

# MERCYONE NEWTON MEDICAL CENTER

## MEDICAL STAFF

## BYLAWS

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## PREAMBLE

These Medical Staff Bylaws, which originate with the Medical Staff, are adopted in order to provide for the organization of the Medical Staff of MercyOne Newton Medical Center (the “Hospital”) and to provide a framework for self-governance of the Medical Staff in order to permit the Medical Staff to discharge its responsibilities in matters involving the quality of medical care, and to govern the orderly resolution of those purposes. These Bylaws provide the professional and legal structure for Medical Staff operations, Medical Staff relations with the Board (as hereinafter defined) as an interrelated component of the Hospital, and relations with applicants and Members. These Bylaws, as adopted or amended, create a system of mutual rights and responsibilities between Members and the Hospital, and are subject to the corporate authority of the Board in those matters where the Board has ultimate legal responsibility.

## 1. DEFINITIONS AND GENERAL PROVISIONS

As used throughout these Bylaws and the Rules and Regulations, the following terms shall have the following meanings:

- 1.1 **Adverse Action** or **Adversely Affect** or **Adverse Affect** means reducing, restricting, suspending, revoking, denying or failing to grant or renew Medical Staff Appointment or Clinical Privileges.
- 1.2 **Advance Practice Clinicians or APC** means an individual, other than a licensed physician, who exercises independent judgment within the areas of his/her professional competence and the limits established by the Board of Directors, the Medical Staff and the applicable State Practice Acts. APCs are eligible for certain Medical Staff membership or privileges in accordance with these Bylaws and may be eligible to exercise practice privileges and prerogatives in conformity with these Bylaws and the Rules and Regulations.
- 1.3 **Appeal** means review of the findings and actions preceding the Appeal, by an appellate review panel, following a Hearing if the Hearing decision has an Adverse Affect on the Member.
- 1.4 **Board or Board of Directors** means the Board of Directors of MercyOne Newton Medical Center.
- 1.5 **Bylaws** means these Bylaws of the Medical Staff, as they may be amended from time to time.
- 1.6 **Clinical Privileges or Privileges** refers to permission granted by the Board, acting upon MEC recommendations, to Practitioners to render specific types of care to inpatients and outpatients, with reasonable access to and use of Hospital equipment, facilities, and Hospital personnel necessary to effectively exercise such privileges, at Hospital facilities.
- 1.7 **Excluded Provider** means an individual or entity that will not be reimbursed under Medicare, Medicaid, and all other Federal Health Care Programs for any item or services furnished, ordered or prescribed. An individual or entity becomes an Excluded Provider for violations such as program related crimes, patient abuse, claims for excessive charges or unnecessary services, receiving or giving kick-

backs, fraud, failing to repay the government for student loans, and/or failing to disclose required information to authorities. The Office of Inspector General, after notice, imposes exclusion upon an individual or entity from all Federal Health Programs, not just Medicare and Medicaid. The exclusion exists until the individual or entity has been reinstated by the Office of Inspector General. A Practitioner who chooses not to provide medical care to Federal Health Program patients is not an Excluded Provider.

An individual who is under threat of exclusion is also not an Excluded Provider. A sanctioned provider is an individual or entity disciplined for program violations by federal or state agencies, but is not an Excluded Provider. Sanctioning can result from a conviction of one of the above violations or imposition of a civil monetary penalty.

- 1.8 **Fair Hearing Plan** means the procedures for Hearings and Appeals applicable to Members as set forth in Section 11 of these Bylaws, as they may be amended from time to time.
- 1.9 **Federal Health Care Program** means Medicare, Medicaid or CHAMPUS or any other federal or state program providing health care benefits which is funded directly or indirectly by the United States government.
- 1.10 **Good Standing** means that an appointee or Member, at the time the issue is raised, has met the attendance and committee participation requirements during the previous Medical Staff year and has not received a suspension or restriction of his or her appointment or Privileges in the previous twelve (12) months; provided, however, that if an appointee has been suspended in the previous twelve (12) months for failure to comply with the Hospital's policies regarding medical records and has subsequently taken appropriate action, such suspension shall not adversely affect the appointee's Good Standing status.
- 1.11 **Governing Documents** means the governing documents and policies of the Hospital and the Bylaws, Rules and Regulations, and Policies.
- 1.12 **HCQIA** means the Health Care Quality Improvement Act, 42 U.S.C. § § 11101 et. seq. and the regulations issued thereunder.
- 1.13 **Hearing** means Notice of and an opportunity to be heard, in a formal proceeding, with a mechanism for making a verbatim transcript, following an Adverse Action.
- 1.14 **Hospital** means MercyOne Newton Medical Center, a private not-for-profit hospital licensed by the State of Iowa and located in Newton, Iowa together with all of the related ambulatory care facilities and rural health clinics for which the Hospital has credentialing responsibility under these Bylaws, if any.
- 1.15 **Investigation** means the focused and purposeful gathering of information, records and other data respecting the competence, professional conduct or practice patterns of a Practitioner for the purpose of determining whether to take or recommend a Professional Review Action. Only the MEC may initiate an Investigation. The routine functioning of the Medical Staff, its committees, and the Hospital's quality

quality/risk/safety functions and all discussions with a Practitioner relating to these matters do not constitute an Investigation.

- 1.16 Medical Executive Committee, Executive Committee or MEC** means the President, Vice President, Secretary-Treasurer, immediate Past President and two members of the active staff elected at the annual meeting, authorized to act on behalf of the Medical Staff, as set forth in these Bylaws.
- 1.17 Medical Staff** means the physicians (doctor of medicine and doctor of osteopathy), podiatrists, and APCs, providing health care services in, or under the auspices of the Hospital subject to the provisions of these Bylaws. The Medical Staff is an integral part of the Hospital and is not a separate entity.
- 1.18 Medical Staff Appointment/Reappointment or Appointment or Reappointment** means appointment or reappointment to the Medical Staff and assignment to a Medical Staff category, or, for an APC, appointment as an Advanced Practice Member of the Medical Staff. Medical Staff Appointment/Reappointment does not automatically confer specific Clinical Privileges.
- 1.19 Medical Staff President** means the president of the Medical Staff, elected by the Members.
- 1.20 Member** means a physician (doctor of medicine or doctor of osteopathy), podiatrist, or APC holding a current license to practice within the scope of his or her license who has been appointed as a member of the Medical Staff.
- 1.21 Notice** means written notification that is either delivered in person or by certified mail, return receipt requested, to the recipient's last known address.
- 1.22 Policies** means policies and manuals of the Medical Staff guiding the activities and structure of the Medical Staff, including all policies and procedures related to Medical Staff and APC and credentialing.
- 1.23 Practitioners** means Members and other APCs who provide services to patients in or under the auspices of the Hospital.
- 1.24 President** means the President of the Hospital, or his or her designee.
- 1.25 Professional Review Action** means: (i) an action or recommendation of a Professional Review Body; (ii) which is taken or made in the conduct of a Professional Review Activity; (iii) which is based on the competence or professional conduct of an individual Practitioner that is harmful or potentially harmful to patients; and (iv) where the action or recommendation affects or might Adversely Affect the Clinical Privileges of the Practitioner or, in the case of Members, Medical Staff Appointment.
- 1.26 Professional Review Activity** means any activity to determine whether a Practitioner may hold Clinical Privileges at the Hospital or, be appointed to the Medical Staff, to determine the scope of such Clinical Privileges or Medical Staff Appointment or to modify such Privileges or Appointment.

- 1.27 **Professional Review Body** means the Hospital, the Board, or any committee of the Hospital or Board that conducts Professional Review Activities. It includes each committee of the Medical Staff that assists the Hospital or the Board in Professional Review Activities.
- 1.28 **Rules and Regulations** refers to the Rules and Regulations of the Medical Staff, as may be adopted and amended from time to time pursuant to these Bylaws.

## **2. PURPOSE, INTERPRETATION, RESPONSIBILITIES AND RIGHTS OF THE MEDICAL STAFF**

**2.1 Purpose of the Medical Staff.** The purposes of the Medical Staff are to reflect, influence and maintain the professional nature of medical practice through such organizational activities as collegial discussion, continuing medical education, participation in providing educational opportunities to nurses and the community.

### **2.2 Interpretation and Application.**

**2.2.1.** These Bylaws shall not impair the authority of the Board to set policy and make decisions on behalf of the Hospital.

**2.2.2.** The Medical Staff, the Board, and the President shall be permitted latitude in applying these Bylaws, to the extent reasonably necessary, so that the fundamental purposes of the Medical Staff and these Bylaws may be carried out.

**2.2.3.** The Medical Staff, the Board, and the President shall be deemed to have complied with these Bylaws whenever action is taken in good faith, in the interest of serving the stated purposes, and in a manner reasonably appropriate to the personnel and resources then available.

**2.2.4.** Time limits and procedures specified in these Bylaws may be temporarily suspended in instances where the Medical Staff or the Board is presented with a new issue and seeks to study it to determine the appropriate policy or rule to follow. While no such actions shall be required to be accomplished in less time than that specified, extensions may be granted or permitted for reasonable cause or the convenience of participants. Time periods within which individual Practitioners are permitted to request a Hearing or an Appellate Review, or to take other action, are intended to impose mandatory limitations and shall be strictly construed absent agreement to the contrary. Any time period set forth in these Bylaws may be changed by agreement of all of the parties affected.

**2.2.5.** Singular and plural noun forms, and masculine and feminine pronoun forms, for stylistic purposes, are used interchangeably, unless the context specifically requires otherwise.

**2.2.6.** These Bylaws are governed by and construed in accordance with HCQIA and other applicable federal laws and regulations and, to the extent not so governed, by state law.

**2.2.7.** Wherever counting days is required in the Governing Documents, the day of the triggering event will not count and the day of the deadline will count. Whenever a deadline falls on a holiday, a Saturday or a Sunday, the deadline will be extended to the next workweek day which is not a holiday. Holiday means those workweek days when Hospital offices are closed. Days refers to calendar days.

**2.2.8.** All Notices that are required by the Governing Documents will be sufficient if delivered or deposited in the United States mail addressed to the individual's address of record, or if electronically written and e-mailed to the recipient at his Hospital e-mail address and/or other last known registered e-mail addresses according to the Hospital's books and records. All persons who are entitled by the Governing Documents to receive Notice must provide e-mail addresses to the Hospital if they wish to receive Notices at any locations in addition to their Hospital e-mail addresses. Except as otherwise required by these Bylaws, all Notices must be given five (5) days in advance of the thing or event being noticed, unless an emergency exists, in which case the Notice shall be as far in advance as circumstances reasonably permit.

**2.2.9.** Where voting contemplated by the Governing Documents is through ballot, ballots may be issued and returned in written or electronic format.

**2.3** **Duties of the Medical Staff as a Whole.** The Medical Staff as a whole shall be accountable to the Board and the Hospital and perform certain functions delegated by the Board, including but not necessarily limited to:

**2.3.1.** Utilizing all available information in order to monitor and evaluate the quality of care, efficiency of care, and the clinical and ethical performance of the Members and APCs with delineated Clinical Privileges;

**2.3.2.** Through the MEC, providing recommendations to the Board regarding applications for Medical Staff Appointment and Clinical Privileges for each Practitioner;

**2.3.3.** Establishing (subject to Board approval) rules, regulations, policies, and methods, to govern professional prerogatives and obligations of Members;

**2.3.4.** Enforcing these Bylaws and the Rules and Regulations by recommending action to the Board in certain circumstances and taking certain action in others;

**2.3.5.** Through Medical Staff leadership, with the assistance of qualified support personnel, engaging in performance improvement activities with development and use of physician-specific performance data, including objective conclusions;

**2.3.6.** Selecting leaders carefully, considering reputation for objectivity and fairness, and organizational skills, including communication skills;

**2.3.7.** Establishing mechanisms whereby Members have input in clinical affairs;

**2.3.8.** Providing continuing education opportunities for Practitioners, and stating whether or not certain levels of participation in these activities is required;



- 2.3.9. Through responsible Medical Staff leaders, pursuing effective courses in accomplishing needed improvements in the performance or behavior of Members;
- 2.3.10. Through responsible Medical Staff leaders, providing periodic reports to the Board;
- 2.3.11. Participating in Hospital performance improvement programs; and
- 2.3.12. Participating with Hospital in identifying and meeting community health care needs, including providing a reasonable amount of charity care in support of the Hospital's commitment to the community and the underserved.

**2.4 Medical Staff Member Rights.** Members are afforded certain rights pursuant to these Bylaws, including but not limited to:

- 2.4.1. Each Member of the Active Staff has the right to an audience with the MEC. In the event such Member is unable to resolve a difficulty working with his/her respective Clinical Committee Chair, that Member may, upon presentation of Notice to the Medical Staff President two (2) weeks in advance of a regular meeting, meet with the MEC to discuss the issue.
- 2.4.2. Any Member of the Active Staff has the right to initiate a recall election of a Medical Staff officer or Clinical Committee Chair.
- 2.4.3. Any Member of the Active Staff may initiate a call for a general Medical Staff meeting. Upon presentation of a petition signed by thirty-three percent (33%) of the Members of the Active Staff, the MEC shall schedule a general Medical Staff meeting for the specific purposes addressed by the petitioners. No business other than that detailed in the petition may be transacted.
- 2.4.4. Any Member of the Active Staff may raise a challenge to any rule or policy established by the MEC. In the event that a rule, regulation or policy is thought to be inappropriate, any such Member may submit a petition signed by thirty-three percent (33%) of the Active Staff Members. When the MEC has received such petition, it will either provide the petitioners with information clarifying the intent of such rule, regulation or policy, and/or schedule a meeting with the petitioners to discuss the issues.
- 2.4.5. Any Member may request a Clinical Committee meeting by presenting a petition signed by forty percent (40%) of the Members of the Clinical Department.
- 2.4.6. Any Member of the Active Staff may have an amendment to these Bylaws or the Rules and Regulations presented to the MEC upon presentation of a petition requesting the same signed by thirty-three

percent (33%) of the Members of the Active Staff eligible to vote on such Bylaws and the Rules and Regulations.

- 2.4.7. The above Member rights do not pertain to issues involving Professional Review Actions, actions that have an Adverse Affect on a Member, or any other matter relating to Appointment/Reappointment or Clinical Privileges. The process for Investigations and the Fair Hearing Plan provide recourse in these matters.

**2.5 Individual Member Responsibilities.** Except as otherwise provided in this Section 2.5, regardless of Medical Staff category each Member with Clinical Privileges must:

- 2.5.1. Take all actions required to help the Medical Staff fulfill its duties, as set forth in Section 2.3.
- 2.5.2. Pledge to provide for continuous care of patients at a generally recognized professional level of quality and efficiency and in compliance with all applicable standards and laws, including the professional ethics codes of the American Medical Association and other recognized bodies as applicable to the Member's specialty and to obtain consultation as necessary, appropriate, or required in the Governing Documents.
- 2.5.3. Complete patients' medical records as specified in the Rules and Regulations and these Bylaws, including factors of timeliness, legibility and accurate content.
- 2.5.4. Participate in the development of practitioner-specific performance data, including quality, efficient practice, accessibility, and attitude, and respond to reasonable suggestions, if properly presented by individuals in authority.
- 2.5.5. Respond to reasonable requests to perform necessary Medical Staff functions, such as serving as a physician analyst of clinical information for quality improvement purposes.
- 2.5.6. Follow the provisions and all requirements of these Bylaws, the Rules and Regulations, and the Policies, and the policies and procedures of the Hospital.
- 2.5.7. Exercise only those Clinical Privileges specifically delineated to him or her.
- 2.5.8. Comply with all state and federal laws regarding the practice of medicine, including without limitation, the prohibitions against fee splitting, self-referrals, and kickbacks.
- 2.5.9. Provide, where appropriate, emergency care and other professional services to patients without regard for their ability to pay.

- 2.5.10.** Participate, consistent with his/her appointment category and Privileges, in the on call coverage of the Emergency Department and other coverage programs including consultations for inpatients, as determined by the MEC and the Board after receiving input from the appropriate Clinical Committee to assist in meeting the patient care needs of the community, provided that such participation in call coverage is a responsibility but not a right and in the event that the MEC and Board agree to alternate arrangements related to this responsibility, this provision of the Bylaws may be automatically amended to reflect such agreement.
- 2.5.11.** Participate in performance improvement and, where appropriate, in peer review activities.
- 2.5.12.** Comply with and assist the Hospital in achieving and maintaining compliance with all applicable regulatory and accreditation standards.
- 2.5.13.** Discharge in a responsible and cooperative manner such reasonable responsibilities and assignments as a Member may assume or receive by virtue of Medical Staff Appointment, including committee, clinical service leadership and officer assignments.
- 2.5.14.** Consent to immediate testing of blood and urine for controlled substances and/or alcohol upon the reasonable request of the Medical Staff President, the President, or the Board.
- 2.5.15.** Work cooperatively with Members, APCs, Hospital administration, Hospital staff and others so as to ensure the efficient operation of the Hospital and the provision of quality and efficient health care to the patient population.
- 2.5.16.** Promptly report, but no later than within seven (7) days of occurrence, to the Medical Staff Office and/or the Medical Staff President all material changes and occurrences set forth in Section 5.8.
- 2.5.17.** Discharge such other Medical Staff obligations as may be lawfully established from time to time by the Medical Staff or the MEC.
- 2.5.18.** Be trained in and appropriately use the Hospital's electronic medical record for all inpatient care, when available, and for outpatient care as applicable.

A Practitioner's failure to satisfy any of these responsibilities may be grounds for denial of Medical Staff Appointment or Clinical Privileges, reduction in Medical Staff Appointment category, restriction, suspension (as set forth in Section 10.7 of these Bylaws) or revocation of Clinical Privileges, or other Adverse Action as determined in a final action of the Board pursuant to these Bylaws.

- 2.6     Compliance with Corporate Responsibility Program and MercyOne Code of Conduct.** It is essential to the Mercy Health Network d/b/a MercyOne ("MercyOne") core values that all persons associated with MercyOne and its affiliated hospitals and facilities at all times conduct themselves in compliance with

the highest standards of business ethics and integrity, as reflected in the Hospital Corporate Responsibility Program including, without limitation, the MercyOne Code of Conduct and the Ethical and Religious Directives for Catholic Health Services (the “ERDs”). Accordingly, failure by a Member to abide by the Corporate Responsibility Program and the Code of Conduct, including any related education and training requirements, is grounds for corrective action pursuant to Section 10 of these Bylaws.

- 2.7 History and Physical Examination.** A medical history and physical examination shall be completed no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed, signed and documented by a physician, an oral and maxillofacial surgeon, or other qualified licensed individual in accordance with state law and the Rules and Regulations. .

When the medical history and physical examination is completed within thirty (30) days before admission or registration, the physician, oral and maxillofacial surgeon, or other qualified licensed individual must complete and document an updated examination of the patient within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The updated examination of the patient, including any changes in the patient’s condition must be completed and documented by a physician or other qualified licensed individual in accordance with state law and the Rules and Regulations.

### **3. ELIGIBILITY FOR MEDICAL STAFF APPOINTMENT AND REAPPOINTMENT**

**3.1 Nature of Medical Staff Appointment and Reappointment.** Appointment and Reappointment of a Member is made by the Board based upon the recommendations of the MEC. Appointment and Reappointment may be extended only to professionally competent Practitioners who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and the Rules and Regulations. No person shall admit a patient to the Hospital unless he or she is a Member with relevant Privileges or has been granted Temporary Privileges as provided herein.

#### **3.2 General Conditions of Medical Staff Appointment and Reappointment.**

**3.2.1.** All Medical Staff Appointments and Reappointments will be for a period not exceeding two (2) years. Terms of Medical Staff Appointment or Reappointment begin on the date of approval by the Board after recommendation of the MEC, or such other date as the Board may specify.

**3.2.2.** Medical Staff Appointment and Reappointment by itself confers no Clinical Privileges. Members must also apply for and hold Clinical Privileges in order to perform patient care services.

**3.2.3.** Members must abide by any responsibilities and duties set forth in these Bylaws, including committee assignments.

**3.2.4.** The Board retains the right to modify, suspend or revoke Medical Staff Appointment or Clinical Privileges in accordance with the provisions of these Bylaws and the Rules and Regulations, or otherwise pursuant to its fiduciary authority.

**3.2.5.** Prior to appointment to the Medical Staff, the National Practitioner Data Bank (the "NPDB") shall be queried. Thereafter, the NPDB shall be queried every two (2) years in conjunction with the reappointment process.

