



# Medical Staff Bylaws

Approved by Board of Directors  
September 20, 2016

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# 1. ARTICLE one: definitions/construction of terms and headings

## 1.1 DEFINITIONS

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

**Administration:** The executive members of the Hospital staff, including the Chief Executive Officer (CEO), Chief Financial Officer (CFO), Chief Nursing Officer (CNO).

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

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

**Allied Health Professional (AHP):** An individual, other than those defined under "Practitioner," who provides direct patient care services in the Hospital under a defined degree of supervision, exercising judgment within the areas of documented professional competence and consistent with applicable law. AHPs are designated by the Board to be credentialed through the Medical Staff system and are granted clinical privileges as either a dependent or independent healthcare professional as defined in these Bylaws. AHPs are not eligible for Medical Staff membership. The Board has determined the categories of individuals eligible for clinical privileges as an AHP are RNs, radiology practitioner assistant (RPA), pathology assistant, physician assistants (PA), certified registered nurse anesthetists (CRNA), clinical psychologists (Ph.D., Psy.D., LPC) and advanced practice registered nurses (APRN).

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

**Board Certification:** A designation for a physician who has completed an approved educational training program and an evaluation process including an examination designed to assess the knowledge, skills and experience necessary to provide quality patient care in that specialty. Board certification shall be from an American Board of Medical Specialties (ABMS) Member Board or from a Member Board of Certification of the Bureau of Osteopathic Specialists or from the American Board of Podiatric Surgery (ABPS) if the applicant is a podiatrist, or from the American Board of Oral/Maxillofacial Surgeons (ABOMS) if the applicant is an oral surgeon. ABMS is the umbrella organization for the 24 approved medical specialty boards in the United States. Member Boards determine whether candidates have received appropriate preparation in approved residency training programs in accordance with established educational standards, evaluate candidates with comprehensive examinations, and certify those candidates who have satisfied the board requirements.

**Board of Directors:** The governing body of the Corporation herein referred to as the "Directors" unless otherwise specifically stated and is governing body of the Hospital, as described in the standards of The Joint Commission (TJC) and the Medicare Conditions of Participation. The Board of Directors may also be referred to as the "Board" unless otherwise specifically stated.

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

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

**Chief of Staff:** A member of the active Medical Staff who is elected in accordance with these Bylaws to serve as chief officer of the Medical Staff of this Hospital.

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

**Compact State License:** A mutual recognition model which allows a nurse to have one nursing license in his/her state of residency which permits practice in reciprocal states, subject to each state's practice law and regulation.

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

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

**Corporate Management:** The officers of the Corporation/Hospital with authority and responsibility for the Hospital.

**Corporation:** The legal owner of the Hospital, **Brim Healthcare of Texas, LLC.**

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

**Criminal Conviction:** Conviction of, or a plea of guilty or *nolo contendere* for any felony or misdemeanor related to the practice of a health care profession, Federal Health Care Program fraud or abuse, third-party reimbursement, or controlled substances or any other criminal offense (excluding parking tickets)

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

**Days:** Calendar days, unless otherwise noted.

**Dentist:** An individual who has received a doctor of dental surgery or a doctor of dental medicine degree and has a current, unrestricted license to practice dentistry.

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

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

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

**Division:** A clinical sub grouping of members of the Medical Staff Department in accordance with their subspecialty or specialized practice interest, as specified in these Bylaws.

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

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

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

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

**Focused Professional Practice Evaluation (FPPE):** Time limited evaluation of a practitioner's competence in performing specific privilege(s); FPPE is implemented for all initially granted privileges and whenever a question arises regarding a practitioner's ability to provide safe, quality care.

**Governing Body:** The Board of Directors of the Hospital or a committee of the Board of Directors, which has been delegated specific authority and responsibility.

**GSA List:** The General Service Administration's List of Parties Excluded from Federal Programs.

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

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

**Hospital:** Wadley Regional Medical Center, 1000 Pine Street, Texarkana, Texas 75501. As the term is used in these Bylaws, it shall mean all of the facilities, services, and locations licensed or accredited as part of the Hospital, which is an organization inclusive of the Medical Staff.

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

**Ineligible Person:** Any individual who: (1) is currently excluded, suspended, debarred, or ineligible to participate in any Federal health care program; or (2) has been convicted of a criminal offense related to the provision of health care items or services and has not been reinstated in a Federal health care program after a period of exclusion, suspension, debarment, or ineligibility.

**Interpersonal and Communication Skills:** Skills that enable the practitioner/professional to establish and maintain professional relationships with patients, families, and other members of health care teams.

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

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

**Medical/Clinical Knowledge:** Knowledge of established and evolving biomedical, clinical, and social sciences, and the application of their knowledge to patient care and the education of others.

**Medical Staff:** The formal organization of all categories of Practitioners designated by the Board to be eligible for Medical Staff membership. The Board has determined that the categories of Practitioners eligible for Medical Staff membership are physicians (MD or DO), maxillofacial/oral surgeons (DDS), dentists (DDS), and podiatrists (DPM). The Medical Staff is an integral part of the Hospital and is not a separate legal entity.

**Medical Staff Office:** The Hospital employee(s) or contractor assigned the responsibility for processing applications for Medical Staff appointments, reappointments, and requests for clinical privileges, and for maintaining documents related to the credentialing process. Medical Staff Office responsibilities are assigned by Administration and the Hospital



employee(s)/contractor who works in the Medical Staff Office is accountable to Administration. The documents maintained by the Medical Staff Office are the property of the Hospital.

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

**Medical Staff Year:** The period from January 1 to December 31 of each year.

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

**Member:** A Practitioner who has been granted and maintains Medical Staff membership.

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

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

**Occasions of Service:** – As applied to non-hospital based physicians, defined as admissions, outpatient surgeries, consultations on hospital inpatients, and outpatient invasive procedures in which the physician is directly involved.

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

**Ongoing Professional Practice Evaluation (OPPE):** A documented summary of ongoing data collected for the purpose of assessing a practitioner's clinical competence and professional behavior.

**Oral and Maxillofacial Surgeon, Qualified:** An individual who has successfully completed a postgraduate program in oral and maxillofacial surgery accredited by a nationally recognized accrediting body approved by the U. S. Department of Education.

