentialing and privileging process; and

(3) satisfy the eligibility criteria in Section 3.B, unless waived by the Board after considering the recommendations of the MEC.
4.E. APPOINTMENT AND REMOVAL OF DEPARTMENT CHIEFS

(1) Except as otherwise provided by contract, department chiefs shall be elected by the Active Staff members of the department, subject to Board confirmation. The election shall be held prior to the beginning of the new Medical Staff year. Those who receive a majority of the votes shall be elected.

(2) Any department chief may be removed by a two-thirds vote of the Active Staff members of the department; or by a two-thirds vote of the MEC; or by the Board, after reasonable notice and opportunity to be heard. Grounds for removal shall be:

(a) failure to comply with applicable policies, Bylaws, or Rules and Regulations;

(b) failure to continue to satisfy any of the criteria in Section 3.B of these Bylaws;

(c) failure to perform the duties of the position held;

(d) conduct detrimental to the interests of the Hospital and/or its Medical Staff; or

(e) an infirmity that renders the individual incapable of fulfilling the duties of that office.

(3) Prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which such action shall be taken at least 10 days prior to the date of the meeting. The individual shall be afforded an opportunity to speak to the department, the MEC, or the Board, as applicable, prior to a vote on such removal.

(4) Department chiefs shall be elected for a term of two years, and there is no limitation on the number of terms they may serve.

4.F. DUTIES OF DEPARTMENT CHIEFS

Each department chief is responsible for the following functions, either personally or in collaboration with Hospital personnel:

(1) all clinically-related activities of the department;

(2) all administratively-related activities of the department;

(3) continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges;

(4) recommending criteria for clinical privileges that are relevant to the care provided in the department;

(5) evaluating requests for clinical privileges for each member of the department;
(6) assessing and recommending off-site sources for needed patient care, treatment, and services not provided by the department or the Hospital;

(7) the integration of the department into the primary functions of the Hospital;

(8) the coordination and integration of interdepartmental and intradepartmental services;

(9) the development and implementation of policies and procedures that guide and support the provision of care, treatment, and services in the department;

(10) recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services;

(11) determination of the qualifications and competence of department personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;

(12) continuous assessment and improvement of the quality of care, treatment, and services provided;

(13) maintenance of quality monitoring programs, as appropriate;

(14) the orientation and continuing education of all persons in the department;

(15) recommendations for space and other resources needed by the department; and

(16) performing all functions authorized in the Credentials Policy, including collegial intervention.
ARTICLE 5

MEDICAL STAFF COMMITTEES AND
PERFORMANCE IMPROVEMENT FUNCTIONS

5.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

This Article and the Medical Staff Organization Manual outline the Medical Staff committees that carry out ongoing and focused professional practice evaluations and other performance improvement functions that are delegated to the Medical Staff by the Board.

5.B. APPOINTMENT OF COMMITTEE CHAIRS AND MEMBERS

(1) All committee chairs and members shall be appointed by the President of the Medical Staff, in consultation with the MEC. Committee chairs shall be selected based on the criteria set forth in Section 3.B of these Bylaws.

(2) Committee chairs and members shall be appointed for initial terms of two years, but may be reappointed for additional terms. All appointed chairs and members may be removed and vacancies filled by the President of the Medical Staff at his/her discretion.

(3) Unless otherwise provided, all Hospital and administrative representatives on the committees shall be appointed by the CEO. All such representatives shall serve on the committees, without vote.

(4) The President of the Medical Staff, the CMO, and the CEO (or their respective designees) shall be members, *ex officio*, without vote, on all committees.

5.C. MEETINGS, REPORTS AND RECOMMENDATIONS

Unless otherwise indicated, each committee described in these Bylaws or in the Medical Staff Organization Manual shall meet as necessary to accomplish its functions, and shall maintain a permanent record of its findings, proceedings, and actions. Each committee shall make a timely written report after each meeting to the MEC and to other committees and individuals as may be indicated.