**3.3 Qualifications for Medical Staff Appointment and Reappointment.** Every Practitioner who applies for or holds a Medical Staff Appointment must, at the time of application for Appointment or Reappointment and continuously thereafter, demonstrate to the satisfaction of the Medical Staff and the Board that he/she meets all of the following qualifications for Medical Staff Appointment/Reappointment and any other qualifications and requirements as set forth in these Bylaws or the Rules and Regulations, or is provided with an exception to these qualifications by the MEC and the Board pursuant to Section 3.4:

**3.3.1.** Demonstrate that he/she has successfully graduated from an approved school of medicine or osteopathy and is board certified or board eligible in accordance with the following:

- a. A physician applicant must have successfully completed an allopathic or osteopathic residency program, approved by the Accreditation Council for Graduate Medical Education (“ACGME”) or the American Osteopathic Association (“AOA”) and be currently board certified or can demonstrate active pursuit of board certification as defined by the appropriate board and be board certified within six (6) years of initial Medical Staff Appointment by the American Board of Medical Specialties or the AOA in the specialty of application;
  - b. Dentists must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation and successfully have completed a post graduate residency and/or fellowship in their specialty that is accredited by the American Dental Association;
  - c. Oral and maxillofacial surgeons must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation and successfully completed an American Dental Association approved residency program and be board certified or board admissible by the American Board of Oral and Maxillofacial Surgery within six (6) years of initial Medical Staff appointment;
  - d. A podiatric physician (“DPM”) must have successfully completed a two (2) year residency program in surgical, orthopedic, or podiatric medicine approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association (“APMA”), and be board certified or board admissible by the American Board of Podiatric Surgery or the American Board of Podiatric Orthopedics and Primary Podiatric Medicine within six (6) years of initial Medical Staff Appointment;
  - e. If an applicant is a graduate of a foreign medical school, the applicant must have successfully completed either the ECFMG or FLEX examination;
- 3.3.2.** Hold a valid, current license to practice in the State of Iowa that is not subject to any actual or pending restrictions, censures, or conditions that would limit practice as a physician, podiatrist, dentist, optometrist, or APC (other than physician collaboration requirements) or any condition required for the practice of his or her profession in the State of Iowa, and if appropriate, hold a current, valid DEA registration; provided, however for purposes of Section 6.18 of these Bylaws (Medico-Administrative Positions), a Member may hold a valid, current Iowa administrative medical license;
- 3.3.3.** Have a record that is free of any arrests, pending criminal charges or actual criminal convictions, meaning conviction of, pleas of guilty, no contest to, any felony charges; or actual or pending conviction of, pleas

of guilty, or no contest to misdemeanor charges in which the underlying allegations involve the practice of a health care profession, Federal Health Care Program fraud or abuse, third party reimbursement, the use of alcohol or controlled substances, crimes of violence or abuse, or crimes of moral turpitude;

- 3.3.4.** Have a record that is free from current or pending Federal Health Care Program sanctions, not be an Excluded Provider or otherwise ineligible for participation in any Federal Health Care Program, including Medicare, Medicaid, and CHAMPUS, and not be on the Medicare exclusion list/OIG sanction list;
- 3.3.5.** Possess current, valid professional liability insurance coverage in amounts set by the Board;
- 3.3.6.** Be able to document his/her background, experience and current clinical competence;
- 3.3.7.** Be able to document his/her adherence to the ethics of his or her profession, his or her good reputation and character, mental and emotional stability, ethical behavior and character, and his or her ability to work harmoniously with others without disruption of the operation of the Hospital or the Medical Staff;
- 3.3.8.** Be free from, or have adequate control over, any physical or mental impairment that would significantly affect his/her ability to practice, including, but not limited to, use or abuse of any type of medicine, substance or chemical that affects cognitive, motor or communication ability in any manner that interferes with, or has reasonable probability of interfering with the qualifications for Medical Staff Appointment or Clinical Privileges such that patient care is, or is likely to be, adversely affected;
- 3.3.9.** Meet any additional qualifications set forth elsewhere in these Bylaws or the Rules and Regulations;
- 3.3.10.** If applicable, participate in or agree to participate in an Organized Health Care Arrangement (“OHCA”) with the Hospital and comply with the policies and procedures of the Hospital relating to the use and disclosure of individually identifiable health information for the purpose of exchanging individually identifiable health information; and
- 3.3.11.** Not provide services covered by a Hospital exclusive contractual arrangement to which the applicant is not a party.

**3.4 Exceptions to Qualifications to Medical Staff Appointment and Reappointment.**

**3.4.1.** APCs who meet the qualifications as set forth in Section 7.2.

**3.4.2.** The MEC may recommend to the Board that the board certification/eligibility requirement described in Section 3.3.1 be waived for candidates with equivalent qualifications. Applicants must demonstrate equivalent training and current competence in the defined dimensions of performance.

**3.4.3.** Only the Board may create additional exceptions to or waive the qualifications in the above Section 3.3 after consultation with the MEC.

**3.5 Effects of Other Affiliations.** No Practitioner shall be automatically entitled to Appointment, Reappointment or Privileges merely because he or she is licensed to practice in this or in any other state, or because he or she is a member of any professional organization, or because he or she is certified by any clinical board, or because he or she is a member of a medical school faculty, or because he or she had, or presently has, staff membership or privileges at another health care facility or in another practice setting. Nor shall any Practitioner be automatically entitled to Medical Staff Appointment, Reappointment or particular Privileges merely because he or she is or was a Member, or had, or presently has, those particular Privileges at Hospital.

**3.6 Ethics and Conduct.** The Code of Ethics of the Practitioner's relevant professional organization shall govern professional conduct.

**3.7 Cooperation.** In addition, every Practitioner, at the time of Appointment and Reappointment, and at any time during the Appointment or Reappointment period, must demonstrate to the satisfaction of the MEC and the Board, a willingness and capability, based on current attitude and evidence of performance, to work with and relate to other Members, members of other health disciplines, Hospital management and employees, patients, and the community in general, in a cooperative, professional manner that is essential for maintaining Hospital operations appropriate to quality and efficient patient care.



## 4. MEDICAL STAFF CATEGORIES

**4.1 Category Assignment and General Characteristics.** Each Member shall be assigned to a Medical Staff category by the MEC and the Board and such assignment shall be made at the time of initial Appointment to the Medical Staff. Changes in Medical Staff category assignment shall be made, ordinarily, only at the time of Reappointment to the Medical Staff.

### **4.2 Category Descriptions.**

#### **4.2.1. Provisional.**

- a. Qualifications. Provisional Members are Members who:
  - i. Have less than six (6) months of Appointment on the Medical Staff;
  - ii. Meet the basic qualifications for Medical Staff Appointment set forth in Section 3.3; and
  - iii. Are eligible for advancement to the Active, Courtesy, Consulting or Community Staff and must become Active, Courtesy, Consulting or Community Members after the twelve (12) month Provisional Staff period if all other criteria are met. If required, due to uncontrolled circumstances, the Provisional status may be extended for one (1) to six (6) month period only.
- b. Prerogatives. Provisional Members may:
  - i. Admit patients in accordance with, and subject to, these Bylaws and the Rules and Regulations, the Hospital's rules, regulations, policies and procedures and such Clinical Privileges as may be granted such Member;
  - ii. Exercise such Clinical Privileges as are granted to him or her;
  - iii. Attend (in a non-voting capacity) meetings of the Medical Staff and of the Clinical Committee in which that person is a Member;
  - iv. Serve on any Medical Staff committee and vote on matters before such committee;
  - v. Attend any Medical Staff or Hospital continuing education programs; and
  - vi. Have all responsibilities assigned to Active Members but may not hold a Medical Staff office.
- c. Responsibilities. Each Provisional Member must:

- i. Discharge all of the basic responsibilities set forth in these Bylaws for Appointment to the Active Staff, as set forth in Section 2.5, except for payment of Medical Staff dues; and
- d. Removal of Provisional Designation. The Provisional designation will be removed when the MEC and the Board receive, from the Medical Staff President, satisfactory assurances that the Practitioner is capable of and willing to fulfill the responsibilities of his or her Medical Staff Appointment, category assignment, and chosen areas of clinical practice. Removal of the Provisional designation shall be at the discretion of the Board, on recommendation of the MEC.
- e. Extension of Provisional Period. The Provisional designation period may be extended for one (1) additional term of six (6) months, once, for good cause, at the discretion of the Board, on the recommendation of the MEC. If at the end of the extension, if performance is not satisfactory to the MEC and the Board, then Medical Staff Appointment, Clinical Privileges, or a specific Clinical Privilege, whatever has been the subject of the extension, shall not be granted.
- f. Termination of Provisional Status or Reduction of Clinical Privileges During the Provisional Period. If there is a recommendation by the MEC to terminate the Provisional Member's Appointment prior to its expiration, to deny advancement from Provisional status or to reduce Clinical Privileges due to questions about qualifications, fitness, behavior, or clinical competence, the Medical Staff President or his or her designee shall give the Provisional Member notice of the recommendation and the Provisional Member shall be entitled to a Hearing and other rights set forth in the Fair Hearing Plan.

#### **4.2.2. Active**

- a. Qualifications. Active Members are Physicians who:
  - i. Meet the basic qualifications for Medical Staff Appointment set forth in Section 3.3;
  - ii. Involved in at least twenty (20) patient contacts during the appointment term;
  - iii. Comply with Medical Staff meeting requirements, accept and accomplish tasks assigned by the Medical Staff President or MEC, and meet other specific obligations such as participating in applicable call coverage requirements.

Hospital-based physicians with a current contract to provide patient services are also eligible to apply for Active Staff membership.

In the event that an Active Member does not meet the qualifications for Reappointment to the Active Staff, and if the Member is otherwise abiding by these Bylaws and the Rules and Regulations, the Member

may be appointed to the Courtesy, Consulting or Community Staff, if approved by the Board after recommendation from the MEC.

b. Prerogatives. Active Members may:

- i. Admit patients in accordance with, and subject to, these Bylaws and the Rules and Regulations, the Hospital's rules, regulations, policies and procedures and such Clinical Privileges as may be granted such Member;
- ii. Exercise such Clinical Privileges as are granted him or her;
- iii. Vote on all matters presented by the Medical Staff or the committee(s) of which he or she is a member; and
- iv. Hold office and sit on or be the chairperson of any committee.

c. Responsibilities. Active Members must:

- i. Meet all of the basic responsibilities of Medical Staff Appointment set forth in Section 2.5;
- ii. Attend Medical Staff meetings, including committee meetings, and meetings of the relevant Clinical Department, provided, however, absence from fifty percent (50%) of the regular meetings for the year without a reasonable excuse shall be considered as resignation from the Active Staff. Reinstatement to the Active Staff category position rendered vacant because of absence from meetings may be made on application in the same manner as in the case of original appointment; and
- iii. Be located within the geographic service area of the Hospital, as defined by the Board, and close enough to be readily available to provide timely care for his/her patients, and have an agreement with another Practitioner with similar Privileges, as determined by the Committee Chair, to cover patients if the Practitioner suddenly becomes unavailable.

**4.2.3. Courtesy.**

a. Qualifications. Courtesy Members are Practitioners who:

- i. Meet the basic qualifications for Medical Staff Appointment set forth in Section 3.3; and
- ii. Are members in Good Standing of the active staff of another accredited, acute-care medical/surgical hospital, or other hospital appropriate to Member's specialty, licensed by the State of Iowa. The Courtesy Staff shall consist of those allopathic physicians or osteopathic physicians who wish to occasionally admit patients to the Hospital, but who do not

wish to become members of the Active Staff or who, by reason of residence, are not eligible for such appointment. If the member of Courtesy Staff admits more than 6 patients per year, the physician may apply for Active Staff membership.

b. Prerogatives. Courtesy Members may:

- i. Admit patients in accordance with, and subject to, these Bylaws and the Rules and Regulations, the Hospital's rules, regulations, policies and procedures and such Clinical Privileges as may be granted such Member;
- ii. Exercise such Clinical Privileges as are granted him or her;
- iii. Attend meetings of the Medical Staff;
- iv. Serve at the pleasure of the Medical Staff on committees (in a voting capacity at the discretion of the committee chair);
- v. Attend any Medical Staff or Hospital continuing education programs; and
- vi. Not hold Medical Staff office and may not vote at Medical Staff meetings.

c. Responsibilities. Courtesy Members must:

- i. Meet the basic responsibilities of Medical Staff Appointment set forth in Section 2.5.

**4.2.4. Consulting.**

a. Qualifications. Consulting Members are Practitioners who:

- i. Are not otherwise Active, Courtesy, Community, Honorary, or Locum Tenens Members of the Medical Staff;
- ii. Meet the basic qualifications for Medical Staff Appointment set forth in Section 3.3 (provided, however, that this requirement shall not preclude an out-of-state Practitioner from Appointment, as may be permitted by law, if that Practitioner is otherwise deemed qualified by the MEC and the Board);
- iii. Possess specialized skills for a specific project or consultation required by the Hospital or a Member; and
- iv. Are members in Good Standing on the active staff of another accredited, acute-care medical/surgical hospital, or other hospital appropriate to Member's specialty.

b. Prerogatives. Consulting Members may:

- i. Exercise such Clinical Privileges as are granted him or her;
  - ii. Attend meetings of the Medical Staff and of the Clinical Committee in which that person is a Member;
  - iii. Serve at the pleasure of the Medical Staff on committees (in a voting capacity at the discretion of the committee chair);
  - iv. Attend any Medical Staff or Hospital continuing education programs; and
  - v. Not hold Medical Staff office and may not vote at medical staff meetings.
- c. Responsibilities. Consulting Members must meet the basic responsibilities of Medical Staff Appointment set forth in Section 2.5.

#### **4.2.5. Community.**

- a. Qualifications. Community Members are Practitioners who:
- i. Are not otherwise eligible to be Active, Courtesy, Consulting, Honorary, or Locum Tenens Members of the Medical Staff or choose not to pursue such status;
  - ii. Meet the basic qualifications for Medical Staff Appointment set forth in Section 3.3 of these Bylaws; and
  - iii. Do not admit or actively participate in the care of patients at the Hospital because such Practitioner's professional practice is solely ambulatory in nature (e.g., internists, family practitioners and pediatricians who have a primary office practice).
- b. Prerogatives. Community Members may:
- i. Be granted Refer and Follow Clinical Privileges only and may not admit or provide inpatient care or consultation to patients at the Hospital;
  - ii. Refer patients for appropriate outpatient laboratory, diagnostic testing, and therapies and treatments (excluding chemotherapy), but may not perform these services his/herself in the Hospital;
  - iii. Attend meetings of the Medical Staff; and
  - iv. Serve at the pleasure of the Medical Staff on committees (in a voting capacity at the discretion of the committee chair);

- v. Attend any Medical Staff or Hospital continuing education programs; and
- vi. Not hold Medical Staff office and may not vote at Medical Staff Meetings.
- c. Responsibilities. Community Members must meet the applicable basic responsibilities of Medical Staff Appointment set forth in Section 2.5 of these Bylaws.

#### **4.2.6. Advanced Practice.**

- a. Qualifications. Advanced Practice Members are Practitioners who:
  - i. Meet the basic qualifications set forth in Section 7.2;
  - ii. Involved in at least fifty (50) patient contacts during the appointment term or cover at least twenty-five (25) shifts during a three-month period;
  - iii. Comply with Medical Staff meeting requirements, accept and accomplish tasks assigned by the Medical Staff President or MEC, and meet other specific obligations such as participating in applicable call coverage requirements.
- b. Prerogatives. Advanced Practice Members may:
  - i. Admit patients in accordance with, and subject to, these Bylaws and the Rules and Regulations, the Hospital's rules, regulations, policies and procedures and such Clinical Privileges as may be granted such Advanced Practice Member;
  - ii. Exercise such Clinical Privileges as are granted him or her;
  - iii. Vote on all matters presented by the Medical Staff or the committee(s) of which he or she is a member; and
  - iv. Hold office and sit on or be the chairperson of any committee as assigned by the Medical Executive Committee.
- c. Responsibilities. Advanced Practice Members must:
  - i. Meet all of the basic responsibilities of Medical Staff Appointment set forth in Section 2.5 and the additional responsibilities set forth in Section 7.6;
  - ii. Attend Medical Staff meetings, including committee meetings, and meetings of the relevant Clinical Department, provided, however, absence from fifty percent (50%) of the regular meetings for the year without a reasonable excuse shall be considered as resignation from the Advanced Practice Staff.

Reinstatement to the Advanced Practice Staff category position rendered vacant because of absence from meetings may be made on application in the same manner as in the case of original appointment; and

#### **4.2.7. Honorary.**

- a. Qualifications. Honorary Members are Practitioners who:
  - i. Are retired from active practice; or
  - ii. Are of outstanding reputation which the Medical Staff wishes to honor; and
  - iii. The Honorary category is restricted to those individuals recommended by the MEC and approved by the Board. Appointment to this category is entirely discretionary and may be rescinded at any time by the MEC and the Board. Reappointment to this category is not necessary, as appointees are not eligible for Clinical Privileges.
- b. Prerogatives. Honorary Members may:
  - i. Have no Medical Staff rights or Clinical Privileges.
  - ii. Attend general Medical Staff meetings in a non-voting capacity, continuing medical education activities, and may be appointed to Medical Staff committees ((in a voting capacity at the discretion of the committee chair).
  - iii. Not hold Medical Staff office.
- c. Responsibilities. Honorary Members have no general Medical Staff obligations, except for any Medical Staff committee obligations, as applicable.

#### **4.2.8. Locum Tenens.**

- a. Qualifications. Locum Tenens Members are Practitioners who:
  - i. Meet the basic qualifications for Medical Staff Appointment set forth in Section 3.3;
  - ii. Admit patients to, or are otherwise involved in the care and supervision of patients in the Hospital;
  - iii. Typically maintain a permanent residence outside of the community served by the Hospital; but during the terms of local assignment, in order to ensure the provision of continuous

care to his or her patients, are located, in the vicinity of the Hospital as required by the Rules and Regulations;

- iv. Would not appropriately be a Member of the Provisional, Active, Courtesy, Consulting, Community, or Honorary Staff; and
- v. Pay such dues (if any) as may be required of Locum Tenens Members applicable to the terms of Medical Staff Appointment or terms of local assignment.

b. Prerogatives. Locum Tenens Members may:

- i. Admit patients in accordance with, and subject to, these Bylaws and the Rules and Regulations, the Hospital's rules, regulations, policies and procedures and such Clinical Privileges as may be granted such Member;
- ii. Exercise such Clinical Privileges as are granted to him or her;
- iii. Attend meetings of the Medical Staff and of the Clinical Committee of which that person is a Member;
- iv. Serve at the pleasure of the Medical Staff on committees (in a voting capacity at the discretion of the committee chair);
- v. Attend any Medical Staff or Hospital continuing education programs; and
- vi. Not hold Medical Staff Office and may not vote.

c. Responsibilities. Locum Tenens Members must:

- i. Meet the basic responsibilities of Medical Staff Appointment set forth in Section 2.5, including but not limited to on call responsibilities;
- ii. Fulfill all responsibilities of the Practitioner for whom they are covering (e.g., on call assignments) or, if retained by the Hospital, all responsibilities as required by the Hospital;
- iii. Notify the Medical Staff Office on the date on which such Member commences the provision of services at the Hospital and notify the Medical Staff Office and Medical Records Office on the date on which he or she ends the provision of services at the Hospital; and
- iv. Continue to cooperate and participate in the completion of all applicable medical records, Professional Review Activities, FPPE activities, and the like, following the date on which he or



she ends the provision of services at the Hospital, or as otherwise determined by the MEC.

### **4.3     Outpatient Services.**

**4.3.1.   Ordering Outpatient Services.** Practitioners who are not Members may order outpatient services, including laboratory services and radiologic services, as set forth in the relevant Hospital policy, provided that the Practitioner meets all of the qualifications set forth in Section 4.3.2.

**4.3.2.   Qualifications for Non-Members to Order Outpatient Services.** A Practitioner who is not a Member may order outpatient services, if the Practitioner is:

- a.     Responsible for the care of the patient for which the order is made;
- b.     Licensed in, or holds a license recognized in, the jurisdiction where he or she sees the patient, to the extent permitted by state law;
- c.     Acting within his or her scope of practice under state law;
- d.     Not an Excluded Provider; and
- e.     Authorized by the Medical Staff to order the applicable outpatient services in accordance with the relevant Hospital policy, as approved by the Board.

## **5. APPOINTMENT AND REAPPOINTMENT**

**5.1 Applicant Agreement and Acknowledgments.** By applying for and holding Medical Staff Appointment or Reappointment, the applicant/Member agrees and acknowledges:

- 5.1.1.** To cooperate in the Appointment and Reappointment process as delineated in these Bylaws and the Rules and Regulations.
- 5.1.2.** That he or she has read and agrees to be bound by these Bylaws, the Rules and Regulations, and the Hospital's policies and procedures and Corporate Responsibility Programs (each applicant will receive or have access to a copy of the Bylaws with his or her application form).
- 5.1.3.** That he or she is willing to appear for an interview as part of the application process.
- 5.1.4.** That he or she authorizes Hospital representatives to obtain validation of information supplied in support of the application, including interviewing other persons who may have information regarding the applicant's character or professional competence and authorizes such persons to provide such information to the Medical Staff and the Hospital.
- 5.1.5.** That he or she releases from liability all Hospital and Medical Staff representatives who evaluate the applicant and his or her qualifications.
- 5.1.6.** That he or she releases from liability all individuals and organizations who provide information relevant to the application.
- 5.1.7.** That he or she is responsible for the truth, accuracy and completeness of information provided and certifies the accuracy and completeness of the information provided by the applicant on, or in conjunction with, the application.
- 5.1.8.** That he or she consents to submit to such physical or mental examinations as the MEC or its designee may require by a physician or physicians mutually acceptable to the applicant and the MEC or its designee. In the event of a disagreement concerning the need for an examination or the choice of the examining physician(s), the matter shall be referred to the Board or its designee, whose decision on the matter will be final. Taking or passing a physical or mental examination is not a part of the application process, but the exercise of Clinical Privileges that are otherwise granted may be made subject to the successful completion of such examination(s).
- 5.1.9.** That he or she consents to the disclosure of any information regarding the applicant's character or professional competence received by the Medical Staff and the Hospital to the NPDB, other hospitals, licensing boards, medical associations or similar persons, and releases the Medical Staff and Hospital from any and all liability for so doing.

**5.1.10.** That he or she pledges to provide his or her patients with continuous quality care at a generally recognized professional level of quality and efficiency and in compliance with all applicable standards and laws.