**Patient Care:** Care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life.

**Pediatric Patient:** A patient 17 years of age and younger.

**Peer:** An individual from the same discipline (for example, physician and physician, dentist and dentist) and with essentially equal qualifications or an individual with greater qualifications who is familiar with the care rendered by the practitioner.

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

**Physician:** An individual who has been educated and trained in the practice of medicine and who holds a current license as a Doctor of Medicine (MD) or Doctor of Osteopathy (DO).

**Podiatrist:** An individual who holds a current license as a Doctor of Podiatric Medicine (DPM).

**Practice-Based Learning and Improvement:** Ability to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.

**Practitioner/Licensed Independent Practitioner (LIP):** An Individual who provides direct patient care in the Hospital, exercising judgment within the areas of documented professional competence and consistent with applicable law. These are individuals who are designated by the State and by the Hospital to provide patient care independently. The Board has determined that the categories of individuals eligible for clinical privileges as a LIP are physicians (MD or DO), maxillofacial/oral surgeons (DDS), dentists (DDS), podiatrists (DPM) and psychologists.

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

**Professionalism:** Behaviors that reflect a commitment to continuous professional development, ethical practice, and understanding and sensitivity to diversity, and a responsible attitude toward the patient, the profession, and society.

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

**Qualified Medical Person or Personnel:** In addition to a physician, Qualified Medical Persons may perform a Medical Screening Examination. These include physician assistants, (PA), advanced practice registered nurses, (APRN), and registered nurses (RN) in peri-natal services, who have demonstrated current competence in the performance of Medical Screening Examinations, and who is functioning within the scope of his or her license and policies of the Hospital has been approved by the Board as a Qualified Medical Person

**Qualified Physician:** A Doctor of Medicine (MD) or a Doctor of Osteopathy (DO) who, by virtue of education, training and demonstrated competence, is granted clinical privileges by the Hospital to perform specific diagnostic or therapeutic procedure(s) and who is fully licensed to practice medicine.

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

**Rules and Regulations:** The Rules and Regulations of the Medical Staff as approved by the MEC and Board of Directors

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

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

**Systems-Based Practice:** An understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.

**Telemedicine:** Medical practice is defined as any contact that results in a written or documented medical opinion and affects the medical diagnosis or medical treatment of a patient. Telemedicine is the practice of medicine through the use of electronic communication or other communication technologies to provide or support clinical care at a distance.

## 1.2 CONSTRUCTION OF TERMS AND HEADINGS

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

## **2. ARTICLE TWO: NAME, PURPOSES & RESPONSIBILITIES**

### **2.1 NAME**

The name of the Medical Staff shall be the "Medical Staff of Wadley Regional Medical Center."

### **2.2 PURPOSES AND RESPONSIBILITIES**

The purposes and responsibilities of the Medical Staff are:

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

### **2.3 PRIVACY PRACTICES**

- 2.3.1 Each member of the Medical Staff, as well every Practitioner or Allied Health Professional with clinical privileges and each Practitioner with temporary privileges (collectively herein referred to as the "Provider" in this paragraph), shall be part of the Organized Health Care Arrangement with the Hospital, which is defined in 45 C.F.R. §164.501, (which is part of what is commonly known as the HIPAA Privacy Regulations) as a clinically-integrated care setting in which individuals typically receive health care from more than one healthcare provider. This arrangement allows the Hospital to share information with the Provider and the Provider's office for purposes of the Provider's payment and practice

operations. The patient will receive one Notice of Privacy Practices during the Hospital's registration or admissions process, which shall include information about the Organized Health Care Arrangement with the Medical Staff, Practitioners or Allied Health Professionals with clinical privileges, and Practitioners with temporary privileges.

### **3. ARTICLE THREE: APPOINTMENT/REAPPOINTMENT**

#### **3.1 NATURE OF MEMBERSHIP AND GENERAL QUALIFICATIONS**

The Medical Staff includes fully licensed Physicians and other Practitioners permitted by law and by the Hospital to provide patient care independently within the Hospital, and whom the Board appoints. Staff membership is a privilege extended by the Hospital, and not a right of any Physician, Practitioner or other person. Membership and/or the permission to exercise clinical privileges shall be extended only to individuals who continuously meet the requirements of these Bylaws. No person shall admit patients or provide services to Hospital patients as a Practitioner or AHP unless he/she is appointed to the Staff or has been granted clinical privileges in accordance with the provisions outlined in these Bylaws. Appointment to the Staff or granting of clinical privileges shall confer on the individual only such prerogatives of membership that are granted by the Board based on their approval of the individual's Staff category or as are afforded to AHPs when clinical privileges are granted to an individual in this category. For purposes of these Bylaws "membership in" is used synonymously with "appointment to" the Staff. The granting of membership or approval of appointment does not automatically confer clinical privileges. A person may be a member of the Staff without having any clinical privileges. The granting of clinical privileges does not automatically confer Staff membership or appointment. A person may be granted clinical privileges without Staff membership or appointment, as in the case of an Allied Health Professional. The Board has determined the categories of healthcare professionals eligible for Staff membership and/or clinical privileges, as defined in these Bylaws. The Hospital-specific mechanism for appointment, reappointment, and for granting, renewing, or revising clinical privileges is fully documented in these Bylaws, and has been approved and implemented by the Medical Staff and the Board. All Medical Staff members and individuals with clinical privileges are subject to these Bylaws and Rules and Regulations. Only those individuals possessing all of the following qualifications shall be eligible for appointment to the Staff or clinical privileges, and these professional criteria shall apply uniformly to all applicants:

##### **3.1.1 Licensure**

The applicant must possess a current unrestricted license in medicine, dentistry, or podiatry in the State of Texas except if the applicant works for a Wadley Regional Medical Center facility located in the state of Arkansas. In this case an Arkansas license is required and the practitioner's privileges are limited to outpatient services only; it is advisable to obtain a Texas license. No applicant is eligible for membership or privileges if they have ever had a license revoked by any state licensing agency. AHP's such as APRN's and CRNA's may practice with a compact RN license but must maintain an advanced practice license in the state of Texas. Proof of licensure in the form of a copy of the license may be included as part of the application for membership. The applicant shall also be required to provide information related to any current or past licensure as a healthcare professional in any other States.