5.D. MEDICAL EXECUTIVE COMMITTEE

5.D.1. Composition:

(a) The MEC shall include the President of the Medical Staff, the President-Elect, the Immediate Past President, the Secretary-Treasurer, the department chiefs, the Medical Director of the hospitalist program, the Medical Director of the Catheterization Lab, the Medical Director of pulmonary/critical care services, and two other Active Staff members elected at large. If a department chief is unable to attend a meeting, he/she
may designate another member of the department to attend in his/her place; however, the designated member (i) must sign an appropriate confidentiality agreement prior to participating, and (ii) may not vote on action items discussed at the meeting.

(b) As may be necessary in order to effectively fulfill its responsibilities, the MEC may add *ex officio* members to the Committee who will serve without vote and/or invite guests to selected meetings to participate in the discussion.

(c) The President of the Medical Staff will chair the MEC.

(d) The CEO shall be an *ex officio* member of the MEC, without vote.

5.D.2. Duties:

The MEC is delegated the primary authority over activities related to the functions of the Medical Staff and performance improvement activities regarding the professional services provided by individuals with clinical privileges. The MEC is responsible for the following:

(a) acting on behalf of the Medical Staff in the intervals between Medical Staff meetings (the officers are empowered to act in urgent situations between MEC meetings);

(b) providing liaison between the Medical Staff, the CEO, and the Board;

(c) recommending directly to the Board on at least the following:

   (1) the Medical Staff’s structure;

   (2) the mechanism used to review credentials and to delineate individual clinical privileges;

   (3) applicants for Medical Staff appointment and reappointment;

   (4) the delineation of clinical privileges for each eligible applicant;

   (5) participation of the Medical Staff in Hospital performance improvement activities and the quality of professional services being provided by the Medical Staff;

   (6) the mechanism by which Medical Staff appointment may be terminated;

   (7) hearing procedures; and

   (8) other appropriate reports and recommendations that the MEC has received from Medical Staff committees, departments, and other groups;
(d) consulting with administration on quality-related aspects of contracts for patient care services;

(e) making appropriate recommendations for improvement when there are variances from established or expected clinical practice patterns;

(f) reviewing (or delegating the review of) quality indicators to ensure uniformity regarding patient care services;

(g) providing leadership in activities related to patient safety;

(h) providing oversight in the process of analyzing and improving patient satisfaction;

(i) prioritizing continuing medical education activities;

(j) participating in identifying community health needs and in setting Hospital goals and implementing programs to meet those needs;

(k) informing the staff of the Joint Commission accreditation program and of the accreditation status of the Hospital, and causing staff members to be actively involved in the accreditation process, including participation in the survey and summation conference;

(l) coordinating the activities and general policies of the various departments and committees;

(m) reviewing, at least every three years, the Bylaws, policies, Rules and Regulations, and associated documents of the Medical Staff and recommending such changes as may be necessary or desirable; and

(n) performing such other functions as are assigned to it by these Bylaws, the Credentials Policy, or other applicable policies.

5.D.3. Meetings:

The MEC shall meet monthly and maintain a permanent record of its proceedings and actions.

5.E. PERFORMANCE IMPROVEMENT FUNCTIONS

(1) The Medical Staff is actively involved in the measurement, assessment, and improvement of at least the following:

(a) patient safety, including processes to respond to patient safety alerts, meet patient safety goals, and reduce patient safety risks;
(b) the Hospital’s and individual practitioners’ performance on Joint Commission and Centers for Medicare & Medicaid Services ("CMS") core measures;

(c) medical assessment and treatment of patients;

(d) medication usage, including review of significant adverse drug reactions, medication errors and the use of experimental drugs and procedures;

(e) the utilization of blood and blood components, including review of significant transfusion reactions;

(f) operative and other procedures, including tissue review and review of discrepancies between pre-operative and post-operative diagnoses;

(g) appropriateness of clinical practice patterns;

(h) significant departures from established patterns of clinical practice;

(i) use of information about adverse privileging determinations regarding any practitioner;

(j) the use of developed criteria for autopsies;

(k) sentinel events, including root cause analyses and responses to unanticipated adverse events;

(l) nosocomial infections and the potential for infection;

(m) unnecessary procedures or treatment;

(n) appropriate resource utilization;

(o) education of patients and families;

(p) coordination of care, treatment, and services with other practitioners and Hospital personnel;

(q) accurate, timely, and legible completion of medical records;

(r) the required content and quality of history and physical examinations, as well as the time frames required for completion, all of which are set forth in Appendix A to these Bylaws;

(s) review of findings from the ongoing and focused professional practice evaluation activities that are relevant to an individual’s performance; and
communication of findings, conclusions, recommendations, and actions to improve performance to appropriate Medical Staff members and the Board.