**5.1.11.** That he or she consents to the sharing among the Medical Staff, Hospital and any other health care providers or entities with which he or she has or is establishing a professional relationship, including, without limitation, other hospitals with which the applicant has applied for medical staff membership or privileges and the applicant's employer, of any information regarding his or her character or professional competence received by the Medical Staff, Hospital or such other health care providers or entities as part of credentialing, quality assessment or peer review processes, and releases the Medical Staff and Hospital from any and all liability for so doing. Such sharing among the Medical Staff, Hospital and other health care providers is permitted at any time during the course of the applicant's relationship with the Hospital, including at and between Appointment and Reappointment.

**5.2     Applications.** Initial applications, reapplications and applications for change in Appointment category or Clinical Privileges are filed and processed in accordance with these Bylaws. The Hospital may refuse to complete processing of an application from any applicant that is known not to meet the qualifications for Medical Staff Appointment and Clinical Privileges outlined in Section 3.3.

**5.3     Professional Criteria for Evaluation of Applications.**

**5.3.1.   Uniformity Applied: No Discrimination.** The professional criteria for Medical Staff Appointment and Clinical Privileges shall be applied uniformly to all applicants. Medical Staff Appointment and Reappointment and the granting, modification or renewal of Clinical Privileges may not be denied to any person on the basis of age, sex, race, religion, creed, national origin, sexual orientation, disability, or any other consideration not impacting the applicant's ability to properly exercise the Clinical Privileges for which he or she has applied.

**5.3.2.   Incomplete or Misrepresented Information.** Material misstatements, false statements, inaccurate or incomplete applications, and omissions or misleading statements are grounds for denial of an application or reapplication, without the applicant being entitled to a Hearing under the Fair Hearing Plan. Failure to update information in the application or upon reapplication will also render an application or reapplication inaccurate, misleading or false and may also be the basis for terminating the application process. Failure to provide any information requested by the MEC or Board during the application or reapplication process within sixty (60) days of the request shall render an application incomplete and null and void with no rights to a Hearing under the Fair Hearing Plan. In the event the application process is terminated and/or an application deemed null and void for any of the reasons set forth in this Section, the applicant shall be notified in writing and appropriate documentation of the notification and supporting information shall be maintained.

- 5.4 Applicant's Burden.** In all matters pertaining to any application for Appointment or Reappointment or for Clinical Privileges, the applicant shall have the burden of producing any information requested by the MEC or the Board relating to his or her application for Appointment, Reappointment or Clinical Privileges.

Processing of the application cannot begin until all required information is on file and validated and any required processing fees have been received from the applicant.

- 5.5 Initial Application.** Each applicant shall provide, in writing or by email, a communication expressing his or her intent to apply for Medical Staff Appointment prior to obtaining the application packet. A completed application for Medical Staff Appointment must contain the following:

**5.5.1. Application Form.** An application for Medical Staff Appointment or Clinical Privileges shall be made in writing on a form used or developed by the MEC and approved by the Board. The form may require, among other things, complete information concerning:

- a. The Medical Staff Appointment category and Privileges applied for;
- b. Names of at least three (3) professional references, only one of whom may be from such applicant's practice group;
- c. Verified information regarding professional school diploma, post-graduate training, all current licenses to practice, and DEA registration;
- d. An accounting of all time since the Practitioner matriculated from professional school to present, including positions held at all institutions and the commencement and completion of each service;
- e. Primary source verification of all applicable information which has been completed by the Medical Staff Office;
- f. Information as to whether any of the following Professional Review Actions have ever been taken or are pending regarding the applicant or whether the applicant has taken voluntary action to avoid any of the following sanctions:
  - i. Termination, restriction and/or limitations of staff membership or clinical privileges at any other hospital or health care facility;
  - ii. Termination of membership/fellowship in local, state or national professional organizations;
  - iii. Loss of specialty board certification/eligibility;
  - iv. Loss, suspension, censure, or probationary status regarding license to practice any profession in any jurisdiction;

- v. Loss of approval to prescribe medication by the DEA;
  - vi. Conviction of a health care related offense or debarred, suspended or otherwise determined ineligible to participate in any Federal Health Care Program; or
  - vii. If physician has entered into a “Letter of Agreement” or “Agreed Order” or similar agreement with any licensure board, he or she must report that information to the Medical Staff as part of the credentialing/recredentialing process, or any time such agreements are entered. If any such professional sanctions have ever occurred or are pending, the particulars thereof shall be reported on the application;
- g. Complete information on health status, including history of physical and mental illness, and information on conditions presently requiring a physician’s care or medication. The applicant must provide information on any health condition that limits or impairs their ability to exercise Privileges applied for or to discharge the responsibilities of Appointment;
  - h. Evidence of Tb skin test or chest x-ray. Screening is not required if prior results have been positive;
  - i. Any current or previous addiction to alcohol, drugs or controlled substances, and whether treatment has ever been sought for the same. If the applicant has ever obtained such treatment, he shall execute consent sufficient under federal and state law to allow the Hospital access to treatment records and to discuss treatment and status with relevant treating professionals with whom the applicant may otherwise have a confidential physician-patient relationship, to the extent reasonably necessary to evaluate the applicant’s present fitness to practice medicine;
  - j. Evidence of current professional liability insurance coverage in amounts that may be determined from time to time and at any time by the Board, with MEC input;
  - k. Information about malpractice judgments, suits, claims and settlements within the last five (5) years;
  - l. Information as to whether the applicant has ever been arrested, charged with or convicted of any felony, misdemeanor, or other criminal act;
  - m. Information from the NPDB;
  - n. Morbidity and mortality data and relevant applicant-specific data as compared to aggregate data, when available;
  - o. Any additional information, required by the MEC or the Board, to adequately evaluate the applicant; and

- p. The applicant's specific requests for membership category, Clinical Department(s), and Privileges.

Once Clinical Privileges have been obtained, a copy of Our Values and Ethics at Work shall be sent to each applicant on behalf of Hospital. Signed confirmation that the applicant has received and read (or been given the opportunity to read) these Bylaws, and Rules and Regulations will be obtained by the Medical Staff Office.

## **5.6 Route of the Completed Application.**

- 5.6.1.** A “Completed Application” includes all information the applicant has been called upon to provide and verification of the information. Each application will be reviewed by the Medical Staff Office to determine whether it may be deemed complete. The Medical Staff Office should collect and verify information within sixty (60) days of the applicant’s delivery of the Completed Application. Following collection and verification of information, applications shall be considered in a timely manner. The timelines and schedule set forth herein are guidelines only and do not create any rights for an applicant to have an application processed within a particular time.
- 5.6.2.** When the application has been deemed complete by the Medical Staff Office, including primary source verification of applicable information, the MEC (or the Credentials Committee, as the case may be) shall review the application and the MEC shall act upon the application at its next scheduled regular meeting. The MEC will then promptly forward its recommendations to the Board, by way of the Medical Staff President. The Board has final authority for granting, renewing or denying Medical Staff Appointment and Clinical Privileges.
- 5.6.3.** The Board shall act as soon as is practical at its next scheduled regular meeting after receiving the MEC’s recommendation, unless the MEC has made a recommendation that Adversely Affects the applicant and the applicant has exercised or waived his or her right to a Hearing under the Fair Hearing Plan, if any. The applicant will be sent written Notice of the Board’s decision within thirty (30) days.
- 5.6.4.** In its discretion, the Board may defer action for a specified period of time, during which time it may refer the matter back to the MEC for specified further action, or seek advice from the President, legal counsel, or others on matters of concern. The Board’s decision shall be final and conclusive, except that if the MEC’s recommendation is one for which the applicant could not request a Hearing, and the Board’s decision is contrary to the MEC’s recommendation and is one for which the applicant has Hearing rights pursuant to the Fair Hearing Plan, the President shall notify the applicant and the applicant shall have thirty (30) days in which to request a Hearing. A decision of the Board shall constitute a Professional Review Action and if the decision Adversely Affects the applicant, may entitle the applicant to Hearing rights

pursuant to the Fair Hearing Plan. The applicant, the President and the MEC will be promptly notified of the decision of the Board.

- 5.6.5.** Withdrawal of an application for reasons other than questions of competence or conduct is not reportable to the NPDB.

**5.7     Reappointment and Renewal of Privileges** The Medical Staff Office shall, at least ninety (90) days prior to the expiration date of the Medical Staff Appointment of each Member, provide such Member with a Reappointment application for use in seeking Reappointment. Each Member who desires Reappointment shall, at least sixty (60) days prior to the expiration date, send the completed Reappointment application to the Medical Staff Office. Members may be subject to late and increased processing fees for submission of a Reappointment application later than the deadline, which shall be listed on the cover letter of their Reappointment packet. Failure to return the Reappointment application may be deemed a voluntary resignation from the Medical Staff and may result in automatic termination of Medical Staff Appointment and Clinical Privileges at the expiration of the Member's current term, at the discretion of the Hospital. A Practitioner whose Medical Staff Appointment and Clinical Privileges are so terminated shall not be entitled to any Hearing rights under the Fair Hearing Plan, but rather shall reapply to the Medical Staff using the application process for initial Appointment, which shall include the payment of all relevant Medical Staff fees or penalties.

- 5.7.2.** Each Medical Staff Appointment and granting of Clinical Privileges shall be for a term not to exceed two (2) years.

- 5.7.3.** The Board reviews and acts on MEC recommendations regarding Reappointment and renewal of Clinical Privileges.

- 5.7.4.** The Reappointment/renewal application includes, at a minimum, the following:

- a. Opportunity to request continuation of present Medical Staff Appointment category;
- b. Opportunity to request a change in Medical Staff Appointment category;
- c. Opportunity to request either additions to or deletions of specific Clinical Privileges; and
- d. Opportunity to provide updated information regarding appointments, honors, articles published, and other activities since the last Medical Staff Appointment.

- 5.7.5.** Applicants for Reappointment must meet the criteria for initial applications. In addition, an applicant for Reappointment must satisfy the following criteria or provide the following information:

- a. Satisfactory evidence of current clinical competence, judgment and clinical and technical skills;
  - b. Performance information, ordinarily accumulated by the Hospital's Quality Improvement Office, reflecting clinical knowledge, skills, and performance, relationships with other physicians, with the Hospital and its employees and with patients, availability, mental and physical stability, technical proficiency and efficiency;
  - c. Information ordinarily accumulated by the Medical Staff Office about the degree of participation in Medical Staff business and educational meetings, and other Medical Staff activities including the ability to work with other health providers and Hospital administrative personnel;
  - d. Such other information as the MEC and/or the Board may require confirming currently dependable performance; and
  - e. Evidence of compliance with Hospital's performance improvement programs.
  - f. History of compliance with the Individual Member Responsibilities at Section 2.5 of these Bylaws and the Governing Documents; and
  - g. Other information, sources, and bases deemed relevant and important by the MEC and the Board.
- 5.7.6.** An application for Reappointment shall be evaluated and processed in the same manner and in accordance with the same timelines as an application for initial Appointment. An application for Reappointment will be reviewed against the backdrop of the applicant's actual performance at the Hospital during the current term as well as information collected from the applicant and outside sources. Matters and events which did not result in an Adverse Affect during the current term can nevertheless be relevant or determinative in the Reappointment process. Matters and events from an earlier term of Appointment are relevant if they help demonstrate a pattern or explain matters and events from a current term.
- 5.7.7.** Courtesy and Consulting Staff, and Active Staff that have not met meeting attendance requirements may be charged a fee, as determined by the MEC, for Reappointment to the Medical Staff.

**5.8 Reporting Obligations Between Routine Reappointment Dates.** Practitioners shall immediately furnish to the MEC, whenever applicable, during their Medical Staff Appointment:

- 5.8.1.** Information if the Practitioner's professional license in any state or other jurisdiction and/or DEA registration has been limited, revoked, restricted, suspended, censured, not renewed or voluntarily relinquished or if such actions are pending;



- 5.8.2.** Information if professional liability insurance is cancelled, or lapses without renewal;
- 5.8.3.** Information about restrictions on, involuntary relinquishment of, suspension or revocation of medical staff membership and/or clinical privileges at another institution, or whether such restrictions, suspensions, or revocations are pending;
- 5.8.4.** Information about malpractice judgments, claims, suits or settlements or pending suits;
- 5.8.5.** Information about significant changes in health status;
- 5.8.6.** Information about any arrests, pending criminal charges or actual criminal convictions, meaning convictions of, pleas of guilty, no contest to any felony charges; or actual or pending conviction of, pleas of guilty, or no contest to misdemeanor charges in which the underlying allegations involve the practice of a health care profession, Federal Health Care Program fraud or abuse, third party reimbursement, the use of alcohol or controlled substances, crimes of violence or abuse, or crimes of moral turpitude;
- 5.8.7.** Information concerning any investigation for any violation involving any Federal Health Care Program, or whether such Member is suspended, debarred or subjected to any other sanction by a government program;
- 5.8.8.** Any information reasonably required by the MEC or the Board to adequately evaluate the Member; and
- 5.8.9.** If Member has entered into a “Letter of Agreement,” “Agreed Order” or similar agreement with any licensure board.

If at any time during a Member’s Appointment or Reappointment, due to the information reported to the MEC hereunder which affects such Member’s ability to meet the qualifications for Appointment as set forth in Section 3.3, such Member shall voluntarily relinquish such Member’s Appointment and Privileges, or withdraw such Member’s application for Appointment and Privileges, at the request of the MEC.

## 6. CLINICAL PRIVILEGES

- 6.1 Clinical Privileges and Obligations: General.** A Member may exercise only those Clinical Privileges which he or she has requested, and the MEC and the Board has granted. A Member shall be entitled to exercise only those Clinical Privileges specifically recommended by the MEC and granted by the Board or its designee beginning on the date of the Board's approval or as otherwise specified by the Board. The exercise of any Clinical Privilege shall be subject to the terms and provisions of the Member's professional license, the terms and provisions of these Bylaws, the Rules and Regulations, and the policies and procedures of the Hospital, all as may be in full force and effect from time to time. Clinical Privileges may be granted, modified or terminated only for reasons related to patient care or the provisions of these Bylaws, and only following the procedures provided herein. Medical Staff Appointment by itself confers no Clinical Privileges.
- 6.2 Responsibilities of Delineations.** Each Clinical Committee must participate in the development of criteria for Clinical Privileges when requested by the MEC.
- 6.3 Requests for Privileges.** Each Practitioner who desires specific Clinical Privileges, Temporary Privileges or a modification of existing Clinical Privileges must make a written request for them. The burden is on the applicant to supply all the necessary information for evaluation.
- 6.4 Basis for the Granting of Privileges.** Privileges are specific to the Hospital and, where appropriate, specific locations of the Hospital where services are provided, and Privileges are awarded on the basis of the applicant's current licensure, non-Excluded Provider status, education, training, experience, competence, ability and judgment. Modification of Privileges will also take into account ongoing monitoring of information concerning the individual's professional performance, judgment and clinical and technical skills. All Privileges granted must relate to:
- 6.4.1.** A Practitioner's documented experience in categories of treatment areas or procedures;
  - 6.4.2.** The results of treatment provided by the Practitioner;
  - 6.4.3.** Assessment of specialized competencies or qualifications required for specific Privileges;
  - 6.4.4.** Interpersonal and communication skills and professional behavior as observed or reported;
  - 6.4.5.** The conclusions drawn from the Hospital's performance improvement activities when available; and
  - 6.4.6.** The Hospital's current capabilities and needs, including the ability of the Hospital to provide adequate facilities in support of the performance of the Privileges, the needs of the Hospital for additional Member's with the specific Privileges, and the long-range plans of the Hospital with respect to the emphasis or de-emphasis of particular specialties and the

opening, closing, or purchase of specific services, resources, and capacity.

**6.5 Qualifications for Clinical Privileges.** It is the policy of the Hospital to grant Medical Staff Appointment and Clinical Privileges only to individuals who continuously meet the criteria for Medical Staff Appointment, and continuously meet the following privileging criteria:

- 6.5.1.** Fulfill the criteria for Medical Staff Appointment as identified in Section 3.3, including continuously maintaining current board certification as applicable, unless this requirement is waived by the Board;
- 6.5.2.** Demonstrate his/her background, experience and training, current competence, knowledge, judgment, ability to perform, and technique in his/her specialty for all Clinical Privileges requested;
- 6.5.3.** Upon request, provide evidence of both physical and mental health that does not impair the fulfillment of his/her responsibilities of Medical Staff Appointment and the specific Clinical Privileges requested by and granted to the applicant;
- 6.5.4.** Have appropriate personal qualifications, including consistent observance of ethical and professional standards. These standards include, at a minimum:
  - a. Abstinence from any participation in fee splitting or other illegal payment, receipt, or remuneration with respect to referral or patient service opportunities; and
  - b. A history of consistently acting in a professional, appropriate and collegial manner with others in previous clinical and professional settings;
- 6.5.5.** Demonstrate appropriate written and verbal communication skills;
- 6.5.6.** Any Member who may have occasion to admit an inpatient must demonstrate the capability to provide continuous care by having a plan to reside and/or have established or plan to establish an office within a reasonable response time to the Hospital, such that the Member is readily available (unless the applicant is joining a group practice in which members of the group live within that distance and can ensure adequate coverage for the Members' patients). The Board shall have discretion to determine a "reasonable" response time from the Hospital. The applicant must provide evidence of acceptable patient coverage to the MEC. This responsibility is independent of other responsibilities relating to emergency department call coverage contained in these Bylaws, the Rules and Regulations, or Medical Staff or Hospital policies;
- 6.5.7.** Demonstrate recent clinical performance within the last twelve (12) months with an active clinical practice in the area in which the Clinical

Privileges are sought, for purposes of ascertaining current clinical competence;

**6.5.8.** Provide evidence of skills to provide a type of service that the Board has determined to be appropriate for the performance within the Hospital and for which a need exists; and

**6.5.9.** Possess and provide any requested information including, but not limited to, a social security number, tax identification number, photo identification, proof of immigration status, and /or any provider identification number.

**6.6     Initial Clinical Privileges.** Each applicant, as part of the initial Medical Staff Appointment application procedure, shall request those specific Clinical Privileges, which he or she wishes to exercise. It is the applicant's burden to provide objective evidence of qualifications in these clinical areas. Requests for Clinical Privileges shall be processed in the same manner as Medical Staff Appointment.

**6.7     Review of Initial Clinical Privileges.**

**6.7.1.** All initial appointees to the Medical Staff and all Members granted new Clinical Privileges, except as otherwise determined by the MEC and the Board or its designee, shall be subject to a period of review of not less than six (6) months. Each initial appointee or Member granted new Clinical Privileges shall be assigned to a Clinical Committee where his or her performance shall be reviewed by the Clinical Committee Chair, or his or her designee.

**6.7.2.** Review of performance shall continue until the MEC receives and accepts by majority vote a written report signed by the appropriate Clinical Committee Chair, or his or her designee, which: (a) describes the review period; (b) evaluates the Member's performance; and (c) concludes, based upon the information available, that the Member is qualified for the unreviewed practice of the Clinical Privileges in question in that Clinical Department.

**6.7.3.** If an initial appointee to the Medical Staff or a Member granted a new Clinical Privilege fails to obtain a favorable report from the appropriate Clinical Committee Chair, or if the MEC fails to accept by majority vote the report of the Clinical Committee Chair, within twenty-four (24) months of the date of commencement of review of performance, the Medical Staff Appointment of the initial appointee, or the Clinical Privilege in question, shall automatically terminate, and the Member, upon request, shall be entitled to a Hearing pursuant to the Fair Hearing Plan.

**6.7.4.** The failure to successfully complete the review of a performance period for a particular Clinical Privilege shall not in and of itself preclude Medical Staff Appointment.

- 6.8 Duration of Clinical Privileges.** Clinical Privileges are awarded for a period not exceeding two (2) years, or for such shorter period as may be specified.
- 6.9 Periodic Renewal of Clinical Privileges.** At Medical Staff Reappointment time, specific Clinical Privilege requests must be updated by the Member and acted on by the MEC and the Board.
- 6.10 Clinical Privileges for New and Cross-Specialty Procedures for Which No Criteria Have Been Established.**
- 6.10.1.** In the event a request for Clinical Privileges is submitted for which no criteria have been established, the request will be tabled for a reasonable period of time, usually not to exceed sixty (60) days, during which the MEC will, upon recommendation from the appropriate Clinical Committee Chair(s) (as determined by the MEC), formulate the necessary criteria and recommend such criteria to the Board. Once objective criteria have been established, the original request will be processed in accordance with these Bylaws.
- 6.10.2.** For the development of criteria, the Practitioner must compile information relevant to the Clinical Privileges requested which may include, but need not be limited to, position and opinion papers from specialty organizations, White Papers from the Credentialing Resource Center and others as available, position and opinion statements from interested individuals or groups, and documentation from other hospitals in the region as appropriate.
- 6.10.3.** Criteria to be established for the Clinical Privilege(s) in question include education, training, board status, or certification (if applicable), experience, and evidence of current competence. Proctoring requirements, if any, will be addressed including who may serve as proctor and how many proctored cases will be required. Hospital related issues such as exclusive contracts, equipment, clinical/support staff and management will be referred to the appropriate Hospital administrator and/or Clinical Committee Chair.
- 6.10.4.** If the Clinical Privileges requested involve two or more specialty disciplines, an ad hoc committee will be appointed by the MEC to recommend criteria for the Clinical Privilege(s) in question. This committee will consist of at least one (1), but not more than two (2), Members from each involved discipline. The chair of the ad hoc committee will be a member of the MEC who has no vested interest in the issue.
- 6.11 Dentists and Podiatrists.**
- 6.11.1.** Dentists and podiatrists may request and receive Clinical Privileges within the scope of their respective licensure. Such Clinical Privileges may be limited or restricted upon the basis of an individual Practitioner's

demonstrated training, experience, competence, professional ethics, or failure to abide by the Hospital's rules and regulations.