##### **3.1.2 Controlled Substance Registration**

To have prescribing privileges for controlled substances, the applicant must possess a current unrestricted Federal Drug Enforcement Administration (DEA) and a Department of Public Safety (DPS) registration. Proof of registration in the form of a copy of the registration certificate(s) may be included as part of the application. Prescribing privileges shall be limited to the classes of drugs granted to the applicant by the DEA and DPS and may be further limited by the Medical Staff through the delineation of medication prescribing privileges based on the scope of practice and current competence of the applicant.

##### **3.1.3 Location of Office**

The applicant must have an office located within the geographic service area of the Hospital as defined by the Board, which is close enough to fulfill their Medical Staff responsibilities and to provide timely and continuous care for their patients in the Hospital.

##### **3.1.4 Professional Education and Training**

The applicant must have graduated from an accredited School of Medicine, Dentistry, Podiatry, or school appropriate to their profession. If the applicant is a physician who is a foreign medical graduate, he/she must have successfully completed the Education Commission for Foreign Medical Graduate (ECFMG) verification of graduation from a foreign medical school. An

applicant Practitioner must also have successfully completed a residency training program approved by the Accreditation Council for Graduate Medical Education (ACGME), American Podiatric Medical Association, or American Osteopathic Association (AOA) in the field of specialty for which the Practitioner requests clinical privileges, or a dental surgery training program accredited by the Council on Dental Education and Licensure of the American Dental Association. An applicant should be board certified and therefore must fulfill Board Certification Requirements stipulated by (i) the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), or the American Board of Oral Maxillofacial Surgery; and (ii) the Department to which the Member is assigned. For those specialty boards with only a written exam, the Medical Staff Member must pass the written examination within three (3) years of completing residency. For those specialty boards with a maximum time limit of greater than ten (10) years for passing the oral / written examination or with no maximum time limit for passing the oral / written examinations, the Medical Staff Member must pass the written exam within three (3) years of completing residency and both written and oral exams with ten (10) years of completing residency. If Board certification expires, the medical staff member has a maximum of one year following expiration to successfully recertify. Medical Staff Members that are unable to comply with this requirement of Board recertification may request an exemption from this requirement only by written request to the Medical Executive Committee outlining the reasons they are unable to comply. The Medical Executive Committee will evaluate the request and make a decision to grant or reject the request on a case by case basis based on the sole discretion of the Medical Executive Committee; their recommendation will be forwarded to the Board of Directors.

#### 3.1.5 Core Competencies

The applicant must be able to demonstrate that he is proficient in the following Core Competencies as defined in these Bylaws:

- (1) Patient Care
- (2) Medical Clinical Knowledge
- (3) Practice Based Learning and Improvement
- (4) Interpersonal and Communication Skills
- (5) Professionalism
- (6) Systems-Based Practice

#### 3.1.6 Current Competence, Experience and Judgment

The applicant must document his/her current clinical competence, experience and judgment with sufficient adequacy, as determined at the discretion of the Medical Executive Committee and the Board, to demonstrate that patients receiving healthcare services from him/her will receive care of the generally recognized professional level of quality and efficiency established by the Hospital. Evidence of current competence and experience shall include, but shall not be limited to, responses to related questions provided in information from training programs, peers, and other facility affiliations. In the case of an applicant for reappointment, evidence of current competence and experience shall also include, but not be limited to, documentation of continuing medical education upon request, the results of performance improvement and peer review, and recommendation(s) provided by Department Chairperson(s). For low/no volume practitioners who do not utilize the hospital with sufficient frequency to allow for an adequate evaluation of current clinical competence, the practitioner will be responsible to provide documentation as outlined in the Medical Staff Bylaws Rules and Regulations.

#### 3.1.7 Conduct/Behavior

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

3.1.8 Professional Ethics and Character

The applicant shall agree to abide by the Principles of Medical Ethics of the American Medical Association, the American Osteopathic Association, the Code of Ethics of the American Dental Association, the Code of Ethics of the American Podiatry Association, or the ethical standards governing the applicant's practice if it is not listed. The applicant shall also agree to abide by the Code of Conduct of Wadley. Must not have had Medical Staff appointment or clinical privileges denied, revoked, resigned, relinquished, or terminated by any health care organization for reasons related to clinical competence or professional conduct; and must not have been convicted of any felony.

3.1.9 Health Status/Ability to Perform

The applicant shall possess the ability to perform the clinical privileges requested. In the event that the applicant has a physical or mental impairment that adversely affects his/her ability to practice within the clinical privileges requested, the applicant shall notify the Chief of Staff. Upon receipt of such notification, the Chief of Staff will meet with the applicant to determine the extent of the impairment. If it is determined that the impairment does not adversely affect the applicant's ability to perform the essential functions of the clinical privileges requested, the Chief of Staff and applicant will discuss whether there is a reasonable accommodation that would enable the applicant to perform such functions. If reasonable accommodation is necessary, the Hospital will provide such accommodation to the extent required by law, or if not so required, as determined to be appropriate within the sole discretion of the Hospital.

3.1.10 Communication Skills

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

3.1.11 Professional Liability Insurance

The applicant shall maintain professional liability insurance coverage for the clinical privileges requested with limits as established by the Board of Director, as a qualification for initial appointment and to cover the term of the individual's Medical Staff membership or clinical privileges (e.g., "claims-made" coverage).

3.1.12 Eligibility to Participate in Federal Programs

The individual shall not currently be an Ineligible Person and shall not become an Ineligible Person.

3.1.13 Physician Ownership Disclosure

If the physician is a referring physician owner, he/she must disclose to the patient, in writing, his/her ownership and/or investment interest in the Hospital. Such disclosure is a condition of continued medical staff membership or admitting privileges. In the event that a referring physician owner fails to comply with such condition, the matter shall be subject to administrative corrective action in accordance with Section 6.6 of these Bylaws. For the purposes of this provision, a "referring physician owner" is a physician who has any ownership and/or investment interest in the Hospital. The written disclosure must, at a minimum, indicate the following: "Dr. [insert name] is one of the proud owners of Wadley Regional Medical Center, a physician-owned hospital under 42 U.S.C. §1395nn. At the time of a referral for any necessary hospital services, each of our patients may choose Wadley Regional Medical Center or any other facility, center or hospital for the purpose of having such services performed as determined by the patient to be in the patient's best interest."