A description of the committees that carry out systematic monitoring and performance improvement functions, including their composition, duties, and reporting requirements, is contained in the Medical Staff Organization Manual.

5.F. CREATION OF STANDING COMMITTEES

In accordance with the amendment provisions in the Medical Staff Organization Manual, the MEC may, by resolution and upon approval of the Board and without amendment of these Bylaws, establish additional committees to perform one or more staff functions. In the same manner, the MEC may dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical Staff functions. Any function required to be performed by these Bylaws which is not assigned to an individual, a standing committee, or a special committee shall be performed by the MEC.

5.G. SPECIAL COMMITTEES

Special committees shall be created and their members and chairs shall be appointed by the President of the Medical Staff or the MEC. Such special committees shall confine their activities to the purpose for which they were appointed and shall report to the MEC.
ARTICLE 6

MEETINGS

6.A. MEDICAL STAFF YEAR

The Medical Staff year is January 1 to December 31.

6.B. MEDICAL STAFF MEETINGS

6.B.1. Regular Meetings:

The Medical Staff shall meet at least one time per Medical Staff year, with this meeting being designated as the Annual Meeting.

6.B.2. Special Meetings:

Special meetings of the Medical Staff may be called by the President of the Medical Staff, the MEC, the CMO, the Board, or by a petition signed by not less than one-fourth of the Active Staff.

6.C. DEPARTMENT AND COMMITTEE MEETINGS

6.C.1. Regular Meetings:

Except as otherwise provided in these Bylaws or in the Medical Staff Organization Manual, each department and committee shall meet as necessary to accomplish its functions, at times set by the presiding officer.

6.C.2. Special Meetings:

A special meeting of any department or committee may be called by or at the request of the presiding officer, the President of the Medical Staff, the CMO, the Board, or by a petition signed by not less than one-third of the Active Staff members of the department or committee, but not by fewer than two members.

6.D. PROVISIONS COMMON TO ALL MEETINGS

6.D.1. Notice of Meetings:

(a) Medical Staff members shall annually be provided a schedule of all regular meetings of the Medical Staff and regular meetings of departments and committees, and no notice other than such schedule shall be required for regular meetings.
(b) When a special meeting of the Medical Staff, a department, and/or a committee is called, the notice shall be provided by mail, e-mail, or personal delivery at least 48 hours prior to the special meeting.

(c) The attendance of any individual at any meeting shall constitute a waiver of that individual’s objection to the notice given for the meeting.

6.D.2. Quorum, Agenda, and Voting:

(a) For any regular or special meeting of the Medical Staff, department, or committee, those Active Staff members present (but in no event fewer than two members) shall constitute a quorum. Exceptions to this general rule are as follows:

1. for meetings of the MEC and the Credentials Committee, the presence of at least 50% of the Active Staff members of the Committee shall constitute a quorum; and

2. for amendments to the Medical Staff Bylaws, at least 10% of the Active Staff members shall constitute a quorum.

(b) The presiding officer for the meeting shall set the agenda for any regular or special meeting of the Medical Staff, department, or committee. Action may be taken only on those items noted on the agenda. Any new item must be either deferred to the next meeting or presented to the voting members in accordance with paragraph (d) of this section.

(c) Recommendations and actions of the Medical Staff, departments, and committees shall be by consensus. In the event it is necessary to vote on an issue, that issue will be determined by a majority vote of those individuals present.

(d) As an alternative to a formal meeting, the Active Staff members of the Medical Staff, a department, or a committee may also be presented with a question by mail, facsimile, e-mail, hand-delivery, or telephone, and their votes returned to the presiding officer by the method designated in the notice. Except for amendments to these Bylaws and actions by the MEC or Credentials Committee (as noted in (a)), a quorum for purposes of these votes shall be the number of responses returned to the presiding officer by the date indicated. The question raised shall be determined in the affirmative if a majority of the responses returned has so indicated.