- 6.11.2.** Each dental and podiatric patient admitted to the Hospital or scheduled for a surgical procedure must have a recorded history and physical examination as required by these Bylaws. A Member will be responsible for the medical treatment and medical record of that patient. A Nurse Practitioner or Physician Assistant who is a member of the Hospital APC staff may also provide a recorded history and physical examination with a co-signature from a member of the Active Medical Staff as may be required under the Bylaws. The dentist or podiatrist performing the procedure will be responsible for the operative report and other appropriate dental or podiatric records. Dentists and Podiatrists may treat patients within the scope of their licensure, and may exercise those Clinical Privileges applied for, recommended by the MEC, and granted by the Board.

The admitting Active Staff Member is responsible for the treatment of any medical problem, which may be present on admission or arise during hospitalization of such dental or podiatric patient.

## **6.12 Remote Providers and Telemedicine Privileges.**

- 6.12.1.** In order to meet patient care needs, the Hospital may enter into agreements with Practitioners, hospitals, or other health care entities to provide clinical services (including but not limited to interpretive and, diagnostic, or consultant services) through remote providers using telemedicine technology. In such instances, the individual Practitioners must be granted appropriate Clinical Privileges, but they are not required to be Members.
- 6.12.2.** Specific Clinical Privileges for the diagnosis and treatment of patients at the Hospital in this manner must be developed and delineated based upon commonly accepted quality standards.
- 6.12.3.** If the agreement for telemedicine services is with an individual Practitioner, the Practitioner must be granted Clinical Privileges in the manner provided for in these Bylaws for on-site Medical Staff Members.
- 6.12.4.** If the agreement for telemedicine services is with a distant Medicare participating hospital, the Hospital may accept the credentialing and privileging performed by the distant Medicare participating hospital as its own, provided that there is a written agreement between the Hospital and the distant Medicare participating hospital, the distant hospital provides a copy of the clinical privileges held by each applicable Practitioner, and the Hospital shares with the distant hospital its performance review data of the Practitioner.
- 6.12.5.** If the agreement for telemedicine services is with a distant telemedicine entity which is not a Medicare participating hospital, the Hospital may

accept the credentialing and privileging performed by the distant telemedicine entity if there is a written agreement specifying that the distant telemedicine entity will credential and privilege the Practitioner and furnish services according to, and in accordance with, all applicable Centers for Medicare and Medicaid Services (“CMS”) conditions of participation applicable to the Hospital, the telemedicine entity ensures that the Practitioners will provide the remote services consistent with their education, training, and competence, and the Hospital shares its performance review data of the relevant Practitioners with the distant telemedicine entity.

**6.12.6.** In all cases, the Practitioner must hold a license to practice in the State of Iowa.

**6.12.7.** In all cases the MEC and the Board must approve the Practitioner’s Clinical Privileges.

**6.12.8.** Temporary Privileges (granted in accordance with Section 6.13) may be used if the Hospital has a pressing clinical need that can be met by a Practitioner providing services via a telemedicine link.

### **6.13 Temporary Privileges**

**6.13.1. Circumstances.** Temporary Privileges are available to Practitioners subject to all requirements in these Bylaws and the Rules and Regulations in only the following two (2) circumstances:

- a. The Practitioner has filed a Complete Application for Medical Staff Appointment and is awaiting review and approval of the MEC and/or the Board and the Practitioner meets the qualifications set forth in these Bylaws for Medical Staff Appointment, verified as described in Section 6.16.6 below; or
- b. The Practitioner has not applied for Medical Staff Appointment but is necessary to fill an important patient care need as determined on a case-by-case basis by the MEC, Chief Medical Officer, Chief of Staff and the Board and meets the qualifications set forth in these Bylaws for Medical Staff Appointment, verified as described in Section 6.16.5 below.

**6.13.2. Duration of Temporary Privileges.** Temporary Privileges are granted for no more than one hundred twenty (120) days.

**6.13.3. Application for Temporary Privileges.** Each applicant for Temporary Privileges, including those who do not seek Medical Staff Appointment, must receive and review a copy of these Bylaws, the Rules and Regulations, and the Policies applicable to the Clinical Privileges sought and agree to abide by them. In addition, applicants must request Temporary Privileges on the form approved by the MEC for that purpose.

- a. Affirmatively demonstrates special circumstances to justify the award of Temporary Privileges without undergoing complete review of the appropriate Medical Staff application; and
- b. Has in the file a current NPDB Report, which has been obtained and evaluated by appropriate staff.

**6.13.4. Processing of Temporary Privileges for New Applications for Appointment.** Requests for Temporary Privileges are processed in the same manner as Medical Staff applications except as otherwise provided in these Bylaws.

**6.13.5. Processing of Temporary Privileges to Meet an Important Care Need.** When Temporary Privileges are requested to meet an important patient care need, the President, or his or her designee, upon the recommendation of the Medical Staff President, may immediately authorize the Practitioner to exercise the Privileges requested after verification of the following:

- a. Current licensure to practice in the State of Iowa;
- b. Current and valid DEA registration, as applicable;
- c. Professional liability insurance in limits not less than the minimum amount specified by the Board, which covers the exercise of the Privileges requested;
- d. The applicant is not and has not been excluded or threatened to be excluded from any Federal Health Care Program;
- e. A current NPDB report evaluated and deemed acceptable by appropriate staff;
- f. The applicant possesses, based upon information reasonably available under the circumstances, the qualifications, current competence, relevant training, and abilities and judgment necessary to exercise the requested Privileges; and
- g. The applicant affirmatively demonstrates special circumstances to justify the award of Temporary Privileges to meet an important patient care need and to expedite the credentialing process.

**6.13.6. Standards for Approval for an Applicant Seeking Medical Staff Appointment.** The President (or his designee), upon the recommendation of the Medical Staff President (or their designees), may grant a request for Temporary Privileges if the applicant meets the qualifications set forth in these Bylaws. Prior to granting Temporary Privileges, it must be verified that the applicant:

- a. Meets all of the qualifications set forth in Section 6.16.5;



- b. Has no current or previously successful challenge to licensure or DEA registration;
- c. Has not been subject to any involuntary limitation, reduction, denial, restriction, termination, relinquishment, or loss of Clinical Privileges or medical staff membership;
- d. Affirmatively demonstrates special circumstances to justify the award of Temporary Privileges and to expedite the credentialing process.

**6.13.7. Procedure After Award.** After Temporary Privileges are granted, the Board must ratify their award at its next regularly scheduled meeting in order for the Practitioner to continue exercising the Temporary Privileges. A grant of Temporary Privileges is a courtesy and does not ensure ratification of an award of Medical Staff Appointment or regular Clinical Privileges.

- a. A Practitioner who receives Temporary Privileges is assigned to a Clinical Committee where the Temporary Privileges will be exercised. The Clinical Committee Chair may impose consultation or reporting requirements on the Practitioner as part of his customary monitoring activities.
- b. Temporary Privileges shall automatically terminate at the end of the designated timeframe unless earlier resigned or not ratified by the Board, as set forth in this Section, or terminated, suspended, renewed, or extended in accordance with these Bylaws, but under no circumstance shall the timeframe of any grant, renewal, or extension of Temporary Privileges exceed one hundred twenty (120) total days.

**6.13.8. Denial or Termination.** The President may, upon consultation with the Chief of Staff and appropriate Clinical Committee Chair, deny, modify or terminate Temporary Privileges. The patients of the Practitioner whose Temporary Privileges were denied, modified, or terminated shall be consulted, to the extent feasible, for the choice of a replacement Practitioner. Termination of Temporary Privileges will be effective as of the date of discharge from the Hospital of the Practitioner's patient(s) then under his or her care in the Hospital, if there is no other Active Staff Member who is qualified to continue to treat the patient.

**6.13.9. Hearing Rights.** Denials, modifications, or terminations of Temporary Privileges, unless otherwise described, are deemed not to relate to the Practitioner's professional competence or conduct and do not entitle him or her to a Hearing under the Fair Hearing Plan. Grounds for denying, modifying, or terminating Temporary Privileges not entitling a Practitioner to a Hearing under the Fair Hearing Plan include, but are not limited to:

- a. The Practitioner's failure to bear the burden of providing sufficient, accurate, and complete information regarding his or her licensure,

DEA registration, non-excluded status, NPDB report, insurance or competence;

- b. The Practitioner's failure to establish special circumstances; and
- c. The available information is insufficient under the circumstances to allow or continue to allow the Practitioner to exercise the requested Privileges.

Denials, modifications, or terminations that expressly relate to a Practitioner's competence or professional conduct entitle the applicant to a Hearing under the Fair Hearing Plan.

**6.13.10. Rights.** If applicable, Practitioners with Temporary Privileges have the same admitting rights as Members in the category to which the Practitioner intends to advance. Such Practitioners may attend and participate in Clinical Committee meetings of which they are a member, but may not vote, hold office, or chair committees.

#### **6.14 Employed Physicians.**

**6.14.1.** The Medical Staff Appointment and Clinical Privileges of a Practitioner who is employed by the Hospital are not coterminous with employment status, unless the Practitioner's employment agreement provides otherwise.

**6.14.2.** The Medical Staff reserves the right to take corrective action under these Bylaws and the Rules and Regulations against a Practitioner employed by the Hospital independent of any employment action. Practitioners employed by the Hospital are also subject to relevant Hospital human resources policies and processes and the terms of any employment agreements.

#### **6.15 Contracted Services.**

**6.15.1.** A Member under an exclusive contract with the Hospital must meet and hold continuously all the necessary qualifications of Medical Staff Appointment and Clinical Privileges applicable to the facilities he or she uses or the services he or she provides.

**6.15.2.** Contract termination, expiration and renewal matters are governed by the contract with the Hospital, and except as otherwise provided herein or in such contract with the Hospital, Medical Staff Appointment and Clinical Privileges are not coterminous with the Hospital contract.

**6.15.3.** When the Hospital enters into an exclusive contract, Members must honor the exclusivity policy and, except in emergencies, arrange for the care of patients in accordance with the Hospital's policy and the terms of the applicable agreements.

**6.15.4.** Applicants to the Medical Staff for Medical Staff Appointment or Clinical Privileges covered by a Hospital exclusive contractual arrangement to which the applicant is not a party will not be accepted or processed.

**6.15.5.** In consultation with the Medical Staff and in accordance with a Board resolution that is based on objective data that meets the needs of the community, the Hospital reserves the right to determine the clinical services which will be the subject of exclusive agreements. Such arrangements must be in accordance with state and federal laws, including any and all relevant antitrust laws, and the Hospital's other contractual agreements.

**6.15.6.** Following the Hospital entering into an exclusive agreement for clinical services, it reserves the right to terminate the Clinical Privileges of Members who are not parties to the exclusive agreement and who hold Clinical Privileges for services covered by the exclusive agreement. In such cases, the holder of the terminated Clinical Privileges is not entitled to any Hearing rights pursuant to the Fair Hearing Plan.

**6.16** **Emergency Privileges.** For purposes of this Section, a "Medical Emergency" is defined as a condition in which serious or permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger. In the case of a Medical Emergency, any Practitioner, to the degree permitted by license and regardless of Medical Staff Appointment or Clinical Privileges, shall be permitted to do, and be assisted by Hospital personnel in doing, everything possible to save the life of the patient or to save the patient from serious harm. A Practitioner exercising Emergency Privileges is obligated to summon all consultative assistance deemed necessary and to arrange for appropriate follow-up by Members with appropriate Privileges. The exercise of Emergency Privileges under this section shall not be considered exercising Clinical Privileges, but rather the right and authority is exclusively for the benefit of the patient.

**6.17** **Disaster Privileges.** If the Hospital's Disaster Plan has been activated and the Hospital is unable to handle immediate patient needs, the President, the Medical Staff President, or their designee may, on a case by case basis consistent with medical licensing and other relevant state statutes, grant Disaster Privileges to selected Practitioners for the provision of patient care, in accordance with the following:

**6.17.1.** The Practitioner must complete a Disaster Privileges form and sign a statement attesting that the information given is accurate.

**6.17.2.** The Practitioner agrees to be bound by all Hospital policies and rules, as well as these Bylaws and the Rules and Regulations, as well as directives from the supervising physician, or other Member.

- 6.17.3.** The Medical Staff oversees the professional practice of Practitioners providing care pursuant to Disaster Privileges and, when possible, the Practitioner must practice under the direct supervision of a Member.
- 6.17.4.** Visible identification is to be worn by any Practitioner practicing pursuant to Disaster Privileges.
- 6.17.5.** As soon as reasonably possible, the following credentials must be made available to the President:
- a. A current photo identification (e.g., driver's license, identification from another hospital, passport);
  - b. Current professional license to practice in the State of Iowa (Note: depending upon the severity of the disaster, out-of-state medical licensure may be accepted if so declared by the State of Iowa);
  - c. Identification that the individual is a member of a Disaster Medical Assistance Team (DMAT);
  - d. Identification that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by federal, state, or municipal entity; and
  - e. Presentation by a current Member with personal knowledge regarding the Practitioner's identity.
- 6.17.6.** At such times as the immediate situation requiring Disaster Privileges is under control, the Medical Staff Office shall verify credentials and privileges of those Practitioners given Disaster Privileges. Primary source verification of licensure shall begin as soon as the immediate situation is under control, and must be completed within seventy-two (72) hours from the time the volunteer Practitioner presents to the Hospital. In the extraordinary circumstance that primary source verification cannot be completed in seventy-two (72) hours (e.g., no means of communication or a lack of resources), it is expected that it shall be completed as soon as possible. In this extraordinary circumstance, there must be documentation of the following: why primary source verification could not be performed in the required time frame; evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and an attempt to rectify the situation as soon as possible. Primary source verification of licensure is only required if the volunteer Practitioner has provided care, treatment, and services under the Disaster Privileges.
- 6.17.7.** Any information gathered that is not consistent with that provided by the Practitioner must be referred to the Medical Staff President (or designee), or appropriate Hospital administration staff who will determine any additional necessary action. The Practitioner's Disaster Privileges will be immediately terminated in the event that any information received through the verification process indicates any

adverse information or suggests the person is not capable of rendering services in a disaster. Termination of Disaster Privileges does not entitle the Practitioner to Hearing rights pursuant to the Fair Hearing Plan.

**6.17.8.** In extreme situations, where communication does not allow verification of information, the decision to grant Disaster Privileges will be made by joint decision of the President and the Medical Staff President (or their designees).

**6.17.9.** Disaster Privileges will be for the duration of the disaster only. Disaster Privileges will automatically be terminated at the end of the need for services.

**6.17.10.** Any individual with the authority to grant disaster privileges shall also have the authority to terminate disaster privileges. Such authority may be exercised in the sole discretion of the Hospital and will not give rise to rights to a Hearing under the Fair Hearing Plan.

**6.18** **Medico-Administrative Positions.** Practitioners with whom Hospital contracts whose duties include clinically related administrative activities must be Members and if desired by the MEC, must obtain Clinical Privileges in the same manner as any other Member. If the termination of the Practitioner's administrative duties occurs and is not based on the Practitioner's professional competence or conduct, the Practitioner's Medical Staff Appointment and Clinical Privileges shall not be affected.

**6.19** **Residents.**

**6.19.1.** Residents must submit all necessary credentials to the President for approval, including proof of insurance and a letter from an appropriate authority stating the Resident is in Good Standing in the program claimed by the Resident, prior to providing care at the Hospital.

**6.19.2.** Residents are not Members and may only provide services within the scope of Privileges recommended by the MEC and approved by the Board. Residents must be supervised by the Clinical Committee Chair, program director, and Members.

**6.19.3.** Residents are required to conform to the same standards of conduct, ethics, and policies, rules and regulations as Members. Residents are not entitled to the Hearing rights under the Fair Hearing Plan. Residents may not hold office, admit patients, or vote unless specifically allowed elsewhere in the Governing Documents. Residents are permitted to serve without vote on all standing and ad hoc committees.

**6.19.4.** Residents may be retained by the Hospital to provide services outside of their graduate medical education training program (i.e., "moonlighting"). In such cases, the Resident must be credentialed for such services in accordance with these Bylaws and related credentialing policies and the

Resident must have the signed permission of his or her program director and act in accordance with their relevant training program policies.

**6.20 Medical Students, Physician Assistant Students, and Nurse Practitioner Students.**

- 6.20.1.** All medical students, physician assistant students, and nurse practitioner students (collectively, “Students”) must register in the Medical Staff Office prior to any patient contact or observation-only status in the Hospital.
- 6.20.2.** All Students must be in an approved medical school program or approved training program. For purposes of this Section, an “approved” program is one fully accredited during the time of the Student’s attendance at the Hospital by the Liaison Committee on Medical Education, by the AOA, by the Commission on Dental Accreditation, by the Council on Podiatric Medical Education of the American Podiatric Medical Association, by the ACGME or by a successor agency to any of these entities or an accrediting agency on file with the United States Secretary of Education.
- 6.20.3.** All Students must provide the required documentation and receive approval from the Medical Staff Office prior to participation in patient care. Participation will be under the supervision of a physician, who must be a Member with Clinical Privileges to perform the procedure. Prior to beginning clerkship or clinical rotation, Students must provide written verification from the approved school/training program which includes:
  - a. Verification as a student in Good Standing;
  - b. Approval of clerkship or clinical rotation, naming specific rotation;
  - c. The exact dates of rotation;
  - d. Verification of health/immunization status; and
  - e. Specific description of liability coverage.
- 6.20.4.** Students’ responsibilities in general shall be limited to the following:
  - a. Students are not Members;
  - b. Students may participate directly in the care of patients or exercise judgment within their areas of responsibility only under the supervision of a sponsoring Member physician, who has ultimate responsibility for patient care. The Member physician shall be solely responsible for on-going supervision of any Student.
  - c. Students are required to conform to the same standards of conduct, ethics and policies, these Bylaws, and Rules and Regulations as Members.

- d. Students are not entitled to any Hearing rights under the Fair Hearing Plan.
  - e. Students may not hold office, serve on Medical Staff committees or admit patients.
- 6.20.5.** The Member, as sponsor, shall be responsible for notifying the Medical Staff Office when a Student is practicing, who will in turn notify all affected Hospital personnel. The Medical Staff Office must obtain the signature of the sponsoring Member physician on the Medical Staff Office “Medical Student/Physician Assistant Student/Nurse Practitioner Student Information Form.” The sponsoring Member physician will maintain evaluation and documentation of the clinical rotation. The Medical Staff Office will not maintain evaluation records for any clinical rotation or observers.

## **6.21 Leave of Absence.**

- 6.21.1.** A leave of absence must be requested for any absence from the Medical Staff and/or patient care responsibilities longer than sixty (60) days if such absence is related to the Practitioner’s physical or mental health or to the ability to care for patients safely and competently. A Practitioner who wishes to obtain a voluntary leave of absence must be in Good Standing and in compliance with all requirements of these Bylaws and the Rules and Regulations, including timely completion of medical records, unless good reason for such non-compliance can be shown to the MEC, and must provide written notice to the Medical Staff President stating the reasons for the leave and the approximate period of time of the leave, which may not exceed two (2) years, except for military service or express written permission by the Board. While on a leave of absence, the Practitioner may not exercise Clinical Privileges or prerogatives and has no obligation to fulfill Medical Staff responsibilities (e.g., meeting attendance, committee service, emergency call service obligations, etc.).
- 6.21.2.** At least thirty (30) calendar days prior to termination of the leave of absence, or at any earlier time, the Member may request reinstatement by written request to the President/CEO, which shall include a summary of his or her activities during the leave and verification that he or she continues to meet the qualifications for Medical Staff Appointment. A Member returning from a leave of absence for health reasons must provide a report from his/her physician indicating that the Member is capable of resuming the exercise of Clinical Privileges safely and completely. In addition, the Member’s physician must be available to answer any questions that the Medical Staff President or the Board may have as part of considering the request for reinstatement. The President/CEO will forward the request to the MEC, which shall then make a recommendation to the Board as to reinstatement and the applicable procedures concerning the granting of Clinical Privileges are followed. If a request for reinstatement is not granted for reasons related

to clinical competency or professional conduct, the Member shall be entitled to request a Hearing and Appeal pursuant to the Fair Hearing Plan.

**6.21.3.** Where a Member's Medical Staff Appointment expires during a leave of absence, or is due to expire upon request for reinstatement, the Member may be granted Temporary Privileges for up to one hundred twenty days (120) days after:

- a. The verification of credentials information in the Member's existing file;
- b. The results of an updated NPDB query have been obtained and evaluated;
- c. The verification of current licensure and DEA certification;
- d. The verification of non-Excluded Provider status;
- e. The verification of current professional liability insurance coverage as specified by the Hospital Bylaws, or the Board; and
- f. Evidence of current competence and current ability to perform the Privileges requested.

**6.21.4.** Prior to the completion of the Temporary Privileges period described in Section 10.12.4 the Member shall be recredentialed and reprivileged in accordance with the process for Reappointment and information from the Member's previous two (2) years of activity shall be considered.

**6.21.5.** A Member whose term of Appointment will expire during a planned leave of absence may be reappointed/reprivileged prior to the start of the leave of absence; or reappointed/reprivileged during the leave of absence. In either case, the Member will be asked to provide the required information upon return from the leave of absence.

**6.21.6.** Failure of a Practitioner, without good cause, to request reinstatement or make application for extension of a leave of absence shall be deemed a voluntary resignation from the Medical Staff, shall result in automatic termination of Medical Staff Appointment, Clinical Privileges, and prerogatives, and shall not be subject to Hearing rights pursuant to the Fair Hearing Plan. Resignation in this manner does not preclude the Member from reapplying for Appointment or Privileges through the usual initial Appointment procedure.