**3.2 HOSPITAL NEED AND ABILITY TO ACCOMMODATE**

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

- 3.2.1 Availability of Facilities Support services  
Clinical privileges shall be granted only for the provision of care that is within the scope of services, capacity, capabilities, and business plan of the Hospital.
- 3.2.2 Exclusive Contracts  
The Board may determine, in the interests of quality of patient care and as a matter of policy, that certain Hospital clinical facilities, services, and coverages may be used only on an exclusive basis in accordance with written contracts between the Hospital and qualified Practitioners.
- 3.2.3 Medical Staff Development Plan  
The Board may decline to accept applications based on the requirements or limitations in the Hospital's Medical Staff development plan which shall be based on identification by the Hospital of the patient care needs within the population served
- 3.2.4 Effects of Declination  
Refusal to accept or review requests for Staff membership or clinical privileges based upon Hospital need and ability to accommodate, as described in this section, shall not constitute a denial of Staff membership or clinical privileges and shall not entitle the individual to any procedural rights of hearing or appeal. Any portion of the application which is accepted (e.g., requests for clinical privileges that are not subject to a limitation) shall be processed in accord with these Bylaws.

### 3.3 EFFECTS OF OTHER AFFILIATIONS

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

### 3.4 NONDISCRIMINATION

No person shall be denied appointment or clinical privileges on the basis of gender, race, religion, creed, or national origin.

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

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

- 3.5.1 Appear for any requested interviews regarding his/her application, or subsequent to appointment or the granting of clinical privileges, to appear for any requested interviews related to questions regarding the applicant's performance;
- 3.5.2 Provide continuous care to his/her patients at the generally recognized professional level of quality and efficiency established by the Hospital; delegate in his/her absence, the responsibility for diagnosis and/or care of his/her patients only to a Practitioner who is a member of the Medical Staff and who is qualified and approved by the Hospital to undertake this responsibility by the granting of appropriate clinical privileges; and seek consultation whenever necessary, and in accordance with the consultation policies of the Medical Staff;
- 3.5.3 Abide by these Bylaws, the Rules and Regulations, and all other rules, policies and procedures, guidelines, and other requirements of the Medical Staff and the Hospital;
- 3.5.4 Abide by all local, State and Federal laws and regulations, TJC standards, and State licensure and professional review regulations and standards, as applicable to the applicant's professional practice;
- 3.5.5 **Discharge such Medical Staff, Department, committee, and Hospital functions for which he/she is responsible based upon appointment, election, or otherwise, including as appropriate, providing on-call coverage for emergency care services within his/her clinical specialty, as required by the Medical Staff and Board of Directors;**



- 3.5.6 Prepare a patient record for each patient, and prepare and complete in a timely, legible manner the medical and other required records for all patients for whom he/she provides care in the Hospital;
- 3.5.7 Cooperate with the Hospital in matters involving its fiscal responsibilities and policies, including those relating to payment or reimbursement by governmental and third party payers;
- 3.5.8 Participate in peer review, quality assessment, performance improvement, risk management, case management/resource management, and other review and improvement activities as requested;
- 3.5.9 Participate in continuing education to maintain clinical skills and current competence.
- 3.5.10 Notify and update the Medical Staff and Hospital immediately upon a change in any qualifications for membership or clinical privileges, as listed in Article Three of these Bylaws or in any Rules and Regulations outlining criteria for clinical privileges (including but not limited to becoming an Ineligible Person);
- 3.5.11 Agree that the Hospital may obtain an evaluation of the applicant's performance by a consultant selected by the Hospital if the Hospital considers it appropriate;
- 3.5.12 Provide evidence of routine health screenings as approved by the Medical Executive Committee; and,
- 3.5.13 Perform such other responsibilities as the Hospital or the Medical Staff may require.

### **3.6 terms of appointment**

Initial appointments and initial granting of clinical privileges shall be provisional and shall be for a period not to exceed two years (24 months). Reappointments shall be for a period not to exceed two years (24 months).

In the event that reappointment has not occurred due to lack of submission of a complete application prior to the established due date, the membership and clinical privileges of the individual will be considered to be voluntarily surrendered upon the expiration of the current term of appointment. In such case, the individual shall be notified, via certified mail prior to the expiration of the term of membership and/or clinical privileges.

At the time of reappointment and/or renewal of privileges, if the practitioner has not met the requirements for any staff category, he/she shall not be eligible for reappointment. The practitioner's membership and/or clinical privileges shall be considered to be voluntarily surrendered upon the expiration of the current term of appointment. In such case, the individual shall be notified, via certified mail, approximately sixty (60) days prior to the expiration of the term of membership and/or clinical privileges.

A member who is deemed to have voluntarily resigned may reapply for staff membership and clinical privileges at any time as a new applicant. Voluntary surrender of membership and/or clinical privileges is not reportable and shall not entitle the individual to a fair hearing and appeal.

### **3.7 CREDENTIALS VERIFICATION and application processing procedures**

#### **3.7.1 Application**

A separate credentials file shall be maintained for each applicant for Staff membership or clinical privileges. Each application for Staff appointment, reappointment, and/or clinical privileges shall be in writing, submitted on the prescribed form, and signed by the applicant. When an individual is applying for initial appointment or reappointment or is initially requesting clinical privileges, he/she shall be provided an application form and shall be provided access to the Bylaws and the Medical Staff Rules & Regulations. Prior to expiration of the current term of membership or clinical privileges for an individual who is a member of the Medical Staff or who currently holds clinical privileges, the individual will be sent a notice of the impending expiration and an application for reappointment and/or renewal of privileges. A Locum Tenens applicant shall complete the original application.