(e) Meetings may be conducted by telephone conference.

(f) Any individual who, by virtue of position, attends a meeting in more than one capacity shall be entitled to only one vote. There shall be no proxy voting.

Robert’s Rules of Order shall not be binding at meetings or elections, but may be used for reference at the discretion of the presiding officer for the meeting. Rather, specific provisions of these Bylaws, and Medical Staff, department, or committee custom, shall prevail at all meetings, and the presiding officer shall have the authority to rule definitively on all matters of procedure.

6.D.4. Minutes, Reports, and Recommendations:

(a) Minutes of all meetings of the Medical Staff, departments, and committees shall be prepared and shall include a record of the attendance of members and the recommendations made and the votes taken on each matter. The minutes shall be authenticated by the presiding officer.

(b) A summary of all recommendations and actions of the Medical Staff, departments, and committees shall be transmitted to the MEC and the CEO. The Board shall be kept apprised of the recommendations of the Medical Staff and its departments and committees.

(c) A permanent file of the minutes of all meetings shall be maintained by the Hospital.

6.D.5. Confidentiality:

(a) Members of the Medical Staff who have access to credentialing and/or peer review information agree to maintain the confidentiality of this information. Credentialing and peer review documents, and information contained therein, must not be disclosed to any individual not involved in the credentialing or peer review processes.

(b) A breach of confidentiality may result in any or all of the following:

(1) dismissal from committee assignment and/or Medical Staff leadership position;

(2) loss of available legal protections (including loss of indemnification for any litigation costs and expenses);

(3) disciplinary action as deemed appropriate by the MEC pursuant to the Medical Staff Credentials Policy; and/or

(4) other appropriate legal action.

6.D.6. Attendance Requirements:

Each Active Staff member is expected to attend and participate in all Medical Staff meetings and applicable department and committee meetings each year.
ARTICLE 7

INDEMNIFICATION

The Hospital shall provide a legal defense for, and shall indemnify, all Medical Staff officers, department chiefs, committee chairs, committee members, and authorized representatives when acting in those capacities, to the fullest extent permitted by the Hospital’s corporate bylaws.
ARTICLE 8

BASIC STEPS AND DETAILS

The details associated with the following Basic Steps are contained in the Credentials Policy and the Policy on Allied Health Professionals in a more expansive form.

8.A. QUALIFICATIONS FOR APPOINTMENT

To be eligible to apply for initial appointment or reappointment to the Medical Staff or for the grant of clinical privileges, an applicant must demonstrate appropriate education, training, experience, current clinical competence, professional conduct, and ability to safely and competently perform the clinical privileges requested, as set forth in the Credentials Policy and the Policy on Allied Health Professionals.

8.B. PROCESS FOR PRIVILEGING AND CREDENTIALING (APPOINTMENT AND REAPPOINTMENT)

Complete applications are transmitted to the applicable department chief, who prepares a written report to the Credentials Committee (and AHP Committee where applicable). That Committee(s) then prepares a recommendation and forwards it, along with the department chief’s report, to the MEC for review and recommendation, and to the Board for final action.

8.C. INDICATIONS AND PROCESS FOR AUTOMATIC RELINQUISHMENT OF APPOINTMENT AND/OR PRIVILEGES

(1) Appointment and clinical privileges may be automatically relinquished if an individual:

(a) fails to do any of the following:

(i) timely complete medical records;

(ii) satisfy threshold eligibility criteria;

(iii) provide requested information;

(iv) attend a special conference to discuss issues or concerns;

(b) is involved or alleged to be involved in defined criminal activity; or

(c) makes a misstatement or omission on an application form.

(2) Automatic relinquishment will take effect immediately and will continue until the matter is resolved, if applicable.
8.D. INDICATIONS AND PROCESS FOR PRECAUTIONARY SUSPENSION

(1) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the President of the Medical Staff, the chief of a clinical department, the CMO, the CEO, or the MEC is authorized to suspend or restrict all or any portion of an individual’s clinical privileges pending an investigation.