## **7. ADVANCE PRACTICE CLINICIANS**

### **7.1 Advance Practice Clinicians.**

- 7.1.1.** Any Advance Practice Clinician may be appointed as an Advanced Practice Member of the Medical Staff. Any APC who functions under the supervision/collaboration of a duly licensed physician, must be supervised by or practice in collaboration with a Member that has Active or Courtesy Staff Appointment at the Hospital.
- 7.1.2.** APCs are welcome at, but are not required to attend, meetings of the Medical Staff, but Advanced Practice Members are required to attend in accordance with these Bylaws.
- 7.1.3.** The employer or sponsor of an APC assumes responsibility for the APC's clinical activities.
- 7.1.4.** All categories of medical or surgical assistants (other than APCs) (e.g., medical assistants, registered nurses, etc.) must be processed by the Hospital's Human Resources department.

### **7.2 APC Qualifications**

- 7.2.1.** The Board of Directors in consultation with the Medical Staff shall determine the services to be provided in the Hospital and the categories of APCs eligible to provide service in the Hospital.
- 7.2.2.** In order to be appointed as an Advanced Practice Member and granted the right to provide services in the Hospital, an APC must:
  - a. Maintain a current license, certificate or other approvals in good standing to practice a health care profession or related service (other than those specified as eligible for Medical Staff Appointment) in the State of Iowa;
  - b. Never have had clinical privileges or scope of practice denied, revoked, resigned, relinquished, or terminated by any health care facility, health plan, or other entity for reasons related to clinical competence or professional conduct;
  - c. Never have been convicted of, or entered a plea of guilty or no contest to any misdemeanor relating to controlled substances, illegal drugs, insurance fraud or abuse or violence or to any felony.
  - d. Possess the necessary experience, background, training, professional ability and physical and mental health to provide quality care to the patients he or she serves;
  - e. Be sponsored, supervised and directed by a Member on the Active or Courtesy Staff, and document such relationship to the satisfaction of Hospital, where applicable;

- f. Adhere strictly to the ethics of his or her profession, the MercyOne Code of Conduct, and the ERDs;
- g. Practice in such a manner that his or her activities do not interfere with the orderly and efficient rendering of services by the Hospital or by Members; work cooperatively and harmoniously with others in the Hospital setting; be willing to participate in and properly discharge APC staff responsibilities; and commit to and regularly assist the Hospital in fulfilling its obligations related to patient care, within the areas of their professional competence;
- h. Provide acceptable evidence of professional liability insurance coverage for the term of the requested appointment or reappointment in an amount not less than the minimum amount determined by the Board of Directors;
- i. Be willing to participate in the discharge of other responsibilities at the request of the President or the Medical Staff President;
- j. Maintain in force and effect professional liability insurance in amounts established by the Board with a carrier reasonably acceptable to the Hospital; and
- k. Not be excluded from any Federal Health Care Program.

**7.3 Delineation of Categories of APCs Eligible to Apply For Privileges.** For each eligible APC category as determined by the Board, the Board shall identify the mode of practice in the Hospital setting (i.e., independent or dependent) and the privileges and prerogatives that may be granted to qualified APCs in that category. The Board may secure recommendations from the MEC as to the categories of APCs which should be eligible to apply for privileges, and shall secure recommendations from the MEC as to the privileges, prerogatives, terms and conditions which may be granted and apply to APCs in each category. The delineation of categories of APCs eligible to apply for privileges and the corresponding privileges, prerogatives, terms, and conditions for each APC category, when approved by the MEC and the Board, shall be set forth in the Medical Staff Rules and Regulations or in a document appended to the Rules and Regulations.

**7.4 Procedure for Granting Practice Privileges.**

**7.4.1.** An APC must apply and qualify for practice privileges, and Practitioners who desire to supervise or direct APCs who provide dependent services must apply and qualify for privileges to supervise approved APCs. Applications for initial granting of privileges, and biennial renewal thereof, shall be submitted and processed in a parallel manner to that provided in these Bylaws, unless otherwise specified in the Medical Staff Rules and Regulations.

**7.4.2.** An APC who does not have licensure or certification in an APC category identified as eligible for privileges in the manner required by

Section 7.4 above may not apply for privileges, but may submit a written request to the President/CEO, asking that the Board of Directors consider identifying the appropriate category of APCs as eligible to apply for privileges. The Board of Directors may refer the request to the MEC for recommendation; but shall consider such request no later than its biennial review.

- 7.4.3. Each APC shall be assigned to the clinical committee appropriate to his/her occupational or professional training and, unless otherwise specified in these Bylaws or the Rules and Regulations, shall be subject to terms and conditions paralleling those specified in these Bylaws, as they may logically be applied to APCs and appropriately tailored to the particular APCs profession.

7.5 **Prerogatives.** The prerogatives which may be extended to an APC shall be defined in the Medical Staff Rules and Regulations or Hospital policies. Such prerogatives may include:

- 7.5.1. Provision of specified patient care services under the medical direction of the committee chair of the clinical committee to which the APC is assigned. For those APCs who are categorized as Dependent, the services must also be provided under the supervision of a physician member of the Medical Staff. In all cases, services provided will be consistent with the scope of the APC's licensure or certification and clinical privileges.
- 7.5.2. Serving on Medical Staff, committees and Hospital committees if requested by the Hospital to do so.
- 7.5.3. Attendance at the meeting of the committee's to which he/she is assigned, as permitted by the committee Rules and Regulations, and attendance at Hospital education programs in his/her field of practice.

7.6 **APC Duties and Responsibilities.** APCs must:

- 7.6.1. Provide patients with quality care in accordance with applicable laws, regulations and standards of practice.
- 7.6.2. Pursue only those clinical activities specifically applied for, acted upon by the MEC, and approved by the Board.
- 7.6.3. Practice only in accordance with the Hospital's scope of practice and supervision requirements.
- 7.6.4. Abide by these Bylaws, the Rules and Regulations, and the policies and procedures of the Hospital as they may exist now or in the future, as appropriate to APCs.
- 7.6.5. Prepare and complete in a timely fashion the medical and other required records reflecting his or her activities at the Hospital.

- 7.6.6. Participate and comply with the Hospital's corporate responsibility programs including, without limitation, any training and education requirements related thereto.
  - 7.6.7. Not admit patients (except as otherwise expressly permitted by Hospital Policy or the Rules and Regulations), but Physician Assistants ("PA's") and CNM's may write admission orders and assume other responsibilities as described in Section 7.7.
  - 7.6.8. Not write orders for patient care unless specifically authorized to do so as part of the APC permitted scope of practice, the APC's collaborative practice or supervision agreement, the CHI/APC Core Privileges and the credentialing process, or in the event of a medical or surgical emergency.
  - 7.6.9. Respond to recommendations made as a result of development and use of Practitioner-specific data in quality improvement activities.
  - 7.6.10. Abide by the entitled "Chemically Impaired Practitioners," "Sexual Harassment," and "Disruptive Practitioners," policies in the Medical Staff Rules and Regulations.
  - 7.6.11. Immediately notify the Medical Staff President in the event his or her required collaborative practice or supervision agreement or corresponding relationship with the supervising or collaborating Member terminates or changes.
- 7.7 **Core Privileges for CNM's and PA's.** The core privileges for APC's will match the CHI Core Privileges for Advanced Practice Clinicians as approved by the Medical Executive Committee and Board of Directors.
- 7.8 **Conditions of Appointment and Reappointment of APCs.** Policies regarding the need for, and appointment/reappointment of APCs shall be at the discretion of the Board. APCs shall be credentialed as Advanced Practice Members using the same appointment and reappointment procedures as those for other Members, as set forth in Section 5 of these Bylaws. Every APC appointed as an Advanced Practice Member agrees to be bound by the conditions of Appointment and the confidentiality, immunity and release provisions set forth in these Bylaws, as such provisions apply to APCs. Each APC appointment/reappointment and grant of Clinical Privileges shall be for a term not to exceed two (2) years.
- 7.9 **Termination of APC Privileges.**
- 7.9.1. Automatic Termination. An APC's Privileges shall automatically terminate, without right of review, in the event:
    - a. The Appointment, contract or related Privileges of the supervising or collaborating Member is suspended or terminated, whether such suspension or termination is voluntary or involuntary;

- b. The supervising or collaborating Member no longer agrees to act as the supervising or collaborating Member for any reason, or the relationship between the APC and the supervising Member, if any, is otherwise terminated, regardless of the reason therefore;
- c. The contract between the Hospital and an APC for the provision of specified services terminates. Specific contractual terms shall, in all cases, be controlling the event that they conflict with provisions in the Governing Documents;
- d. The APC's license or certification to practice expires, is revoked, or is suspended; or
- e. The APC fails to maintain the required professional liability insurance.

**7.9.2.** Action by the Medical Staff President. The APC's Privileges may also be limited, suspended, or terminated for other reasons by the Medical Staff President, subject to the review procedure set forth in Section 7.9 of these Bylaws.

**7.10 APC Review Process.** APCs shall not be entitled to Hearing rights under the Fair Hearing Plan, but rather an APC may appear on his or her own behalf (for reasons other than for automatic termination as specified in Sections 7.7.1) within fifteen (15) days of receiving Notice of such action

**7.10.1.** Before the MEC to discuss any disagreement about the MEC's recommendation regarding requested appointment, reappointment, and/or Clinical Privileges; and

**7.10.2.** Before the Board or relevant committee thereof to discuss a Board decision to terminate the appointment and/or specific Clinical Privilege of the APC.

Neither of such appearances shall constitute a Hearing or be conducted as such pursuant to the Fair Hearing Plan. Before such appearances, the affected APC shall be informed of the reasons for the action or proposed action and at the appearance the APC may present information relevant thereto. A report of the findings and recommendations following the appearances shall be made by the Medical Staff President to the MEC and the Board. The Board shall consider the recommendation of the MEC and the Board's decision shall be final.

**7.11 Supervising or Collaborating Members.** Suspension, termination or curtailment of the Privileges of an APC with whom a physician Member has a collaborative practice or supervision agreement shall not be deemed to adversely affect the Privileges of the physician Member and shall not trigger Hearing rights under the Fair Hearing Plan on behalf of the physician Member. The supervising or collaborating physician Member is responsible for the care rendered by the APC in such instances.

## 8. OFFICERS AND MEETINGS

### 8.1 List of Officers, Terms, and Succession.

Officers of the Medical Staff and their respective terms shall include:

<u>Office</u>	<u>Term</u>
President	2 Years
Vice-President	2 Years
Secretary/Treasurer	2 Years

Officers shall begin to serve on the first day of the Medical Staff year, commencing January 1st of said year. No member of the Medical Staff shall serve more than two (2) consecutive terms in office.

### 8.2 Eligibility Requirements.

#### 8.2.1. Officers must:

- a. Be Members in Good Standing on the Active Staff and continue to meet the requirements of an Active Staff Member during the term of office.
- b. Have previously served in a significant leadership capacity on the Medical Staff.
- c. Demonstrate a willingness to attend training sessions and to serve as an officer.
- d. Have no pending recommendations concerning Medical Staff Appointment or Clinical Privileges which could Adversely Affect the Member.
- e. Be willing to attend continuing education related to Medical Staff leadership and/or credentialing functions prior to or during the term of office.
- f. Have demonstrated an ability to work well with others.
- g. Have excellent administrative and communication skills.
- h. Recognize and agree to the commitment of time to perform the duties of the relevant office.
- i. Disclose in advance leadership positions on another hospital's medical staff or in a facility that is directly competing with the Hospital.

**8.2.2.** Any elected officer of the Medical Staff must attend at least fifty percent (50%) of assigned Medical Staff committee meetings.

**8.2.3.** Officers shall not hold two (2) offices simultaneously.

**8.2.4.** Officers shall not simultaneously hold office on a medical staff of any other hospital or other health care facility.

**8.3** **Selection of Officers.** In selecting its officers, the Medical Staff shall consider the responsibilities involved and candidates' interest, availability, organizational skills (including communication, writing and oral skills), and reputation for objectivity and fairness, all of which are required to best provide Medical Staff participation in Hospital affairs.

**8.4** **Nomination, Election, Vacancies.**

**8.4.1. Nominations.** A slate of officer candidates shall selected by the Nominating Committee which is comprised of three (3) Members of the Active Staff appointed by the Medical Staff President. Nominations for officers are allowed from the floor.

**8.4.2. Election.** Officers are elected by a simple majority vote of the Members that are present and eligible to vote.

**8.4.3. Vacancies.** Officer vacancies shall be filled by special election as soon as reasonably possible after the vacancy occurs, except that the Vice-President will fill any vacancy in the office of President and the special election will be for a replacement Vice-President.

**8.5** **Removal / Resignation of Officers.**

**8.5.1.** Failure of an officer to maintain Active Staff status will result in automatic removal from office.

**8.5.2.** In addition, the Medical Staff may, by a two-thirds majority (2/3) vote, remove any officer for failure to fulfill his or her responsibilities, malfeasance in office, physical or mental infirmity to a degree that renders him or her incapable of fulfilling the duties of the office, or conduct detrimental to the interests of the Hospital and/or Medical Staff.

**8.5.3.** An officer may resign by providing written notice to the Medical Staff President which sets forth the effective date of resignation. If the officer resigning from office is the Medical Staff President, then such notice shall be provided to the Secretary/Treasurer.

**8.6** **Duties of Officers.**

**8.6.1. Medical Staff President.** The Medical Staff President shall:

- a. Act in coordination and cooperation with the President/CEO in all matters of mutual concern within the Hospital;
- b. Call, preside at, and be responsible for the agenda of all general staff meetings of the Medical Staff;
- c. Serve on the MEC and serve as its chairperson;

- d. Serve as an ex-officio member of all other Medical Staff committees unless his/her membership in a particular committee is required by the Bylaws, in which case he/she shall serve as a voting member of the committee;
- e. Be responsible for the enforcement of these Bylaws and the Rules and Regulations;
- f. Appoint Medical Staff committee members to all standing, special, and multi-disciplinary committees, except as otherwise provided;
- g. Present the views, policies, and needs of the Medical Staff to the Board and President;
- h. Interpret the policies of the Board to the Medical Staff, and report to the Board on performance and maintenance of quality and efficient care;
- a. Assure performance of Medical Staff functions in accordance with these Bylaws and the Rules and Regulations;
- b. Counsel, advise, and/or admonish individual Members when there are questions about clinical performance, disregard for these Bylaws and the Rules and Regulations, lack of respect for co-workers, inefficient practice, suspected impairment, or practicing outside the limits of granted Clinical Privileges;
- c. Act as the spokesman for the Medical Staff to such groups as the MEC and other Medical Staff committees, Hospital executive/management staff, nursing and other Hospital departments, and the Board;
- d. Act as primary spokesman for the Medical Staff with outside agencies, where applicable, such as during the Hospital's survey by CMS;
- e. Analyze information, including but not limited to, applications for Medical Staff Appointment and Clinical Privileges, patient care information resulting from Hospital quality improvement activities, capital improvement needs of the Medical Staff, staffing needs, and the relevancy of the Rules and Regulations;
- f. Evaluate causes for, and participate in responses to untoward incidents involving Members;
- g. Serve as a coordinating point by providing information about Hospital and Medical Staff affairs to Members; and
- h. With the help of relevant support personnel, plan and conduct meetings of the MEC and the Medical Staff.



**8.6.2. Vice-President.** In the absence of the President, the Vice-President assumes the duties and authority of the President. In addition, the Vice-President shall:

- a. Serve on the MEC;
- b. Automatically succeed the President when the latter fails to serve for any reason;
- c. Succeed the President at the end of the President's term;
- d. Be responsible for the educational activities of the Medical Staff;

**8.6.3. Secretary-Treasurer.** The Secretary-Treasurer shall:

- a. Serve on the MEC;
- b. Provide for accurate and complete minutes of all Medical Staff meetings;
- c. Provide for a record of attendance at Medical Staff meetings;
- d. Attend to all correspondence on behalf of the Medical Staff; and
- e. Make minutes and correspondence available to the Board.

**8.7 Meetings of the General Medical Staff.**

**8.7.1.** The Medical Staff shall hold a regular meeting at least quarterly.

**8.7.2.** One regular meeting, at which officers are elected, shall be designated as the annual meeting of the Medical Staff.

**8.7.3.** Special meetings of the Medical Staff may be called at any time by the MEC, Medical Staff President, by thirty-three percent (33%) of the Members of the Active Staff, or by the Board, and are held at the time and place designated in the meeting notice.

**8.8 Notice of Meetings.** Notice of all meetings of the Medical Staff, the MEC, and of Medical Staff committees, shall be provided in a timely manner, by mail, fax, conspicuous posting, or other reasonable means, which shall be no less than seven (7) days and no more than thirty (30) days prior to the meeting.

**8.9 Quorum.** A quorum (whether for a Medical Staff meeting, or a meeting of a Medical Staff committee) shall be the presence of fifty percent (50%) of the Members eligible to vote at said meeting, except for meetings of the MEC, in which case a quorum shall be the presence of fifty percent (50%) of the members of the MEC. Once a quorum has been established, actions taken during the meeting are binding. Unannounced new business may be introduced and acted upon at a meeting only if a quorum is present. "Presence" includes appearance via telephone or video conference with approval from the Medical Staff President at the Medical

Staff President's sole discretion following a showing of "good cause" by the Member, such as the Member is out of the country.

- 8.10 Attendance Requirements.** Members of the Medical Staff assigned to Medical Staff categories with voting privileges (i.e., the Active Staff) are required to attend at least fifty percent (50%) of the regular and special Medical Staff meetings, and of meetings of Medical Staff committees of which they are a member.
- 8.11 Minutes.** Minutes of meetings shall include a record of attendance and actions taken. A permanent file of minutes of Medical Staff meetings and Medical Staff committee meetings shall be maintained in the Medical Staff Office.
- 8.12 Agenda.** The agenda for the annual meeting of the Medical Staff will be set by the Board and the MEC. The MEC shall set the agenda of other regularly scheduled Medical Staff meetings and the agenda for special Medical Staff meetings shall be set by whomever calls the special meetings.
- 8.13 Majority Vote.** Except as otherwise specified in these Bylaws, actions taken at a meeting at which a quorum has been established are by majority vote (i.e., at least 51%).
- 8.14 Action Without a Meeting.** Valid action may be taken without a meeting if it is acknowledged by a writing setting forth the action so taken which is signed by at least two-thirds (2/3) of the Members entitled to vote.
- 8.15 Rules of Order.** In matters not specifically addressed in these Bylaws, the Rules and Regulations or Hospital rules manuals, and wherever they do not conflict with these Bylaws, the latest edition of Robert's Rules of Order shall be followed.

## 9. MEDICAL STAFF COMMITTEES AND FUNCTIONS

**9.1 Representation on Hospital Committees.** Members shall participate, as requested, on Hospital committees dealing with matters that affect the Medical Staff (examples: Surgery/Anesthesia/Tissue & Transfusion Committee, Infection Control Committee, Peer Review Committee, OB/Nursery Committee, , Quality/Utilization Committee, Cardiac Rehab/Emergency Room/Respiratory Therapy/Trauma Committee, Pharmacy and Therapeutics Committee, Hospitalist/Inpatient Committee, Grievance Committee, and Ethics Committee). Such committees operate in accordance with the Bylaws of the Hospital, the Rules and Regulations, and any applicable policies and procedures.

### **9.2 Characteristics Common to All Committee.**

**9.2.1. Peer Review Confidentiality.** To the extent that committees perform as Professional Review Bodies, the proceedings and records of the committees shall be confidential and shall be regarded as Peer Review Matter (as defined in Section 12.3.3.) within the meaning of these Bylaws. All tangible Peer Review Matter must be securely stored in the Medical Staff Office.

**9.2.2. Committee Meetings.** All Members participating in a Medical Staff committee are expected to attend committee meetings and may be removed from services on a Medical Staff committee for poor attendance at the meetings.

### **9.3 Medical Executive Committee.**

**9.3.1. Function.** The MEC shall hold executive function and shall act on behalf of the Medical Staff between meetings of the Medical Staff. The MEC may appoint, with the Board's approval, other standing and special committees as may from time to time be necessary and desirable to perform specific Medical Staff functions.

**9.3.2. Composition.** The MEC shall include physicians and other Practitioners and individuals as determined by the Medical Staff. The MEC shall consist of the following:

Voting Members:

- a. President
- b. Vice-President
- c. Immediate Past-President
- d. Secretary-Treasurer
- e. Two members of the Active Medical Staff elected at an annual meeting;
- f. Additional Practitioners, if/as determined by the Medical Staff

Non-Voting Members:

- g. Chief Executive Officer
- h. Additional Practitioners, if/as determined by the Medical Staff

**9.3.3. Selection and Removal of MEC Members.** Because the MEC consists of the officers of the Medical Staff and the President, each such member of the MEC shall be elected/appointed and removed from the MEC in the same manner such member is elected/appointed to and removed from his or her respective titled position.

**9.3.4. Meetings.** The MEC shall meet at least every other month, plus on special call. If unable to meet every other month, the next scheduled meeting shall include agenda items of the cancelled meeting. A permanent record of the MEC's proceedings and actions shall be maintained in the Medical Staff Office.