#### **3.7.2 Burden on Applicant**

The applicant for appointment, reappointment, and/or clinical privileges shall have the burden of producing adequate information for a proper evaluation of his/her qualifications for membership or clinical privileges. Neither the Medical Staff nor the Board shall have any obligation to review or consider any application until it is complete, as defined in these Bylaws. The applicant shall provide accurate, up-to-date information on the application form, and shall be responsible for ensuring that all supporting information and verifications are provided, as requested. It shall be the responsibility of the applicant to ensure that any required information from his/her training programs, peer references, or other facilities is submitted directly to the Medical Staff Office by such sources. The applicant shall be responsible for resolving any deficiencies regarding the application. If during the processing of the application the Hospital or the Medical Staff or any committee or representative thereof, determines that additional information or verification, or an interview with the applicant is needed, further processing of the application may be stayed and the application may not be considered complete until such additional information or verification is received, or the interview is conducted. A Medical Staff Officer or Department Chairperson or the Board may request that the applicant appear for an interview with regard to the application. The Medical Staff Office shall notify the applicant by special notice of the specific information being requested, the time frame within which a response is required, and the effect on the application if the information is not received timely. Failure to provide a complete application, as defined in these Bylaws, within 90 days after being provided with an application form for appointment or clinical privileges, or failure to appear for any requested interview, shall be deemed a voluntary withdrawal from the application process. Voluntary withdrawal from the application process shall not be considered an adverse action, and shall not entitle the applicant to exercise procedural rights outlined in these Bylaws in the event of such withdrawal. The Medical Staff Office shall provide special notice to an individual regarding his/her withdrawal from the application process due to lack of requested information or failure to appear for an interview. The completed application shall include, without limitation:

- 3.7.2.1 Identifying information, including name, social security number, date of birth, any aliases, a copy of a government-issued photo ID, a passport-type photograph, any biometric identification required to verify identification or background, and addresses of office and residence.
- 3.7.2.2 For new applicants, evidence of citizenship in the United States of America (e.g., birth certificate showing place of birth in this country, naturalization papers, or USA passport), or evidence that the applicant is in the USA legally and has the required permission(s) to work in this country. For applicants who are not USA citizens who are requesting reappointment or renewal of privileges, evidence of a current visa and current work permit shall be required.
- 3.7.2.3 For a new applicant, written permission for a background check (SSN verification; criminal history; check of Violent Sexual Offender Registry; OIG-GSA exclusions List; U.S. Government Terrorist List), and submission of any fees associated with processing a background check.
- 3.7.2.4 Evidence of current licensure and information regarding past licensure in any healthcare profession;
- 3.7.2.5 Evidence of controlled substance registration (federal DEA), and Texas Department of Safety (DPS) if applicable;
- 3.7.2.6 For a new appointment, the names and addresses of educational institutions, and dates of attendance, for undergraduate and postgraduate education, including professional degrees earned, or in the case of a foreign graduate, ECFMG certificate;
- 3.7.2.7 For reappointments or renewal of clinical privileges, the applicant's participation in continuing education, specifically as related to the clinical privileges requested;
- 3.7.2.8 At initial appointment, the names of at least three peers who will provide information as to the applicant's experience, current competence, judgment, conduct, ethics and character, and ability to perform the clinical privileges requested. The peers shall be someone with current knowledge **of the** applicant. The program director shall serve as one peer for those who have recently

- completed a training program. For an applicant for reappointment, the name of one peer reference shall be obtained;
- 3.7.2.9 Information regarding specialty board certification, if any, including the name of the specialty board(s), and dates of certification;
  - 3.7.2.10 Information regarding all current and all past healthcare facility affiliations, including the name and address of the facility(s), dates of affiliation, and a procedure log/number of patient contacts from the most recent affiliations within the past six months to two years, as requested;
  - 3.7.2.11 Evidence of current professional liability insurance, including the name of the carrier, amount and dates of coverage, and professional practice covered;
  - 3.7.2.12 National Provider Identifier (NPI);
  - 3.7.2.13 Information as to any current, possible, or pending sanctions affecting participation in any Federal Health Care Program, or any actions which might cause the applicant to become an Ineligible Person, as well as any sanctions from a professional review organization;
  - 3.7.2.14 Accurate and complete disclosure with regard to the following queries:
    - 3.7.2.14.1 Whether the applicant's professional license or controlled substance registration (federal DEA), Texas Department of Public Safety (DPS) registration in any jurisdiction, has ever been disciplined, restricted, revoked, suspended, or surrendered, or whether such action is currently pending, or whether the applicant has voluntarily or involuntarily relinquished such licensure or registration in any jurisdiction;
    - 3.7.2.14.2 Whether the applicant has had any voluntary or involuntary termination of Medical Staff membership, or voluntary or involuntary limitation, reduction, loss, or denial of clinical privileges at another Hospital;
    - 3.7.2.14.3 Whether the applicant has had any notification of, or any involvement in a professional liability action, including any final judgments or settlements involving the applicant; and,
    - 3.7.2.14.4 Whether the applicant has ever been subject to a criminal conviction, as defined in these Bylaws, or whether any such action is pending.
  - 3.7.2.15 A statement from the applicant that he/she agrees to abide by the ethical code and standards governing his/her profession;
  - 3.7.2.16 A statement from the applicant that his/her health status is such that he/she has the ability to perform the clinical privileges that he/she is requesting, pursuant to Article Three, Section 3.1.7;
  - 3.7.2.17 A statement from the applicant that he/she has received and read the current Staff Bylaws, Rules and Regulations, and policies and agrees to be bound by them, including any future Bylaws, Rules and Regulations and policies which may be duly adopted;
  - 3.7.2.18 A statement from the applicant that he/she received and read the Hospital Code of Conduct and agrees to be bound by it;
  - 3.7.2.19 A pledge from the applicant to provide continuous care to his/her patients, as defined in these Bylaws;
  - 3.7.2.20 A statement from the applicant consenting to the release and inspection of all records or other documents that may be material to an evaluation of his/her professional qualifications, including all health information and medical records necessary to verify the applicant's health status as required by Section 3.1.9, and for a new applicant permission to conduct a background check, and a statement providing immunity and release from civil liability for all individuals requesting or providing information relative to the applicant's professional qualifications or

background, or evaluating and making judgments regarding such qualifications or background.