(2) A precautionary suspension is effective immediately and will remain in effect unless it is modified by the CEO or MEC.

(3) The individual shall be provided a brief written description of the reason(s) for the precautionary suspension.

(4) The MEC will review the reasons for the suspension within a reasonable time.

(5) Prior to, or as part of, this review, the individual will be given an opportunity to meet with the MEC.

8.E. INDICATIONS AND PROCESS FOR RECOMMENDING TERMINATION OR SUSPENSION OF APPOINTMENT AND PRIVILEGES OR REDUCTION OF PRIVILEGES

Following an investigation, the MEC may recommend suspension or revocation of appointment or clinical privileges based on concerns about (a) the clinical competence or clinical practice of any member of the Medical Staff, including the care, treatment or management of a patient or patients; (b) the known or suspected violation by any member of the Medical Staff of applicable ethical standards or the Bylaws, policies, Rules and Regulations of the Hospital or the Medical Staff; or (c) conduct by any member of the Medical Staff that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff, including the inability of the member to work harmoniously with others.

8.F. HEARING AND APPEAL PROCESS, INCLUDING PROCESS FOR SCHEDULING AND CONDUCTING HEARINGS AND THE COMPOSITION OF THE HEARING PANEL

(1) The hearing will begin no sooner than 30 days after the notice of the hearing, unless an earlier date is agreed upon by the parties.

(2) The Hearing Panel will consist of at least three members or there will be a Hearing Officer.

(3) The hearing process will be conducted in an informal manner; formal rules of evidence or procedure will not apply.

(4) A stenographic reporter will be present to make a record of the hearing.
Both sides will have the following rights, subject to reasonable limits determined by the Presiding Officer: (a) to call and examine witnesses, to the extent they are available and willing to testify; (b) to introduce exhibits; (c) to cross-examine any witness on any matter relevant to the issues; (d) to have representation by counsel who may call, examine, and cross-examine witnesses and present the case; and (e) to submit proposed findings, conclusions, and recommendations to the Hearing Panel.

The personal presence of the affected individual is mandatory. If the individual who requested the hearing does not testify, he or she may be called and questioned.

The Hearing Panel (or Hearing Officer) may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

The affected individual and the MEC may request an appeal of the recommendations of the Hearing Panel (or Hearing Officer) to the Board.
ARTICLE 9

AMENDMENTS

9.A. MEDICAL STAFF BYLAWS

(1) Neither the Medical Staff nor the Board may unilaterally amend these Medical Staff Bylaws.

(2) Amendments to these Bylaws may be proposed by the Bylaws Committee, by the MEC, or by a petition signed by at least 25% of the members of the Active Staff.

(3) All proposed amendments must be reviewed by the MEC prior to a vote by the Medical Staff. The MEC may, in its discretion, provide a report on them either favorably or unfavorably at the next regular meeting of the Medical Staff, or at a special meeting of the Medical Staff called for such purpose. The proposed amendments may be voted upon at any meeting if notice has been provided at least 14 days prior to the meeting. To be adopted, (i) a quorum of at least 10% of the Active Staff must be present at the Meeting, and (ii) the amendment must receive a majority of the votes cast by the Active Staff members at the Meeting.

(4) As an alternative to a formal meeting, the MEC may also present proposed amendments to the Active Staff by mail ballot, facsimile, or e-mail, to be returned to the Medical Staff Office by the date indicated by the MEC (which date may not be sooner than 14 days from the date of the notice). Along with the proposed amendments, the MEC may, in its discretion, provide a written report on them either favorably or unfavorably. To be adopted, (i) the amendment must be voted on by at least 10% of the Active Staff, and (ii) the amendment must receive a majority of the votes cast by the Active Staff members.

(5) The MEC shall have the power to adopt technical, non-substantive amendments to these Bylaws, which are needed because of reorganization, renumbering, or punctuation, spelling, or other errors of grammar or expression.

(6) All amendments shall be effective only after approval by the Board.