**9.3.5. Duties.** The MEC shall be accountable to and responsible for making recommendations directly to the Board for its approval, and shall:

- a. Implement and enforce the Governing Documents;
- b. Monitor and evaluate care provided at the Hospital and develop clinical policies for patient care;
- c. Participate in organizational performance improvement activities, including operative and invasive procedures, blood usage, drug usage reviews, medical record and other reviews such as risk and patient safety activities;
- d. Conduct or coordinate utilization review activities;
- e. Recommend to the Board all matters relating to appointments, reappointments, Medical Staff category assignments, and Clinical Privileges;
- f. Provide continuing education opportunities responsive to quality assessment/improvement activities, new state-of-the-art developments and other perceived needs;
- g. Develop and maintain surveillance over drug utilization policies and practices;
- h. Investigate and control nosocomial infections and monitor the Hospital's infection control program;
- i. Plan for response to fire and other disasters by the Medical Staff, for Hospital growth and development, and for the provision of services required to meet the needs of the community;

- j. Direct Medical Staff activities, including review and revision of these Bylaws, staff officer and committee nominations, liaison with the Board and Hospital administration, and review and maintenance of Hospital TJC and state accreditation;
- k. Coordinate the care provided by Members with the care provided by the nursing service and with the activities of other Hospital patient care and administrative services;
- l. Engage in other functions reasonably requested by the Medical Staff, Hospital administration and the Board; and
- m. Directly report its actions and recommendations to the Medical Staff as a whole.

**9.3.6. Credentialing Duties.** The MEC also accomplishes the credentialing function of the Medical Staff by making recommendations to the Board. Credentialing responsibilities include, but are not necessarily limited to:

- a. Insisting on validation of information provided in support of applications;
- b. Conducting a thorough, objective and fair review of applications for Medical Staff Appointment and Clinical Privileges, both initial Appointment and Reappointment;
- c. Seeking such additional information as is deemed necessary to make confident recommendations about applicants to the Board;
- d. Forwarding a recommendation on each Complete Application for Medical Staff Appointment and/or Clinical Privileges, whether initial, renewal, or requested change; and
- e. Resolving problems with Members pursuant to Section 10 of these Bylaws.

**9.3.7. Delegation and Removal of Authority.** In addition to those duties and responsibilities of the MEC set forth herein, the Medical Staff may delegate the MEC to act on the Medical Staff's behalf on certain matters by a two-thirds (2/3) vote of the Members of the Active Staff. The Members of the Active Staff may also remove the MEC's delegated authority upon a two-thirds (2/3) vote.

**9.4 Credentials Committee.** The Credentials Committee will serve as a sub-committee of the Executive Committee to review credentials of all applicants for Medical Staff membership or clinical privileges, all applications for reappointment, conduct such investigations as are necessary and take such actions or make such recommendations regarding membership, clinical privileges, assignment to clinical services, in accordance with the provisions of Article III, IV, V, and VI of these Bylaws. The recommendations of this committee are to be made to the Executive Committee.

## **9.5 Nominating Committee.**

**9.5.1. Function.** The function of the Nominating Committee is to nominate officers when up for election. Therefore, the Nominating Committee is active every two (2) years.

**9.5.2. Composition.** The members of the Nominating Committee are selected by the Medical Staff President.

**9.5.3. Duties.** The Nominating Committee shall:

- a. Nominate a slate of officer candidates for any officer vacancies; and
- b. Conduct the balloting for the election of officers.

## **9.6 Bylaws Committee.**

**9.6.1. Function.** The function of the Bylaws Committee is to recommend changes to the Bylaws and the Rules and Regulations for review by the MEC.

**9.6.2. Composition.** The Bylaws Committee shall consist of at least four (4) Members of the Active Staff with experience in medical staff issues, one (1) of which shall be the Past-President. The chairman of the Bylaws Committee shall be appointed by the Medical Staff President.

**9.6.3. Duties.** The Bylaws Committee shall:

- a. On at least an every two year basis, review the Bylaws and the Rules and Regulations;
- b. On at least an every two year basis, recommend changes to the Bylaws and the Rules and Regulations for consideration by the MEC;
- c. Perform such duties related to the Bylaws and accreditation as the MEC or the President deems necessary; and
- d. Meet as frequently as necessary to make such reviews.

## **9.7 Additional Committees.**

**9.7.1.** The accomplishment of the following functions may or may not require the existence of separate, established committees. The functions consist of collection of relevant information (e.g., monitoring; use of performance indicators) and presentation to responsible individuals/groups for evaluation and action (e.g., evaluation/conclusions, problem-solving).

**9.7.2.** The Medical Staff shall evidence that these functions are effectively accomplished by reporting such functions to the MEC, and the Board.

**9.7.3.** The Medical Staff may establish other committees to serve such functions as set forth in the Rules and Regulations.

## **9.8     Clinical Committees and Clinical Committee Chairs**

**9.8.1.** Members shall be assigned to at least one Clinical Committee, but may also be granted Appointment or Clinical Privileges in other Clinical Committees consistent with the Clinical Privileges granted.

**9.8.2.** Each Clinical Committee shall have a Clinical Committee Chair with overall responsibility for the supervision and satisfactory discharge of his or her assigned functions as listed below.

**9.8.3.** The qualifications and roles and responsibilities of the Clinical Committee Chairs include the following:

- a. Qualifications. Clinical Committee Chairs must be Members in Good Standing and certified by an appropriate specialty board or have affirmatively established comparable competence through the credentialing process. However, non-Active Staff Members may only be eligible for selection as Clinical Committee Chairs in accordance with this Section 9.8.3 if approved in advance by a majority vote of the Active Staff.
- b. Selection of Clinical Committee Chairs. Clinical Committee Chairs shall be elected every two (2) years by those Members who are eligible to vote. For the purpose of this election, each individual eligible to be a Clinical Committee Chair shall be nominated by the Nominating Committee at least thirty (30) days prior to the meeting at which election is to take place. The recommendations of the Nominating Committee shall be circulated to the voting Members of each Committee at least seven (7) days prior to the election. Nominations also may be made from the floor when the election meeting is held, as long as the eligible nominee is present and consents to the nomination. Election of the Clinical Committee Chair shall be subject to ratification by the MEC and the Board. In the event of a vacancy, the MEC shall appoint an interim Clinical Committee Chair who shall serve in that capacity pending the completion of a special election.
- c. Removal of Clinical Committee Chairs. A Clinical Committee Chair may be removed from office for just cause (e.g. loss of licensure, loss of Appointment, misappropriation of funds, inability to fulfill basic duties of the office, or gross malfeasance) by a two-thirds (2/3) vote of the Members eligible to vote.
- d. Roles and Responsibilities. The Clinical Committee Chairs' responsibilities shall be developed by the MEC with input from the Members.

**9.8.4.** To carry out its function, each Clinical Committee and its elected Clinical Committee Chair shall:

- a. Cooperate and participate with the MEC and other Medical Staff committees, conduct retrospective patient care reviews for the purpose of analyzing and evaluating the quality of care within the Clinical Department. Such reviews will be conducted at least quarterly or at such intervals as shall be determined by the MEC in compliance with the standards of CMS. Each Clinical Committee shall review all clinical practice performed under its jurisdiction whether or not any particular Practitioner whose work is subject to such review is a Member in that Clinical Department;
- b. Conduct, participate in, and make recommendations regarding the need for continuing education programs pertinent to the Clinical Committee or section within the Clinical Committee and to address educational needs identified in quality improvement monitoring;
- c. Monitor adherence to Medical Staff and Hospital policies and procedures; requirements for alternative coverage and for consultations; sound principles of clinical practice; and regulations relating to patient safety;
- d. Submit timely reports to the MEC on a regular basis concerning findings of the Clinical Department's patient care evaluation and monitoring activities; recommendations for maintaining and improving the quality of care provided in the Clinical Committee and the Hospital; and such other matters as may be requested from time to time by the MEC or the Medical Staff President; and
- e. Establish such committees or other mechanisms as are necessary and desirable to properly perform the functions assigned to it.

**9.9 Risk Management.** MEC members shall participate in Hospital risk management activities, according to the Risk Management Plan.



## **10. CORRECTIVE ACTION AND INVESTIGATIONS**

**10.1 Reporting of Impaired Members.** All Practitioners must ensure that quality, safe care is delivered to Hospital patients. Any suspicion of impairment shall be reported immediately. For purposes of these Bylaws, “impaired” or “impairment” is defined as being unable to practice medicine or provide services within a Practitioner’s scope of practice with reasonable skill and competency, and/or an inability to function safely and effectively because of physical or mental illness, including deterioration through the aging process or loss of motor skills, or the use or abuse of alcohol, drugs, or other mind altering substances.

**10.1.1.** At any time, if a Member feels that he or she may have an impairment, he or she may self-refer to an appropriate professional for either internal or external resources to diagnose and/or treat the condition of concern. Any self-referral for diagnosis and/or treatment for impairment shall be reported to the Clinical Committee Chair, Medical Staff President, MEC, or President by the Member.

**10.1.2.** An individual (or the MEC) who suspects a Practitioner of being impaired must give an oral or, preferably, a written report to the President or the Medical Staff President. The report must be factual and shall include a description of the incident(s) that led to the belief that the Practitioner might be impaired. The individual (or the MEC) making the report does not need to have proof of impairment, but must state the facts that led to the suspicions of impairment.

**10.1.3.** Matters relating to a Practitioner’s health may be addressed in accordance with the Practitioner health or impaired physician policy and may be referred for Investigation in accordance with these Bylaws.

### **10.2 Collegial Intervention.**

**10.2.1.** These Bylaws require each Member to cooperate with the Hospital, Medical Staff officers, Clinical Committee Chairs and Medical Staff committees in order to continuously improve individual and collective performance. From time to time, these entities or persons may choose to hold routine discussions with a Member or multiple Members in order to provide education, assistance in providing quality medical care, and encouragement to participate in performance improvement, resource management, or other activities with the Hospital. The routine function of performance improvement, resource management or other programs, and the discussion among Members in that context, does not constitute an Investigation nor entitle members to Hearing rights or right to counsel pursuant to the Fair Hearing Plan or the right to have counsel present.

**10.2.2.** Practitioners are expected to conduct themselves in accordance with the expectations set forth in these Bylaws, the Rules and Regulations, and related policies. Conduct which falls below such expectations may be addressed in accordance with the appropriate policy and may be referred for corrective action in accordance with this Section 10.

**10.2.3.** These Bylaws encourage the use of progressive steps by Medical Staff leaders and Hospital management, beginning with collegial and educational efforts, to address issues pertaining to clinical competence or professional conduct. The goal of these efforts is to arrive at voluntary actions by a Member to resolve an issue that has been raised.

**10.2.4.** Collegial intervention is a part of the Hospital's Professional Review Activities and may include, but is not limited to, the following:

- a. Advising colleagues of applicable policies, such as policies regarding appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;
- b. Proctoring, monitoring, consultation, and letters of guidance; and
- c. 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.

**10.2.5.** The relevant Medical Staff leader(s), in conjunction with the President, may determine whether a matter should be handled in accordance with another policy (e.g., code of conduct policy, practitioner health policy, peer review policy) or should be referred to the MEC for further action pursuant to this Section 10.

**10.2.6.** The relevant Medical Staff leader(s) will determine whether to document a collegial intervention effort. Any documentation that is prepared will be placed in the Member's confidential file. The Member will have an opportunity to review the documentation and respond to it. The response will be maintained in the Member's file along with the original documentation.

**10.3** **Application/Identification of a Need for Corrective Action.** Corrective action is appropriate whenever a serious question has been identified by information developed routinely in the course of performance evaluation activities, or by an incident report or complaint from a Member, patient, Hospital employee or contractor, or visitor in writing, supported by reference to specific facts or activities that the party believes may support corrective action, or where collegial efforts have not resolved an issue, regarding:

**10.3.1.** The clinical competence, judgment skills or clinical practice of any Member, which is detrimental to the health or welfare of any patient or is below acceptable standards of care with medical practice, including the care, treatment or management of a patient or patients;

**10.3.2.** The known or suspected violation by any Member of applicable ERDs, the Code of Conduct, the Standards of Conduct, or these Bylaws, the Rules and Regulations, policies, and applicable bylaws, rules and policies of the Hospital; and/or

**10.3.3.** Conduct by any Member that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital, patient care professional, or the Medical Staff, including the inability of Members to work harmoniously with others, the matter may be referred to the Medical Staff President, Clinical Committee Chair, the chairperson of a standing committee, or the President. The person to whom the matter is referred shall make sufficient inquiry to satisfy himself or herself that the question raised is credible, including meeting with the affected Member, and, if so, shall forward it in writing to the MEC. No actions taken pursuant to this Section shall constitute an Investigation.

**10.3.4.** Confirmed and documented patterns or incidents, of the above described issues that could adversely impact patients, the Medical Staff, the Hospital or its employees, must be addressed by the MEC and the Board in a timely manner.

#### **10.4    Investigation.**

**10.4.1.** A Clinical Committee Chair, the chairperson of any medical staff committee with responsibility for assessing professional competence or conduct, a Medical Staff officer, the President, the MEC or the Board (“Complainant”) may initiate an inquiry into the need for an Investigation. Whenever more than one complaint is filed against the same Member arising out of essentially the same circumstances, the Medical Staff President may, in his or her discretion, consolidate the several complaints and treat them as one for purposes of the procedures set forth in these Bylaws.

**10.4.2.** When a Complainant has reason to believe that a corrective action may be necessary, the Complainant (other than the MEC itself) shall submit a written request for an inquiry to the MEC, detailing the specific conduct that precipitates the request.

**10.4.3.** Before submitting a request, any Complainant may, but need not, discuss the matter with the Member. Such a discussion does not constitute an Investigation.

**10.4.4.** An Investigation does not begin until such time as the MEC formally declares, by action documented in the minutes, that an Investigation is warranted.

**10.4.5.** The MEC must determine if an Investigation is warranted or direct the matter to be handled pursuant to another policy (e.g., impaired physician or physician health, peer review or disruptive physician policy) or to proceed in another manner. In making this determination the MEC may discuss the matter with the Member. If an Investigation is warranted, the MEC must conduct one.

- a. The MEC may investigate on its own, or it may assign the task to an investigative ad hoc committee (“investigating body or committee”) consisting of one or more persons. Ad hoc committee members may, but need not be physicians, Members, or persons associated with the Hospital.
- b. The investigating body or committee conducting the Investigation shall have the authority to review relevant documents and interview individuals. It shall also have available to it the full resources of the Medical Staff and the Hospital, as well as the authority to use outside consultants, if needed. An outside consultant or agency may be used (and will be considered part of the investigating body or committee) whenever a determination is made by the Hospital and investigating committee that:
  - i. the clinical expertise needed to conduct the review is not available on the Medical Staff;
  - ii. the individual under review is likely to raise, or has raised, questions about the objectivity of other Members; or
  - iii. the Members with the necessary clinical expertise would not be able to conduct a review without risk of allegations of bias, even if such allegations are unfounded.

**10.4.6.** The MEC shall inform the Member that an Investigation has begun and shall provide a summary of the specific issues being investigated. Notification may be delayed if, in the MEC’s sole judgment, informing the individual immediately would compromise the Investigation or disrupt the operation of the Hospital or the Medical Staff. The investigating body or committee may request the attendance of the Member, upon reasonable Notice, for purposes of an interview to provide relevant information to the Investigation. A summary of the meeting shall be made and included in the investigating body or committee’s report.

- a. No person who performs any part of an Investigation may be in direct economic competition with the Member, unless waived by said Member.
- b. The Medical Staff President and President shall be fully informed of the progress and intentions of the MEC regarding the Investigation.
- c. Before making a recommendation that would constitute a Professional Review Action or any other disciplinary measure, the MEC must extend a reasonable opportunity to the Member, by Notice, to be heard.

**10.4.7.** Neither initial discussions with the Member nor any subsequent interview or meeting held as part of the above Investigation constitutes a Hearing and does not entitle the Member to be represented by legal counsel nor to any Hearing rights under the Fair Hearing Plan.

**10.4.8.** The investigating body or committee shall make a reasonable effort to complete the Investigation and issue its report within thirty (30) days of the commencement of the Investigation, provided that an outside review is not necessary. When an outside review is necessary, the investigating body or committee shall make a reasonable effort to complete the Investigation and issue its report within forty-five (45) days of receiving the results of the outside review. These time frames are intended to serve as guidelines and, as such, shall not be deemed to create any right for an individual to have an Investigation completed within such time periods. In the event the investigating body or committee is unable to complete the Investigation and issue its report within these time frames, it shall inform the Member of the reasons for the delay and the approximate date on which it expects to complete the Investigation.

**10.4.9.** At the conclusion of an Investigation where the investigating body or committee was not the MEC, the investigating body or committee shall prepare a written report with its findings and conclusions and shall forward its written report to the MEC for consideration. The written report may include recommendations for appropriate resolution which may include corrective action. Despite the status of any Investigation, at all times the MEC shall retain the authority and discretion to take whatever action may be warranted by the circumstances, including precautionary suspension, termination of the Investigation, or other action.

**10.4.10.** Upon the receipt of the investigating body or committee's report and findings, or where the MEC served as the investigating body or committee, the MEC must consider the findings and conclusions and prepare a written recommendation with supporting documentation within a reasonable amount of time not to exceed ninety (90) days from submission of the investigating body or committee's report, sending a copy to the Member. The MEC may:

- a. Conclude that the complaint is without merit and that no corrective action is warranted, forwarding the recommendation and documentation to the Board for ratification in accordance with the provisions of this Section;
- b. Recommend no action (i.e., a letter of guidance, counsel, warning, reprimand, non-concurrent mandatory monitoring/consultation, training or education) or action that does not Affect Adversely the Member's Appointment or Clinical Privileges and forwarding the recommendation and documentation to the Board for ratification in accordance with the provisions of this Section; or
- c. Recommend the taking of a Professional Review Action, in which event it must give the Member Notice in accordance with the Fair Hearing Plan.

No member of the MEC may take part in the consideration or vote on the recommendation if he or she is in direct economic competition with the Member affected.

- 10.4.11** A recommendation by the MEC of a Professional Review Action that would entitle the Member to request a Hearing pursuant to the Fair Hearing Plan shall be forwarded to the President, who shall promptly inform the Member by special Notice. The President shall hold the recommendation until after the individual has completed or waived a Hearing and Appeal pursuant to the Fair Hearing Plan.
- 10.4.12** If the MEC makes a recommendation that does not entitle the individual to request a Hearing pursuant to the Fair Hearing Plan, it shall take effect immediately and shall remain in effect unless modified by the Board.
- 10.4.13** The MEC may at any time reconsider its recommendation in light of new information and alter its recommendation.
- 10.4.14** When applicable, any recommendations or actions that are the result of an Investigation or Hearing and Appeal shall be monitored by Medical Staff leaders on an ongoing basis through the Hospital's performance improvement activities or pursuant to the applicable policies regarding conduct, as appropriate.
- 10.5** **Subsequent Action by the Board.** The Board shall review the determination or deferral of the matter by the MEC, and either adopt the determination or action or initiate other corrective action as may be appropriate.
  - 10.5.1.** The Board may reject, modify or accept the recommendation of the MEC, including an MEC recommendation that involves a limitation, modification, suspension or revocation of Clinical Privileges or Medical Staff Appointment.
  - 10.5.2.** In the event the Board considers a modification to the recommendation of the MEC that would entitle the individual to request a Hearing, the President shall inform the Member by special Notice. No final action shall occur until the Member has completed or waived a Hearing and Appeal pursuant to the Fair Hearing Plan.
- 10.6** **Probationary Status.** Probation, when imposed, is for a specified time period, and may apply to Medical Staff Appointment, all granted Clinical Privileges, or one or more specific Clinical Privileges. Probationary status is removed as soon as the MEC and the Board are satisfied that the problem necessitating the imposition of probationary status is resolved.
- 10.7** **Precautionary Suspension.**
  - 10.7.1.** In the event that a Practitioner's actions pose an imminent danger to the life or well being of any individual, including but not limited to, patients, other Members, the Hospital or its personnel; or to reduce a substantial and

imminent likelihood of significant impairment of the life, health and safety of any person and immediate action is required to protect such individual(s) then any two (2) of the following: MEC, Clinical Committee Chair, the Medical Staff President, the President, or the Board Chairperson, shall have the authority to:

- a. Summarily suspend all or any portion of the Clinical Privileges or Appointment of the Member in question which suspension shall be immediately effective; or
- b. Afford the Practitioner an opportunity to voluntarily refrain from exercising Clinical Privileges pending an Investigation.

Any suspension pursuant to this Section 10.7.1 does not imply final finding of fact or responsibility for the situation that caused the suspension.

**10.7.2.** Notice of such restriction or suspension shall be promptly given to the Practitioner by the Hospital, the MEC or the Board.

**10.7.3.** Precautionary suspensions remain in effect until resolved as hereafter provided.

**10.7.4.** Immediately upon the imposition of a precautionary suspension, the Medical Staff President or Clinical Committee Chair in which the Practitioner holds Clinical Privileges shall promptly assign to another Member the responsibility for care of any hospitalized patients of the summarily suspended Member, considering where feasible, the wishes of the patient.

**10.7.5.** As soon as practical, the MEC shall convene to review the action. The MEC shall make every effort to convene within fourteen (14) days after the imposition of a precautionary suspension and to interview the Practitioner involved. The affected Practitioner may request to be present at the meeting. The meeting is not a Hearing and shall not to be construed as such, nor shall it entitle the Practitioner to have legal counsel present. At this meeting the Practitioner may provide relevant information to the MEC in a manner and upon such terms as the MEC deems appropriate.

**10.7.6.** Based on the information available to the MEC, the MEC may continue the suspension as imposed, terminate the precautionary suspension, or modify it to an action that does not Adversely Affect the Member. A termination or modification of the precautionary suspension to an action that does not Adversely Affect the Member shall have the effect of restoring all Member rights and Clinical Privileges, subject to further Board action.