- 3.7.2.21 A statement from the applicant agreeing that in the event of an adverse action concerning his/her Staff membership or clinical privileges, he/she will exhaust all remedies afforded by these Bylaws before resorting to formal legal action or commencing legal proceedings.
- 3.7.2.22 In the case of an applicant for initial appointment to the Medical Staff, a signed Medicare Acknowledgement.
- 3.7.2.23 A signed Information Security Agreement at the time of application for initial appointment, and during the reappointment process, which pledges that as a condition of membership or holding clinical privileges, the individual shall abide by the privacy policies of the Hospital.
- 3.7.2.24 All applications must include a specific written request for clinical privileges using prescribed forms.
- 3.7.2.25 As a condition of consideration for initial and continued appointment to the Medical Staff, every applicant shall specifically agree to provide to the Medical Staff and the Hospital, with or without request, any new or updated information that is pertinent to the individual's professional qualifications or any question on the application form, including but not limited to any change in Federal Health Care Program Ineligible Person status, including but not limited to any change in licensure or DEA status or any exclusion or other sanctions imposed or recommended by the Federal Department of Health and Human Services or any state, the receipt of a QIO citation, and/or a quality denial letter concerning alleged quality problems in patient care.
- 3.7.2.26 Any fees as may be required by the Board for initial appointment or reappointment.

### **3.7.3 Verification Process**

Upon the receipt of a completed application form, including all required attachments and other requested documentation, the Medical Staff Office shall arrange to verify the qualifications and obtain supporting information relative to the application. The Medical Staff Office shall consult primary sources of information about the applicant's credentials, where feasible. Verification may be provided through a letter or computer printout obtained from the primary source or it may be verbally or electronically transmitted (e.g., telephone, facsimile, email, Internet) information when the means of transmittal is directly from the primary source to the Hospital and the verification is documented. If the primary source has designated another organization as its agent in providing information to verify credentials, the Hospital may use this other organization as the designated equivalent source. The Medical Staff Office shall notify the applicant of any problems in obtaining required information. Any action on an application shall be withheld until the application is completed, meaning that all information has been provided and verified, as defined in these Bylaws. The following information shall be verified for all applicants for appointment, reappointment, or clinical privileges, except as specified:

- 3.7.3.1 Current licensure shall be verified through the state Medical Board for all applicants. For new applicants, current and past licensure in other states shall also be verified through applicable state licensure boards.
- 3.7.3.2 For individuals requesting prescribing privileges, federal DEA registration shall be verified through the US Department of Commerce, National Technical Information Service's electronic verification mechanism, and DPS registration shall be verified through the Texas Department of Public Safety.
- 3.7.3.3 For new applicants, completion of medical school or other post-graduate programs appropriate to the applicant's healthcare profession shall be verified through the AMA, the school's registrar's office, or the National Student Clearinghouse, and through the ECFMG in the case of a foreign medical school graduate.

- 3.7.3.4 For new applicants, internship, residency, or other applicable postgraduate training shall be verified through the program's registrar's office or program director's office.
- 3.7.3.5 Information reported pursuant to the HCQIA shall be obtained from the National Practitioner Data Bank.
- 3.7.3.6 The OIG Sanction Report, GSA lists shall be checked to ensure that the applicant is not listed.
- 3.7.3.7 Professional liability insurance shall be verified, and claims history information shall be obtained.
- 3.7.3.8 A short application as approved by the Medical Executive Committee, the state License, NPDB, OIG, EPLS and professional liability insurance shall be queried with each occurrence a Locum Tenens returns within the two year period of the original application.
- 3.7.3.9 Data and information regarding professional performance shall be requested from available sources including the number of cases/procedures performed during a specified time. Affiliation letters shall be obtained from all current and former health care organizations from the previous 10 years. A minimum of 5 current affiliations shall be obtained for those specialties with numerous affiliations. Two of the most recent affiliations shall be obtained for Locum Tenens practitioners.
- 3.7.3.10 The applicant's health status as applicable to their ability to perform the clinical privileges requested shall be verified in accordance with Article Three, Section 3.1.9, and as part of information requested from the applicant's peers.
- 3.7.3.11 Letters from the applicant's peers shall be obtained. Three peer letters of reference shall be required for initial applicants. For those who have recently completed a training program, one of the three peer references shall be obtained from the Program Director. One letter of reference shall be required for applicants for reappointment or renewal of clinical privileges. The Department Chairperson may serve as this peer reference in such cases unless the Chairperson is not a peer.
- 3.7.3.12 For reappointments or the renewal of clinical privileges, information regarding the applicant's number of cases, treatment results and conclusions drawn from quality assessment, performance improvement activities, and other information regarding the applicant's history of meeting the criteria for membership or clinical privileges, as defined in these Bylaws, shall be assembled for review.
- 3.7.3.13 Specialty board certification shall be verified through consultation with the American Board Medical Specialties (ABMS), the American Board of Osteopathic Specialties (ABOS), the American Board of Podiatric Surgery (ABPS) and the American Board of Oral/Maxillofacial Surgeons (ABOMS), or a comparable specialty board, as applicable.
- 3.7.3.14 With regard to new applicants for Staff membership or clinical privileges, or applicants for reappointment who are not active at the Hospital, evidence of qualifications and competence shall be verified through correspondence with the Medical Staff offices of other facilities where the applicant is affiliated and actively practicing.
- 3.7.3.14 When the hospital has an agreement to accept residents who are vetted by the training program, a short application as approved by the Medical Executive Committee shall be completed. State licenses, NPDB, Criminal Background Check, OIG, and EPLS sanctions shall be queried. Professional liability insurance shall be provided by the training program. If during the training program's vetting process, any unusual issue is identified with a resident that has been accepted into the program, the Program Medical Director will disclose the issue(s) to the hospital's Credentials Committee prior to the resident's rotation in the hospital.

3.7.3.15 The hospital accepts a Non-Staff Telemedicine contract firm's credentialing so long as they are Joint Commission accredited or accredited by another agency who has deemed status. In addition, the Medical Staff Services Department verifies the following upon initial application and every two years thereafter: TX State License, Federal and local sanctions and the NPDB. Professional liability insurance shall be provided in accordance with these bylaws.

#### **3.7.4 Application Processing**

After verification is accomplished and the application is fully complete it shall be reviewed and processed as follows: The timeframe for processing a completed application, beginning with the date the completed application was first received, shall not exceed 180 days.