(7) If the Board has determined not to accept a recommendation submitted to it by the MEC or the Medical Staff, the MEC may request a conference between the officers of the Board and the officers of the Medical Staff. Such conference shall be for the purpose of further communicating the Board’s rationale for its contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the recommendation. Such a conference will be scheduled by the CEO within two weeks after receipt of a request for same submitted by the President of the Medical Staff.
9.B. OTHER MEDICAL STAFF DOCUMENTS

(1) In addition to the Medical Staff Bylaws, there shall be policies, procedures and rules and regulations that shall be applicable to all members of the Medical Staff and other individuals who have been granted clinical privileges or a scope of practice. All Medical Staff policies, procedures and rules and regulations shall be considered an integral part of the Medical Staff Bylaws, and shall be amended in accordance with this section.

(2) The Credentials Policy addresses the following matters: qualifications for appointment, the process for granting initial appointment, clinical privileges, reappointment, collegial intervention, the investigation process, automatic relinquishments, precautionary suspensions, and the process for hearings and appeals.

(3) The Medical Staff Organization Manual lists the departments of the Medical Staff. The Medical Staff Organization Manual also contains a description of the committees of the Medical Staff.

(4) The Policy on Allied Health Professionals addresses the following matters as they relate to allied health professionals: process for determining need for new allied health professionals, qualifications for appointment, the process for granting clinical privileges or a scope of practice initially and on an ongoing basis, collegial intervention, investigations and suspensions, and procedural rights.

(5) An amendment to the Credentials Policy or the Policy on Allied Health Professionals may be made by a majority vote of the members of the MEC, provided that the written recommendations of the Credentials Committee (and the AHP Committee where applicable) concerning the proposed amendments shall have first been received and reviewed by the MEC. Notice of all proposed amendments to these two documents shall also be provided to each Active Staff member of the Medical Staff at least 14 days prior to the vote by the MEC, and any such member may submit written comments on the amendments to the MEC. In addition, any Active Staff member may personally address the MEC concerning the proposed amendments, provided this individual notifies the President of the Medical Staff of this request at least two days prior to the meeting.

(6) An amendment to the Medical Staff Organization Manual or the Medical Staff Rules and Regulations may be made by a majority vote of the members of the MEC. Notice of all proposed amendments to these two documents shall be provided to each Active Staff member of the Medical Staff at least 14 days prior to the vote by the MEC, and any such member may submit written comments on the amendments to the MEC. In addition, any Active Staff member may personally address the MEC concerning the proposed amendments, provided this individual notifies the President of the Medical Staff of this request at least two days prior to the meeting.

(7) All other policies of the Medical Staff may be adopted and amended by a majority vote of the MEC. No prior notice is required.
(8) Amendments to Medical Staff policies and to the Rules and Regulations may also be proposed by a petition signed by at least 25% of the Active Staff. Any such proposed amendments will be reviewed by the MEC, which may comment on the amendments before they are forwarded to the Board for its final action.

(9) Adoption of and changes to the Credentials Policy, the Policy on Allied Health Professionals, the Medical Staff Organization Manual, the Medical Staff Rules and Regulations, and other Medical Staff policies will become effective only when approved by the Board.

(10) The present Medical Staff Rules and Regulations are hereby readopted and placed into effect insofar as they are consistent with these Bylaws, until such time as they are amended in accordance with the terms of these Bylaws. To the extent any present Rule or Regulation is inconsistent with these Bylaws, it is of no force or effect.

9.C. CONFLICT MANAGEMENT PROCESS

(1) When there is a conflict between the Medical Staff and the MEC with regard to:

(a) proposed amendments to the Medical Staff Rules and Regulations,

(b) a new policy proposed by the MEC, or

(c) proposed amendments to an existing policy that is under the authority of the MEC,

a special meeting of the Medical Staff to discuss the conflict may be called by a petition signed by at least 25% of the Active Staff. The agenda for that meeting will be limited to attempting to resolve the differences that exist with respect to the amendment(s) or policy at issue.

(2) If the differences cannot be resolved at the meeting, the MEC shall forward its recommendations, along with the proposed recommendations pertaining to the amendment or policy at issue offered by the members of the Active Staff, to the Board for final action.

(3) 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.