**10.7.7.** The MEC shall promptly notify the Member and the Board of its determination. Thereafter, the determination of the MEC shall be

reviewed by the Board. The Board may ratify or modify the MEC's recommendation.

**10.7.8.** If the MEC is one of the suspending entities under this Section, it may recommend a Professional Review Action and give the required Notice of Hearing pursuant to the Fair Hearing Plan without the need to reconvene and reconsider its own suspension, if it believes it has already conducted an adequate Investigation.

**10.7.9.** If the MEC or the Board takes or recommends a Professional Review Action as a result of a precautionary suspension, the MEC or the Board, as the case may be, must give the individual prompt Notice of his or her right to request a Hearing under the Fair Hearing Plan.

## **10.8 Automatic Suspensions and Terminations.**

**10.8.1. Events Resulting in Automatic Suspension or Termination.** The following events result, without further Notice or action, in an automatic termination or suspension of a Member's Appointment and Clinical Privileges:

- a. Actions Affecting State License to Practice or DEA Registration. If a Practitioner's actions result in his/her state license to practice or DEA registration being revoked, suspended, censured, restricted/limited for disciplinary reasons, not renewed by the relevant agency, or voluntarily relinquished by the Practitioner, then Medical Staff Appointment and Clinical Privileges are automatically revoked, suspended or limited to at least the same extent as the state licensure to practice or DEA registration, subject to reapplication by the Practitioner when/if his license is reinstated, or limitations are removed, whatever is the case. However, an indefinite suspension of licensure or registration shall be treated as a revocation of Appointment and Privileges, as applicable.
- b. Exclusion from a Federal Health Care Program. A Member must, immediately upon notice of any proposed or actual exclusion from any Federal Health Care Program, disclose to the President, or his or her designee, by telephone call and in writing, any notice to the Member or his representative of proposed or actual exclusion of the Member from any Federal Health Care Program. The Member may make a request in writing for a meeting with the President and the President of the Medical Staff, or their designees, to contest the fact of the exclusion and present relevant information. If requested, such a meeting shall be held as soon as possible but in no event later than five (5) business days from the date of the written request. The President and the Medical Staff President or their designees shall determine within ten (10) business days following the meeting, and after such follow-up investigations as they deem appropriate, whether the exclusion had in fact occurred, and whether the



- Member's Appointment and Clinical Privileges shall be immediately terminated. The determination of the President and the Medical Staff President or their designees regarding the matter shall be final, and the Member shall have no Hearing rights pursuant to the Fair Hearing Plan. The Member shall be given Notice of the termination in the most expeditious manner possible, and shall also promptly receive Notice of the termination.
- c. Sanctions by a Government Program. Any Practitioner will be automatically suspended from the Medical Staff if they are sanctioned by a Federal Health Care Program.
  - d. Failure to Comply With Meeting Requirements. For Members of Medical Staff categories requiring compliance with meeting attendance requirements, unexcused absences from more than fifty percent (50%) of general Medical Staff meetings or required meetings of Medical Staff committees of which the Member is a member, will result in an admonishing letter and probationary Active Staff status for six (6) months. If during that six (6) month time, meeting requirements are not complied with, then the Member loses the right to vote or hold office, regardless of the level of his/her clinical activity at the Hospital. Additionally, failure without good cause of a Practitioner, after Notice, to appear at a meeting of the MEC, of an investigating body or committee, or of the Board called to discuss the proposed taking of a Professional Review Action or any other disciplinary action shall result in the automatic suspension of the Member's Appointment and Privileges.
  - e. Lapse or Failure to Carry Liability Insurance. If the Board and MEC have established a minimum level or requirement for liability insurance coverage for Practitioners with Clinical Privileges, and if a Practitioner's liability insurance lapses or is cancelled without renewal, then the Practitioner's rights and Clinical Privileges are automatically suspended until the effective date of his or her new liability insurance coverage, unless otherwise determined by the Board, considering the input of the MEC.
  - f. Criminal Activity. Any arrest, pending criminal charges or actual criminal convictions, meaning conviction of, pleas of guilty, or no contest to any felony charges; or actual or pending conviction of, plea of guilty, or no contest to misdemeanor charges in which the underlying allegations involve the practice of a health care profession, Federal Health Care Program fraud or abuse, third party reimbursement, the use of alcohol or controlled substances, crimes of violence or abuse, or crimes of moral turpitude. The Member may make a request in writing for a meeting with the President and the Chief of Staff, or their designees, to present relevant information. If requested, such a meeting shall be held as soon as possible but in no event later than five (5) business days from the date of the written request. The President and the Chief of Staff or

their designees shall determine within ten (10) business days following the meeting, and after such follow-up investigations as they deem appropriate, whether the Member's Appointment and Clinical Privileges shall be immediately terminated. The determination of the President and the Chief of Staff or their designees regarding the matter shall be final, and the Member shall have no Hearing rights pursuant to the Fair Hearing Plan. The Member shall be given Notice of the termination in the most expeditious manner possible, and shall also promptly receive Notice of the termination.

- g. Reciprocal Automatic Action. Any suspension, restriction, limitation, leave of absence, or other condition imposed upon a Practitioner at one [insert system] hospital shall automatically and immediately be effective at Hospital. Such reciprocal automatic action is an automatic administrative action and is not a Professional Review Action or the basis Hearing rights pursuant to the Fair Hearing Plan.
- h. As Provided in the Rules and Regulations. The occurrence of any event set forth in the Rules and Regulations which the Rules and Regulations specify shall result in an automatic termination or suspension.

**9.8.2.** Practitioner's Appointment and Clinical Privileges will be automatically relinquished upon notice to the Practitioner by the MEC, without entitlement to Hearing rights pursuant to the Fair Hearing Plan, if the individual fails to satisfy any of the other threshold eligibility criteria set forth in these Bylaws.

**10.8.3.** Automatic relinquishment of Appointment and Clinical Privileges will take effect immediately upon Notice to the Hospital and will continue until the matter is resolved, if applicable. If an individual engages in any patient contact at the Hospital after the occurrence of an event that results in automatic relinquishment of Appointment and Privileges, without notifying the Hospital of that event, then the relinquishment will be deemed permanent.

**10.8.4.** Failure of the Practitioner to resolve the underlying matter leading to an individual's Clinical Privileges being automatically relinquished in accordance with this Section (other than exclusion from a Federal Health Care Program), within seven (7) days of the notice of relinquishment will result in automatic resignation from the Medical Staff. The Practitioner's Clinical Privileges and Appointment remain suspended during such period until the MEC acts.

**10.8.5.** With the exception of exclusion from a Federal Health Care Program, the MEC must promptly meet and consider any evidence the Practitioner submits.

- a. If the MEC determines that grounds for automatic termination did not exist, it must immediately restore the Practitioner to full Appointment or Clinical Privileges, as appropriate.
- b. If the MEC determines that grounds for termination were valid, it must promptly give Notice to the Member that the termination remains in effect and that he/she may reapply for such Appointment or Privileges for which he/she may qualify at such time as the grounds for termination are resolved.
- c. Automatic terminations are not Professional Review Actions and do not entitle a Practitioner to any Hearing or Appeal rights pursuant to the Fair Hearing Plan, nor right to legal counsel with the MEC.

**10.8.6.** Requests for reinstatement will be reviewed by the relevant Clinical Committee Chair, Medical Staff President and President. If a favorable recommendation is made for reinstatement, the Member may immediately resume exercising Clinical Privileges at the Hospital. This determination will then be forwarded to the MEC and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the MEC and the Board for review and recommendation.

## **10.9 Temporary Administrative Suspensions.**

**10.9.1.** A Member's Clinical Privileges (except with respect to patients already admitted to the Hospital) may be suspended for failure to properly complete medical records. Such suspension is effective upon receipt of a notice of deficiency.

- a. Failure to Complete Medical Records. All portions of each patient's medical record, including discharge summaries, shall be completed within time frames specified in the Rules and Regulations after the patient's discharge. Failure to do so (unless there are acceptable extenuating circumstances as approved by the MEC) automatically results in the record being defined as delinquent, notification to the Practitioner of the delinquency, and temporary suspension of the Member's admitting and Clinical Privileges until such time as the delinquent record is completed.

**10.9.2.** Temporary administrative suspensions remain in effect for as long as the deficiency remains uncured, provided that failure of the Practitioner to resolve the underlying matter leading to the temporary administrative suspension within sixty (60) days of the notice of deficiency will result in automatic resignation from the Medical Staff.

**10.9.3.** A Member may appeal a temporary administrative suspension to the MEC. The MEC's determination is final and is not subject to further review.

**10.9.4.** The Medical Staff President or the MEC may allow exceptions and permit exercise of Clinical Privileges upon a showing by the Member of special circumstances.

**10.9.5.** If a temporary administrative suspension lasts longer than thirty (30) days and the MEC has determined that the deficiency was based on professional conduct or competence and had the potential to adversely affect patient care, the Practitioner shall be entitled to the Hearing rights pursuant to the Fair Hearing Plan and the suspension may be reportable to the NPDB and/or the state licensure board.

**10.9.6.** Temporary administrative sanctions imposed hereunder do not limit the MEC or the Board from taking other corrective action when a Member fails to properly complete medical records.

#### **10.10 Board Ratification**

**10.10.1.** If the MEC recommends action to the Board under this Section that does not Affect Adversely a Member and the Board approves the recommendation, the recommendation becomes final.

**10.10.2.** If the MEC recommends action to the Board under this Section that does not Affect Adversely a Member and the Board disagrees with the MEC's recommendation and takes an action that does not Affect Adversely the Member, the decision is final.

**10.10.3.** If the MEC recommends action to the Board under this Section that does not Affect Adversely a Member and the Board disagrees with the MEC's recommendation and takes a Professional Review Action, it must give the Practitioner Notice of his right to a Hearing under the Fair Hearing.

**10.10.4.** The Board must promptly notify the Practitioner of any decision it makes under this Section.

**10.11 Right to a Fair Hearing and Appeal.** Circumstances under which a Medical Staff applicant or Member is entitled to a Hearing on the facts and/or an Appeal of the Board's decision, and the specific procedure to be followed for Hearings and Appeals, are described the Fair Hearing Plan at Section 11 of these Bylaws. Except as otherwise noted herein, automatic effects of a Member's actions do not entitle the Member to a Hearing pursuant to the Fair Hearing Plan.

**10.12 Resignation.** A Member may resign his or her Appointment or Privileges, including specific individual Privileges, by submitting a written resignation to the Board. The resignation is effective when acted upon by the Board. The Board may condition acceptance of the resignation upon the Member's orderly completion of medical records or other pending responsibilities of the Member or the fulfillment of negotiated contractual terms.

## 11. FAIR HEARING PLAN

**11.1 Grounds for a Hearing.** The following recommendations/actions actions, when based on the competence or professional conduct of the individual, shall be considered Professional Review Actions and shall give rise to a Member's right to request a Hearing pursuant to the Fair Hearing Plan:

- a. Denial of Medical Staff Appointment or Reappointment;
- b. Denial of Clinical Privilege(s) or requested additional or modified Clinical Privileges;
- c. Removal or restrictions on Clinical Privileges for a period of more than thirty (30) days;
- d. Revocation of Medical Staff Appointment;
- e. Reduction or denial of Medical Staff category assignment, if such action Adversely Affects the Member's Clinical Privileges; or
- f. Any other action constituting a Professional Review Action HCQIA.

Neither voluntary nor automatic relinquishment of Clinical Privileges, as provided for elsewhere in these Bylaws, nor the imposition of any consultation requirement, or a requirement for retraining, additional training or continuing education, no matter whether imposed by the MEC or the Board, shall constitute grounds for a Hearing and shall take effect immediately, unless such action constitutes a Professional Review Action under HCQIA.

**11.2 Actions Not Giving Rise to a Hearing.** There is no right to a Hearing in the case of an action or recommendation consisting of any of the following, unless and to the extent that any of the following constitute a Professional Review Action under HCQIA:

- a. initiation of a focused review or an Investigation into any matter;
- b. the sending of charts or records for external review in aid of a focused review or Investigation;
- c. the formulation or giving of any report;
- d. requesting or requiring a person to appear before any authorized person or group in connection with an Investigation;
- e. denying or refusing to accept an application for Appointment or reappointment to the Medical Staff or for Privileges because:
  - i. the application is incomplete;

- ii. the application prima facie demonstrates that it does not meet minimum objective requirements;
- iii. the application is for Privileges in a department, specialty or service which is fully staffed;
- f. denial or revocation of Temporary Privileges;
- g. conditions imposed during the period of Provisional Appointment or Privileges;
- h. automatic sanctions imposed under Section 10.8;
- i. supervision, observation or concurrent monitoring which does not restrict exercise of Privileges;
- j. issuing a warning, admonition or reprimand of any kind;
- k. counseling of any kind, including voluntary and involuntary corrective counseling;
- l. a denial of a request for waiver or modification of any professional liability insurance requirement.

### **11.3 Notice and Request for a Hearing**

**11.3.1. Notice of Professional Review Action or Recommendation.** When a Professional Review Action is recommended, the Member shall be given Notice promptly by the President, in writing, return receipt requested. The Notice shall include a statement of the specific Professional Review Action taken or recommended and the grounds for the Professional Review Action together with the identity of patient records and any other relevant information supporting the Professional Review Action. The Notice also shall include a summary of the individual's Hearing rights pursuant to the Fair Hearing Plan, including that the Member must request a Hearing within thirty (30) days of receipt of the Notice and a statement that if he/she does not personally appear at the Hearing, he/she forfeits all rights to a Hearing and Appeal;

**11.3.2. Request for Hearing.** The applicant or Member has thirty (30) days following receipt of the Notice of a recommendation for a Professional Review Action to request a Hearing. The request must be by written Notice, mailed return receipt requested, to the President. The request for a Hearing must indicate in what respect, from the affected Member's point of view, the action or recommendation is in error and on what points the Member wishes to Appeal. The request must be postmarked on or before the 30<sup>th</sup> day following the individual's receipt of the Notice. If a Hearing is not requested within thirty (30) days, the applicant or Member has waived his or her right to a Hearing and has accepted the recommendation, which will become effective immediately.

**11.3.3. One Hearing.** No applicant or Member shall be entitled to more than one (1) Hearing upon the same Professional Review Action.

#### **11.4 The Hearing: Procedural Details**

**11.4.1. Arrangements for the Hearing.** Upon receipt of a request for a Hearing, the President will schedule the Hearing and mail a Notice of the Hearing, return receipt requested, to the person who requested the Hearing, of its time, place and date, which shall not be less than thirty (30) days after the date of the Notice of the Hearing, but as soon thereafter as possible, considering the schedules and availability of all concerned. The Notice of the Hearing shall also include a list of witnesses (if any) expected to testify at the Hearing on behalf of the professional body making the Adverse Action and the identity of the Hearing Panel and the Presiding Officer.

The statement and attached information may be amended or added to at any time, even during the Hearing, if additional material is relevant to the Hearing, and provided that the person requesting the Hearing and his or her counsel have sufficient time to study the additional information and offer rebuttal.

**11.4.2. Presiding Officer.** The President may appoint a person to preside at the Hearing (the “Presiding Officer”). The Presiding Officer may be legal counsel to the Hospital, but in any event must not act as a prosecuting officer or as an advocate for the Board or Medical Staff. The Presiding Officer may participate in private deliberations of the Hearing Panel, and may provide legal advice to it, but is not entitled to vote on its recommendations unless the Presiding Officer is also the chairperson of the Hearing Panel, as described below. The Presiding Officer may, following the Hearing, continue to advise the Board and Medical Staff on the matter. The Presiding Officer may not be in direct economic competition with the person requesting the Hearing.

If no Presiding Officer is appointed, the designated chairperson of the Hearing Panel will be the Presiding Officer.

The Presiding Officer may, in his/her sole discretion, hold a pre-Hearing conference to simplify or clarify the issues to be heard, resolve disputes, facilitate settlement, specify the timing and order of witnesses or to address any other matter that may facilitate the just, speedy and inexpensive disposition of the Hearing.

The Presiding Officer ensures that all participants have a reasonable opportunity to be heard, maintains order, determines the order of procedure of the Hearing in accordance with these Bylaws, may set reasonable time limits for the Hearing, and makes rulings on questions pertaining to matters of procedure and admissibility of evidence. It is understood that the Presiding Officer at all times is concerned that all relevant information be made available to the Hearing Panel for its deliberations and recommendations to the Board. The Presiding Officer may make official mention of matters

relating to the issues under consideration. All participants in the Hearing are informed of such matters, and they are noted in the record of the Hearing. Either party may request that a matter be officially mentioned or may provide a counter argument to be included in the Hearing record.

The Presiding Officer shall have the authority to:

- a. advise the Hearing Panel on the standard of review at the Hearing and on the procedures and standards applicable to the Hearing process and the matter under review;
- b. scheduled and conduct pre-Hearing proceedings;
- c. determine the order of or procedure for presenting evidence and statements during the Hearing and allot time to the parties;
- d. make all rulings on questions which pertain to matters of law, procedure or the admissibility of evidence;
- e. require the exchange of information, documents, case outlines, witness lists, and exhibits between the parties, and the common marking of exhibits;
- f. require the witnesses be sworn and that testimony be taken under oath;
- g. request the stipulation of uncontested facts; and
- h. if the Presiding Officer determines that a party to a Hearing is not proceeding in an efficient and expeditious manner, take such discretionary action as he or she deems necessary.

**11.4.3. The Hearing Panel.** The President, after considering the recommendations of the Medical Staff President and the Board Chairperson, appoints a Hearing Panel of not less than three (3) Members, at least two (2) of whom must be physicians. Knowledge of the matter being considered does not preclude appointment to the Hearing Panel, as long as the individual indicates that such prior knowledge will not interfere with rendering a decision on the basis of evidence present at the Hearing, but Members who have actively participated in the consideration of the matter at any previous level are not eligible for appointment to the Hearing Panel. No member of the Hearing Panel may be in direct economic competition with the person requesting the Hearing or have other business, family or professional relationship likely to undermine their ability to render a decision on the basis of evidence presented at the Hearing. The President will also designate a Hearing Panel chairperson. A member of the Hearing Panel may also not be expected to be called as a witness at the Hearing.

**11.4.4. Establishing Qualifications.** The President shall furnish the members of the Hearing Panel and the Presiding Officer with a questionnaire confirming the members of the Hearing Panel or the Presiding Officer:



(i) are not disqualified due to any of the factors listed above; (ii) are not aware of any business, family or practice relationship that would undermine their ability to serve; and (iii) will be able to decide the matter based on the evidence produced at the Hearing. The completed and signed questionnaires shall become a part of the Hearing record. The President may remove a member of the Hearing Panel or the Presiding Officer based on their responses to the questionnaires.

**11.4.5. Hearing Officer.**

- a. In very limited circumstances where a Hearing Panel of impartial peers is unavailable, after consulting with the MEC, the President or his or her designee, may appoint an individual, with background, knowledge, and experience appropriate to the subject matter of the Hearing, to serve as a Hearing Officer, provided that such individual is not in direct economic competition with the individual requesting the Hearing, is not professionally associated with, related to, or involved in a referral relationship with, the individual requesting the Hearing, and has not demonstrated to have an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter.
- b. If a Hearing Officer is appointed instead of a Hearing Panel, the President or his or her designee, after consulting with the MEC, may determine to have the Hearing Officer also serve as the Presiding Officer (in which case all references in this Section to the “Hearing Panel” or “Presiding Officer” shall be deemed to refer to the Hearing Officer). Alternatively, the President or his or her designee, after consulting with the MEC, may determine to appoint a Presiding Officer in addition to the Hearing Officer (in which case all references in this Section to the “Hearing Panel” shall be deemed to refer to the Hearing Officer).

**11.4.6. Representation.** The individual requesting the Hearing may be represented by an attorney, or other person of the individual’s choice, who shall enter his appearance in writing with the President of the Hospital at least ten (10) days prior to the date of the Hearing. The Hospital may be represented by counsel in the Hearing, and counsel for the Hospital shall enter his/her appearance in the same manner.

**11.4.7. Specified Rights.** The person requesting the Hearing and the Hospital may:

- a. Choose to have a record made of the proceedings, copies of which may be obtained by the Member upon payment of any reasonable charges associated with the preparation thereof;
- b. Call and examine witnesses;
- c. Introduce exhibits and evidence determined to be relevant by the Presiding Officer, regardless of its admissibility in a court of law;

- d. Cross-examine witnesses, on matters determined by the Hearing Panel or Presiding Officer, as applicable, to be relevant to the issues;
- e. Provide rebuttals at the Hearing for any evidence presented; and
- f. Submit a written statement at the close of the Hearing.
- g. Even if the person requesting the Hearing decides not to testify on his or her own behalf, he or she may still be called as a witness and examined as if under cross-examination.

**11.4.8. Burden of Proof.** It is incumbent on the MEC or the Board, whichever made the Professional Review Action, to come forward with evidence in support of its decision or recommendation. However, the burden of proof is on the person who requested the Hearing. The MEC or the Board, whichever body rendered the decision from which the Member has requested the Hearing, shall name a spokesman to act on its behalf at the Hearing (in addition to any legal counsel representing the Hospital).

Unless the Hearing Panel finds that the individual who requested the Hearing has proven that the recommended Professional Review Action was unreasonable, not supported by substantial evidence brought before the Hearing Panel, or otherwise unfounded, the Hearing Panel shall recommend in favor of the MEC or the Board (whichever group's action occasioned the Hearing).