3.7.4.1 Department Report: The Medical Staff Office shall make available the complete application and all supporting materials to the Chairperson of each Department in which the applicant seeks privileges, and request the documented evaluation and recommendations as to the staff category, in the case of applicants for Staff membership, the Department to be assigned, the clinical privileges to be granted, and any concerns regarding the clinical privileges requested. In the event that the applicant is the Department Chairperson, the Chief of Staff shall make the evaluation and recommendations. The Department Chairperson(s)' evaluation and recommendations shall be transmitted to the Credentials Committee within sixty (60) days. The time frame for completion of the Department recommendation shall be within sixty (60) days of receipt of a complete application.

3.7.4.2 Credentials Committee Report: Upon recommendation from the Department Chairperson, The Credentials Committee shall review the application, supporting materials, and any such other available information as may be relevant to the applicant's qualifications. The Credentials Committee shall then prepare a written report recommending appointment and staff category in the case of applicants for staff membership, the Department to be assigned, the clinical privileges to be granted, and any special conditions to be placed on the clinical privileges to be granted. In the event there are any adverse recommendations, the reasons shall be stated. The timeframe for completion of the Credentials Committee action shall be at the next regular meeting of the committee.

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

3.7.4.3.1 More than three concurrent licenses to practice (e.g., license to practice in two or more other states in addition to this State);

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

3.7.4.3.3 Inability to confirm identity;

3.7.4.3.4 Inability to confirm legal permission to reside and/or work in the USA;

3.7.4.3.5 Any indication of a voluntary or involuntary loss of one or more privileges at another hospital affiliation or restriction or loss of a license, DEA or DPS registration certificate, past or present;

3.7.4.3.6 Frequent changes in location;

3.7.4.3.7 Any gap in work history more than three months

- 3.7.4.3.8 Any other inconsistent or less than favorable information about the applicant's professional qualifications, competence or character, as judged by the Department Chairman, Credentials Committee, Medical Executive Committee, or Board of Director.
- 3.7.4.4 Medical Executive Committee Recommendation: The Medical Executive Committee shall receive the recommendation from the Credentials Committee and review information as may be relevant to the applicant's qualifications. The Medical Executive Committee shall prepare a written report and recommendations for the Board as to Staff appointment and staff category in the case of applicants for Staff membership, the Department to be assigned, the clinical privileges to be granted, and any special conditions to be placed on the clinical privileges to be granted. In the event there are any adverse recommendations, the reasons shall be stated. The time frame for the Medical Executive Committee to decide on a recommendation to the Board shall be at the next regular meeting of the committee following receipt of the Credentials Committee's report.
- 3.7.4.5 Effect of MEC Recommendation
- 3.7.4.5.1 *Deferral: The MEC may defer making a recommendation where the deferral is not solely for the purpose of causing delay. A decision by the MEC to defer the application for further consideration shall state the reasons for the deferral; provide direction for further investigation, and state time limits for such further investigation. As soon as practical after the deferral, such decision to defer the application shall be followed with a subsequent favorable or adverse recommendation. The MEC may delegate the responsibility for further consideration to the Department Chairperson as deemed appropriate.*
- 3.7.4.5.2 *Favorable Recommendation: When the recommendation is completely favorable, the application shall be forwarded promptly to the Board for action at the Board's next regular meeting.*
- 3.7.4.5.3 *Adverse Recommendation: If the recommendation of the MEC is adverse under Article Seven of these Bylaws, the Chief of Staff shall promptly notify the applicant. Such notice shall contain the information prescribed in Article Seven of these Bylaws. In such case, the applicant shall be entitled to procedural rights provided in Article Seven of these Bylaws, and the recommendation need not be transmitted to the Board until after the applicant has exercised or waived such rights.*
- 3.7.4.6 Board Action: Unless subject to the provisions of the fair hearing and appeal provisions in these Bylaws, the Board shall act on the application at its next regular meeting following receipt of the recommendation from the MEC.
- 3.7.4.6.1 *If the Board adopts the recommendation of the MEC, it shall become the final action of the Hospital.*
- 3.7.4.6.2 *If the Board does not adopt the recommendation of the MEC, the Board may either refer the matter back to the MEC with instructions for further review and recommendation and a time frame for responding to the Board, or the Board may take unilateral action. If the matter is referred back to the MEC, the MEC shall review the matter and shall forward its recommendation to the Board. If the Board adopts the recommendation of the MEC, it shall become the final action of the Hospital.*
- 3.7.4.6.3 *If the action of the Board is adverse to the applicant, the Secretary of the Board shall promptly send written notice to the applicant. Such notice shall contain the information prescribed in Article Seven of these Bylaws. In such case, the applicant shall be entitled to procedural rights provided in Article Seven of these Bylaws, and the adverse decision of the Board shall not become final until after the applicant has exercised or waived such rights. At its next regular*

*meeting, after all of the applicant's hearing and appeal rights under these Bylaws have been exhausted or waived, the Board shall take final action.*

*3.7.4.6.4 All decisions to appoint shall include a delineation of clinical privileges (with exception of appointees to the Honorary staff category), the assignment of a staff category and Department affiliation, and any applicable conditions placed on the appointment or clinical privileges. The applicant shall be so notified.*

*3.7.4.6.5 Subject to any applicable provisions of Article Seven, notice of the Board's final decision shall be given in writing through the Secretary of the Board to the applicant within seven (7) working days of the final decision. In the event a hearing and/or appeal were held, Article Seven shall govern notice of the Board's final decision.*

### **3.8 CREDENTIALS SUBJECT TO ONGOING VERIFICATION**

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

- 3.8.1 Current licensure;
- 3.8.2 Drug Enforcement Administration registration, Department of Public Safety;
- 3.8.3 Professional liability insurance;
- 3.8.4 Specialty board certification, if applicable; and,
- 3.8.5 Eligibility to participate in the Federal Health Care Program. (The OIG Sanction Report and GSA list shall be checked every six months.)