(4) Nothing in this section is intended to prevent individual Medical Staff members from communicating positions or concerns related to the adoption of, or amendments to, the Medical Staff Rules and Regulations or other Medical Staff policies directly to the Board. Communication from Medical Staff members to the Board will be directed through the CEO, who will forward the request for communication to the Chair of the Board. The
CEO will also provide notification to the MEC by informing the President of the Medical Staff of all such exchanges. The Chair of the Board will determine the manner and method of the Board’s response to the Medical Staff member(s).
ARTICLE 10

ADOPTION

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

Originally adopted by the Medical Staff: December 29, 2006
Revisions Adopted: October 16, 2007
Revisions Adopted: March 8, 2010
Revisions Adopted: February 28, 2011
Revisions Adopted: May 31, 2011
Revisions Adopted: October 7, 2011
Revisions Adopted: November 1, 2012
Reviewed & Accepted As Is: November 10, 2015
Revisions Adopted: November 3, 2016
Reviewed & Accepted As Is: December 11, 2018
Reviewed & Accepted As Is: December 14, 2021

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Revisions Approved: October 31, 2007
Revisions Approved: March 31, 2010
Revisions Approved: March 29, 2011
Revisions Approved: June 28, 2011
Revisions Approved: October 25, 2011
Revisions Approved: November 27, 2012
Reviewed & Accepted As Is: November 19, 2015
Revisions Approved: November 29, 2016
Reviewed & Accepted As Is: December 21, 2018
Reviewed & Accepted As Is: December 21, 2021
APPENDIX A

HISTORY AND PHYSICAL EXAMINATIONS

(1) A medical history and physical examination must be performed and documented in the patient’s medical record within 24 hours after admission or registration (but in all cases prior to surgery or an invasive procedure requiring anesthesia services) by an individual who has been granted privileges by the Hospital to perform histories and physicals. The scope of the medical history and physical examination will include:

(a) patient identification;

(b) chief complaint;

(c) history of present illness;

(d) review of systems, to include at a minimum:
   
   (i) cardiovascular;

   (ii) respiratory; and

   (iii) gastrointestinal;

(e) personal medical history, including medications and allergies;

(f) physical examination, to include pertinent findings in those organ systems relevant to the presenting illness and to co-existing diagnoses;

(g) data reviewed;

(h) assessments, including problem list;

(i) plan of treatment;

The medical history and physical examination may include, if appropriate, the following:

(j) family medical history;

(k) social history, including any abuse or neglect; and

(l) if applicable, signs of abuse, neglect, addiction or emotional/behavioral disorder, which will be specifically documented in the physical examination and any need for restraint or seclusion will be documented in the plan of treatment.
In the case of a pediatric patient, the history and physical examination report must also include: (i) developmental age; (ii) length or height; (iii) weight; (iv) head circumference (if appropriate); and (v) immunization status.

(2) If a medical history and physical examination has been completed within the 30-day period prior to admission or registration, a durable, legible copy of this report may be used in the patient’s medical record, provided that the patient has been reassessed within 24 hours of the time of admission/registration or prior to surgery/invasive procedure, whichever comes first. The update of the history and physical examination must reflect any changes in the patient’s condition since the date of the original history and physical or state that there have been no changes in the patient’s condition.

(3) When the history and physical examination is not performed or recorded in the medical record before a surgical, diagnostic operative or invasive procedure, the operation or procedure will be canceled unless the attending physician states in writing that an emergency situation exists. If it is an emergency situation and a history and physical has been dictated but has not been transcribed, there will be a statement to that effect in the patient’s chart, with an admission note by the attending physician. The admission note must be documented immediately prior to surgery (same day as surgery) and will include, at a minimum, an assessment of the patient’s heart rate, respiratory rate and blood pressure.

(4) A Short-Form history and physical may be used for ambulatory or same day procedures. The Short-Form shall include, unless otherwise required by applicable state or federal law or agency regulations, at least the following:

(a) relevant history of the present illness or injury;
(b) any medical disorders;
(c) regular medications taken by the patient;
(d) any known allergies;
(e) findings of physical examination; and
(f) diagnosis and planned procedure.

(5) The current obstetrical record will include a complete prenatal record. The prenatal record may be a legible copy of the admitting physician’s office record transferred to the Hospital before admission. An interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.