**11.4.9. Pre-Hearing Procedures.**

- a. Outlines of Case. At any time during the proceedings, the Presiding Officer may require the affected Practitioner and the MEC to each submit a case outline setting forth, so far as is then reasonably known, issues which each party proposes to raise at the Hearing; witnesses whom each party proposes to call at the Hearing and the subject or subjects on which each witness will testify; a description of written or documentary evidence which each party anticipates introducing as evidence at the Hearing; a short summary of what the party expects to demonstrate at the Hearing in support of its position; and/or the specific result requested from the Hearing Panel.
- b. Pre-Hearing Conference. Prior to the scheduled Hearing, the Presiding Officer shall conduct a pre-Hearing conference in person or by conference call to discuss possible stipulations of fact, amendments to the grounds for action or the issues in the dispute, and changes in the witness or evidence lists, and to narrow the issues for Hearing. The Presiding Officer shall have authority to limit the issues, arguments, witness, and exhibits at the Hearing to conform to the orders and stipulations at the pre-Hearing conference. Failure of either party to appear and participate in the preliminary meeting shall be deemed to be acceptance of all agreements and decisions made at or as a result of the preliminary meeting.

**11.4.10. Provision of Relevant Information.**

- a. Prior to receiving any confidential documents, the individual requesting the Hearing must agree that all documents and information will be maintained as confidential and will not be disclosed or used for any purpose outside of the Hearing. The individual must also provide a written representation that his/her counsel and any expert(s) have executed Business Associate Agreements (“BAAs”) in connection with any Protected Health Information (as defined at 45 C.F.R. § 160.103) contained in any documents provided.
- b. Upon receipt of the BAA and representation, the individual requesting the Hearing will be provided with a copy of the following:
  - i. copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the individual's expense;
  - ii. reports of experts relied upon by the MEC; and
  - iii. copies of relevant minutes (with portions regarding other physicians and unrelated matters deleted).

The provision of this information is not intended to waive any privilege under the state peer review protection statute.

- c. The MEC or the Board, whichever made the Professional Review Action, will be provided with a copy of the following:
  - i. copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the Hospital's expense;
  - ii. reports of experts relied upon by the individual requesting the Hearing; and
  - iii. any written responses or submissions made by the individual requesting the Hearing to the investigating body or committee; and
  - iv. iv. copies of any other documents upon which the individual requesting the Hearing anticipates relying at the Hearing.

The provision of this information is not intended to waive any privilege under the state peer review protection statute

- d. The individual will have no right to discovery beyond the above information. No information will be provided regarding other Practitioners on the Medical Staff.

- e. Prior to the pre-Hearing conference, on dates set by the Presiding Officer or as agreed upon by both sides, each party will provide the other party with its proposed exhibits. All objections to documents or witnesses, to the extent then reasonably known, will be submitted in writing in advance of the pre-Hearing conference. The Presiding Officer will not entertain subsequent objections unless the party offering the objection demonstrates good cause.
- f. Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for Appointment or the relevant Clinical Privileges will be excluded.
- g. Neither the individual, nor any other person acting on behalf of the individual, may contact Hospital employees whose names appear on the MEC's witness list or in documents provided pursuant to this Section concerning the subject matter of the Hearing, until the Hospital has been notified and has contacted the employees about their willingness to be interviewed. The Hospital will advise the individual once it has contacted such employees and confirmed their willingness to meet with the individual. Any employee may agree or decline to be interviewed by or on behalf of the individual who requested a Hearing.

**11.4.11. Admissibility of Evidence.** No written evidence, testimony, or documentation shall be considered by the Hearing Panel, which has not been made available to both parties for rebuttal, or received as evidence at a meeting at which both sides have had the opportunity to be present. Any evidence shall be admitted by the Presiding Officer at the Hearing which is relevant to the issues before the Hearing Panel and is the sort of evidence upon which reasonable persons are accustomed to rely in the conduct of serious affairs without regard to the admissibility of such evidence in a court of law. The Hearing Panel may, but is not required to, adhere to state or federal rules governing the presentation of evidence or examination of witnesses at trial or in a court of law. The Hearing Panel may itself question witnesses, call additional witnesses, and request documentation of charges or claims made.

**11.4.12. List of Witnesses.** Each party must provide the other in writing, at least ten (10) days in advance of the Hearing, a written list of names and addresses of witnesses to be called. The witness list of either party may be amended at any time during the course of the Hearing for good cause shown. Testimony of character witnesses and patients who can testify to their confidence in the affected Practitioner will not be considered relevant to the proceedings.

**11.4.13. Failure to Appear.** If the individual requesting the Hearing, without good cause, fails to appear at the time the Hearing is scheduled, such failure constitutes voluntary acceptance of the Adverse Action, which then will become effective immediately. Failure without good cause of the Board or MEC or its designee to appear and proceed at such

a Hearing will be deemed to constitute a withdrawal of the recommendation or action involved.

**11.4.14. Nonpublic Hearing.** Proceedings will be conducted in private before the parties and their representatives, the Hearing Panel members, and the court reporter.

**11.4.15. Postponements and Extensions.** Postponements and extensions of the Hearing may be requested by either party, but will be permitted by the Hearing Panel only for good cause.

**11.4.16. Hearing Record.** A record of the Hearing will be maintained by a shorthand reporter or court reporter retained by the Hospital or by electronic audio or audio/video recording. Copies of the record may be obtained by the applicant or Member upon payment of any reasonable charges imposed by the court reporter associated with the preparation thereof.

**11.4.17. Attendance by Panel Members.** No quorum is required in order for the Hearing Panel to proceed, but the decision of the Hearing Panel must be by majority of all those appointed to the Hearing Panel.

**11.4.18. Recess.** The Hearing Panel may recess the Hearing and reconvene the same for the conveniences of the participants or for the purpose of obtaining new or additional evidence or consultation.

**11.4.19. Conclusion of the Hearing Procedure and Post-Hearing Written Statement.** After both parties have concluded their presentation of oral and written evidence, the Hearing is closed. Each party shall have the right to submit a post-hearing written statement for the Hearing Panel's consideration, which shall be included as part of the Hearing record. The Presiding Officer shall set the date for submission of the post-hearing written statement(s).

**11.4.20. Recommendation.** Within thirty (30) days after conclusion of the Hearing(or such longer time period reasonably determined to be necessary by the Presiding Officer), and following any private deliberations that may be necessary, a recommendation and a report containing the reasons for the recommendation shall be prepared by the Hearing Panel and delivered to the President. At any time prior to rendering its decision, the Hearing Panel may, in its discretion, upon fair notice to each party, reconvene the Hearing and receive additional evidence or argument. The recommendation must be based on the evidence produced at the Hearing. The supporting evidence may be stated as "Factual Findings" of the Hearing Panel and contain a proposed report to the NPDB.

**11.4.21. Further Distribution of Hearing Panel Report and Recommendation.** The President shall send a copy of the Hearing Panel's report and recommendation, return receipt requested, to the body

whose Professional Review Action initiated the Hearing. That body then decides whether to modify its original recommendation or action, considering the report and recommendation of the Hearing Panel. That body shall forward its final recommendation to the President. Upon receipt of the final recommendation, the President shall forward a copy of the same, together with the Hearing Panel's report and recommendation, to the affected Practitioner. The final recommendation of the body whose Professional Review Action initiated the Hearing shall be forwarded to the Board for approval, but if the final recommendation of such body continues to be adverse, the Board shall not act until the affected Practitioner has either waived his/her right to Appeal or has requested an Appeal pursuant to these Bylaws.

**11.5 Notice And Request For An Appeal.** Within thirty (30) days of receiving Notice of the Hearing Panel's decision, the individual or the Hospital representative may request an appellate review of the decision. This request must be by written notice, mailed return receipt requested to the President and to the other party. The request must be postmarked on or before the thirtieth (30<sup>th</sup>) day following receipt of the Notice of the Hearing Panel's decision. The request must include a brief statement of the reasons for the Appeal. The sole grounds for reversal of a decision or Appeal are the following types of errors:

- a. Substantial failure on the part of the Medical Staff or the Board to comply with these Bylaws in the conduct of proceedings affecting the individual;
- b. That the recommendation or action was made or taken arbitrarily, capriciously, or with prejudice;
- c. That a recommendation or action of the MEC or Hearing Panel or the decision of the Board was not supported by substantial evidence.

If an Appeal is not requested within the thirty (30) day time period, the individual and the Hospital have accepted the decision and the action taken is immediately effective and the final recommendation of the body whose Professional Review Action initiated the Hearing shall be forwarded to the Board for final approval.

**11.6 Appeal: Procedural Details.**

**11.6.1. Arrangements for Appellate Review.** When an Appeal is requested, the Board Chairperson, or his or her designee, within ten (10) days of receiving such request, shall schedule and arrange for an appellate review. Notice of the time, date and place will be given to the appealing party. The date for appellate review must not be less than thirty (30) days after the request is received. When the individual appealing is under suspension, then the appellate review shall be held as soon as arrangements can reasonably be made, but not more than twenty (20) days from receiving the Appeal request. The stated times within which

appellate review must be accomplished may be extended by the Board for good cause shown.

#### **11.6.2. Appellate Review Panel and Procedures.**

The Board Chairperson shall appoint an Appellate Review Panel of not less than three (3) persons, which must include at least one (1) physician, which may include members of the Board, but which may not include persons in direct economic competition with the individual appealing, playing any part in the presentation of the Appeal or having participated in any earlier Investigation or decision of the matter. The Appellate Review Panel considers the Hearing Panel's record.

The Appellate Review Panel may accept additional oral or written evidence only if the party seeking to admit additional evidence can demonstrate on the basis of the record that he or she was deprived of the opportunity to admit it at the Hearing which is under Appeal.

Each of the two parties in the matter have the right to present a written statement in support of their position on the Appeal and, in its sole discretion, the Appellate Review Panel may allow a representative of each party to appear personally and make oral arguments.

The Appellate Review Panel's function is not to function as a Hearing Panel and rehear evidentiary presentations. Rather, the Appellate Review Panel's function is to review the Hearing Panel's record, to accept additional evidence as provided above, and to determine only whether:

- a. there was substantial failure on the part of the Medical Staff or the Board to comply with these Bylaws in the conduct of proceedings affecting the individual;
- b. the Adverse Action was made or taken arbitrarily, capriciously or with prejudice; or
- c. the recommendation or action of the MEC or the Hearing Panel, or the decision of the Board was not supported by substantial evidence.

Unless it remands the matter back to the Hearing Panel for further consideration, the Appellate Review Panel must make a recommendation to the Board within thirty (30) days after conclusion of the appellate review and based on its determination with respect to the foregoing issue, the Appellate Review Panel will recommend, in writing, final action to the Board. If the Appellate Review Panel determines there was no error of the type specified in a. through c. above, then the Appellate Review Panel will recommend that the decision, action or recommendation under Appeal be made final.

**11.6.3. Only One Appeal.** An individual is entitled to only one appellate review of any Professional Review Action.

**11.7 Board Action.** Upon receipt of the Appellate Review Panel’s recommendation (or upon receipt of the final recommendation of the body whose Adverse Action initiated the Hearing, in the absence of an Appeal):

**11.7.1.** The Board may accept, modify, or reverse the recommendation of the Appellate Review Panel (or the body whose Adverse Action initiated the Hearing, in the absence of an Appeal) only for good cause. But the Board shall not function as another appellate forum. When further review is necessary, a report back to the Board shall be accomplished within thirty (30) days, unless a reasonable extension is granted by the Board. The final Board decision is arrived at within thirty (30) days after the conclusion of the appellate review (or Hearing, in the absence of an Appeal), and is provided in writing delivered in person or by certified mail to the affected Practitioner and to the MEC, including a statement of the basis for the decision.

**11.7.2.** The decision of the Board following the Appeal (or Hearing, in the absence of an Appeal) is effective immediately, is final, and is not subject to further Hearing or Appeal rights pursuant to the Fair Hearing Plan.

**11.8 Reapplication Following an Adverse Action on Appellate Review.** If the final decision of the Board following an Appeal Adversely Affects the individual, the individual may re-apply for Appointment to the Medical Staff, or for the denied Clinical Privileges, whatever is applicable, one (1) year or later from the Board’s final decision or Appeal, unless the Board provides otherwise in its final written decision.

**11.9 Reporting Requirements.** The Hospital must report to the NPDB and/or the state board of licensure, as required:

**11.9.1.** Each final Professional Review Action that Adversely Affects a Member’s Clinical Privileges;

**11.9.2.** Suspension or voluntary withdrawal of Appointment or Clinical Privileges for a period in excess of thirty (30) days either:

- a. While the Practitioner is under Investigation; or
- b. In return for not conducting an Investigation.

**11.10 Exhaustion of Remedies.** If a Professional Review Action described in Section 11.1 of this is taken or recommended, the applicant or Member must exhaust the remedies afforded by these Bylaws before resorting to legal action. For purposes of this Section, the term “Member” may include “applicant” as applicable under the circumstances.

## **12. CONFIDENTIALITY IMMUNITY AND RELEASE**

**12.1 Agreement to Be Bound.** By submitting an application for Medical Staff Appointment or a request for Clinical Privileges, regardless of whether the



applicant is awarded such Appointment or Clinical Privileges, each Practitioner agrees to be bound by the specific provisions of this Section 12.

## **12.2 Information Collection and Handling.**

**12.2.1.** “Hospital Representatives” (defined in this Section to mean the Board, each Board member, each Board committee, the President, the Medical Staff President, the Medical Staff, each Member, officer and committee thereof, each attorney and each other individual who is authorized to gather, analyze, use or disseminate information concerning Practitioners) are specifically authorized to solicit, receive and act upon information relating to a Practitioner’s qualifications.

**12.2.2.** Third parties are specifically authorized to release information about a Practitioner’s qualifications to Hospital Representatives.

**12.2.3.** Hospital Representatives are specifically authorized to release information about a Practitioner’s qualifications to other hospitals, health care entities, authorized health care licensing, data collection or reporting agencies, to the extent consented to in this Section 12 or to the extent required or permitted by law.

## **12.3 Confidentiality in Professional Review Activities.**

**12.3.1.** Members who serve on Professional Review Bodies are entitled to preserve the confidentiality of their Professional Review Activities from disclosure to reviewed Practitioners and to others in order to foster candid and complete assessments of professional qualifications. Practitioners whose qualifications are reviewed are likewise entitled to the confidentiality and disclosure of information about them to others only in the manner permitted by law and by these Bylaws.

**12.3.2.** Practitioners are forbidden to disclose Peer Review Matter (as defined below) to any other person, except as expressly provided in this Section.

**12.3.3.** “Peer Review Matter” includes:

- a. Information, data, reports or records supplied by any person to a Hospital Representative in furtherance of a Professional Review Activity;
- b. Information, data, reports or records created by a Professional Review Body or by any of its members, employees, assistants or persons under contract in the course of a Professional Review Activity;
- c. Conversations, discussions, deliberations, testimony or other oral communications relating to Professional Review Activities; and
- d. Reports that a Professional Review Body may take to the NPDB.

**12.3.4.** Peer Review Matter may be disclosed to others only:

- a. As may be permitted or required by law or by a court of competent jurisdiction; or
- b. As may be specifically authorized in a written consent by both the Practitioner and the unanimous approval of the Professional Review Body.

#### **12.4 Immunity and Release.**

**12.4.1.** Each of the following persons acting in good faith is immune from civil liability for damages or other relief, and each Practitioner specifically releases from all civil liability:

- a. Each person who provides information to a Hospital Representative in furtherance of a Professional Review Activity;
- b. Each Hospital Representative who participates in a Professional Review Activity, including but not limited to, each Professional Review Body; each person acting as a member or staff to the Professional Review Body; each person under contract or other formal arrangement with either a Hospital Representative or the Professional Review Body; and each person who participates with or assists the Professional Review Body; and
- c. Each third person to whom a Hospital Representative releases information.

**12.4.2.** In the event that a Hospital Representative takes or investigates the taking of a Professional Review Action, each Practitioner agrees to exhaust all steps set forth in these Bylaws, including administrative review and the exercise of his rights, if any, pursuant to the Fair Hearing Plan as his or her exclusive remedy respecting that Professional Review Action.

#### **12.5 Immunities Cumulative.** The immunities provided in this Section are cumulative and do not limit or restrict immunities that are otherwise available under law.

### **13. RULES AND REGULATIONS AND POLICIES**

- 13.1.1.** The Medical Staff must adopt the Rules and Regulations and Policies as necessary to specifically implement the general principles found in these Bylaws.
- 13.1.2.** The Rules and Regulations and Policies may be adopted by the Medical Staff acting through the MEC.
- 13.1.3.** Prior to sending any amendment to the Rules and Regulations to the Board, the proposed amendments to the Rules and Regulations must be communicated to the Medical Staff. Rules and Regulations are then effective only upon approval by the Board. The Medical Staff has thirty (30) days to review and object to any amendment to the Rules and Regulations proposed by the MEC. If twenty-five percent (25%) of the Members eligible to vote file a written objection to a proposed amendment to the Rules and Regulations within thirty (30) days of reviewing the Notice thereof, the proposed amendment to the Rules and Regulations will not be implemented.
- 13.1.4.** The MEC is not required to circulate proposed amendments to the Policies to the Medical Staff prior to sending the proposed amendment to Board; however, following approval by the MEC and the Board, the Medical Staff shall be notified immediately of all amendments to the Policies.
- 13.1.5.** If there is an urgent need to amend the Rules and Regulations to comply with a law, regulation, or accreditation standard, the MEC may provisionally approve such amendment without prior Notice to the Medical Staff. However, the MEC must immediately notify the Medical Staff of the urgent amendment.
- 13.1.6.** As an alternative to the MEC proposing an amendment to the Rules and Regulations or the Policies, the Members of the Active Staff may propose an amendment to the Rules and Regulations or the Policies by a petition signed by at least thirty three and one-third percent (33 1/3%) of the Members of the Active Staff. After such petition is presented to the MEC for action, if the MEC does not approve the proposed amendment, then the proposed amendment shall be submitted to all of the Members of the Active Staff for a vote, and if approved by a majority of the Members of the Active Staff, shall be forwarded to the Board for approval and implementation.
- 13.1.7.** Such petition shall first be submitted to the MEC for its consideration and approval. The MEC shall act on such petition at its next scheduled meeting.
- 13.1.8.** Existing Rules and Regulations and Policies are deemed to continue in effect unless and until they are amended or replaced by action of the

MEC, subject to approval of the Board. The Rules and Regulations and Policies are effective upon approval by the Board.


#### **14. AMENDMENT OF BYLAWS**

- 14.1** The Medical Staff has the responsibility to formulate and propose these Bylaws and amendments to these Bylaws and to review and revise them when necessary to reflect the Hospital's current practice with respect to the Medical Staff's organization and functions. The Medical Staff must exercise this responsibility in good faith and in a reasonable, responsible, and timely manner.
- 14.2** These Bylaws and amendments to these Bylaws are not effective until they are approved by both the Medical Staff and by the Board. Notwithstanding these Bylaws and the Rules and Regulations, the Board has the authority to act consistent with its fiduciary duty.
- 14.3** Proposed amendments to these Bylaws shall be presented to the MEC, which reports on them, either favorably or unfavorably, to the Medical Staff for action. If the MEC votes favorably on the proposed amendments, the proposed amendments shall be presented to the Medical Staff for a final vote. If the MEC votes unfavorably, then the proposed amendment may still be presented for a final vote of the Medical Staff upon a petition signed by at least thirty three and one-third percent (33 1/3%) of those Members eligible to vote.
- 14.4** Except as otherwise provided herein, for the purpose of adopting an amendment to these Bylaws, sixty six and two-thirds (i.e., 66 2/3%) vote of the Members eligible to vote is required. Amendments so made are effective when approved by the Board.
- 14.5** The MEC shall have the power to approve technical corrections such as reorganization or renumbering of the Bylaws, or punctuation, spelling or other errors of grammar, expression or inaccurate cross-references. No substantive amendments are permitted pursuant to this Section. Corrections may be effected by motion and acted upon in the same manner as any other motion before the MEC. After approval, such corrections shall be communicated in writing to the Medical Staff and the Board. Such corrections are effective upon adoption by the MEC; provided however, they may be rescinded by vote of the Medical Staff or the Board within one hundred twenty (120) days of the date of adoption by the MEC. For purposes of this Section, "vote of the Medical Staff" shall mean a majority of the votes cast, provided at least twenty-five percent (25%) of the voting Members cast ballots.
- 14.6** These Bylaws and related documents are reviewed at least bi-annually and revised as necessary.
- 14.7** Neither the Medical Staff nor the Board may unilaterally amend these Bylaws or the Rules and Regulations.

## 15. ADOPTION OF BYLAWS

Prior to adoption, these Bylaws shall be circulated to all Members, along with a ballot on which the Member shall vote, at least two (2) weeks prior to the date on which the ballots are due to the Medical Staff Office. These Bylaws shall be adopted upon sixty six and two-thirds (i.e., 66 2/3%) vote of Members eligible to vote. Ballots which are not returned indicating either an affirmative or negative vote will be considered an affirmative vote by the Member. Following adoption and approval by the Medical Staff the amendment and adoption of these Bylaws shall become effective as and when approved by the Board. Once adopted and approved, these Bylaws shall replace in their entirety the existing Medical Staff Bylaws (the "Existing Bylaws"); however, any credentialing activities, Investigations, or Hearings commenced and ongoing under the Existing Bylaws shall continue pursuant to the terms of the Existing Bylaws until such time as the activity, Investigation, or Hearing is complete.

REVIEWED, REVISED AND APPROVED by the Medical Staff on January 27, 2020.

  
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Medical Staff President

REVIEWED AND APPROVED by the Board of Directors on January 28, 2020.

  
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Chairman of the Board