### **3.9 ASSISTANCE WITH EVALUATION**

The Board, the CEO, the Staff, or any committee involved in the review or evaluation of applications for Staff membership or clinical privileges, or the ongoing review or evaluation of performance of those who currently hold Staff membership or clinical privileges, may as part of these duties:

- 3.9.1 Obtain the assistance of an independent consultant or others to evaluate the healthcare professional being subject to review;
- 3.9.2 Consider the results of performance improvement or quality assessment activities of other hospitals or health care institutions with respect to the healthcare professional under evaluation;
- 3.9.3 Request or require the healthcare professional under evaluation to submit to interviews with consultants who may be retained to assist in the review or evaluation process;
- 3.9.4 Subject to Federal or State regulations, request that specific patient records or categories of records of patients treated by the healthcare professional under evaluation be submitted for review, subject to appropriate protection of patient confidentiality; and,
- 3.9.5 Require detailed statements, data and information concerning matters that may impact the qualifications, professional competence or conduct of the healthcare professional under evaluation, including information concerning threatened or pending legal or administrative proceedings.

### **3.10 PERFORMANCE PROFILING**

The Board has ultimate responsibility for the quality and appropriateness of patient care services. To meet this responsibility, the Board shall direct and enforce the establishment of a performance improvement and quality assessment program with the requisite quality assessment processes. Processes shall include the measurement, monitoring, analysis, and improvement of the quality and appropriateness of services provided by individual Medical Staff members and other



individuals with clinical privileges. The Medical Staff shall participate in quality assessment and performance improvement activities as defined in the Hospital's Performance Improvement Plan.

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

Relevant information from Hospital performance improvement activities that is specific to an individual shall be considered and compared to aggregate information when these measures are appropriate for comparative purposes in evaluating the individual's professional performance, judgment, clinical or technical skills. Any results of peer review regarding the individual's clinical performance shall also be included. The data, measures and profiles may include, but are not limited to, clinical and other information regarding each individual's:

- 3.10.1 Quality and appropriateness of patient care, including patient care outcomes;
- 3.10.2 Malpractice and professional liability experience;
- 3.10.3 Utilization of Hospital resources and facilities;
- 3.10.4 Timely, legible and accurate completion of patient medical records;
- 3.10.5 Attainment and maintenance of board certification;
- 3.10.6 Maintenance of required levels of professional liability insurance coverage; and
- 3.10.7 Completion of continuing medical education requirements.

### **3.11 Provisional Status AND PROCTORING**

Clinical proctoring is an objective evaluation of an individual's actual clinical competence by a monitor or proctor who represents the Medical Staff and is responsible to the Medical Staff. When required as a condition of granting specific privileges or when a committee of the Medical Staff requires the individual's actual clinical competence to be evaluated for any other reason, the individual shall be proctored or observed. In most instances, proctors act as monitors to evaluate the technical and cognitive skills of another Practitioner and do not directly participate in patient care, have no physician/patient relationship with the patient being treated, do not receive a fee from the patient, represent the Medical Staff, and are responsible to the Medical Staff.

On occasion, when new procedures/equipment are introduced to the hospital, a proctor shall be obtained from outside the hospital medical staff. The proctor shall provide documentation of education in the procedure /equipment he is training as well as a current license in the state where he practices and must have no state or federal sanctions.

Initial appointments and initial granting of clinical privileges shall be provisional for a period not to exceed two years (24 months). If an initial appointee's privileges are granted subject to proctoring or other evaluation activities, the individual shall be proctored for the number and type of cases, procedures or treatments specified by the clinical Department as appropriate to the patient care and services provided by Department members. The proctored care shall be relevant to the privileges granted. The purpose of the observation is to determine the individual's eligibility for advancement from provisional status and for exercising the clinical privileges provisionally granted. At the end of the provisional period the individual must qualify for and be advanced to a non-provisional status. Advancement shall be based upon a favorable recommendation of the individual's Department Chairperson based on the Chairperson's review of any proctoring reports, chart reviews, and/or relevant data from quality assessment activities, a favorable recommendation of the MEC, and approved by the Board. No one may be on provisional status for a total period longer than twenty-four (24) months. An individual's failure to perform adequate occasions of service to provide evaluation of the individual's competence shall be deemed a voluntary relinquishment of membership and clinical privileges. Such individual shall not be entitled to the hearing and appeal rights under these Bylaws. Failure to advance to a non-provisional status due

to performance issues shall entitle the individual to the hearing and appeal rights under these Bylaws.

### **3.12 PREVIOUSLY DENIED OR TERMINATED APPLICANTS**

An applicant who has received an adverse decision regarding appointment and/or clinical privileges shall not be considered again for at least one year after notice of the decision. Any such application shall be processed as an initial appointment. Notwithstanding any other provisions in these Bylaws, if an application is tendered by an applicant who has been previously denied membership and/or clinical privileges, or who has had membership and/or clinical privileges terminated due to lack of sufficient qualifications required to maintain membership or clinical privileges, or whose prior application was deemed incomplete and withdrawn, and it appears that the application is based on substantially the same information as when previously denied, terminated, or deemed withdrawn, then the application shall be deemed insufficient by the Department Chairperson and returned to the applicant as unacceptable for processing. No application shall be processed, and no right of hearing or appeal shall be available in connection with the return of such application.

### **3.13 MEDICO-ADMINISTRATIVE OFFICERS**

#### **3.13.1 Defined**

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

#### **3.13.2 Appointment, Clinical Privileges and Obligations**

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

#### **3.13.3 Effect of Removal from Office or Adverse Change in Membership Status or Clinical Privileges**

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

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

### **3.14 INDIVIDUALS providing professional services by contract**

#### **3.14.1 QUALIFICATIONS AND SELECTION**

Practitioners ("Contract Practitioners") providing clinical services shall be subject to the same procedures as all other applicants for membership or privileges and shall be subject to the same obligations of Staff membership or clinical privileges, as outlined in these Bylaws. Additional requirements for employment or a contractual agreement may be

imposed. The Staff, as in the case of other Practitioners, shall recommend the clinical privileges of Contract Practitioners to admit and/or treat patients.

#### **3.14.2 Effect of Contract Termination on Medical Staff Membership or Clinical Privileges**

The terms of any written contract between the Hospital and a Contract Practitioner or Contractor shall take precedence over these Bylaws as now written or hereafter amended. Such contract may provide, for example, that the Staff membership and clinical privileges of a Contract Practitioner or individuals providing services through a Contractor are automatically terminated or modified in the event of termination of the written contract, and the Contract Practitioner or individuals providing services through a Contractor have no rights to a hearing and appeal or otherwise with regard to such termination or modification of Staff membership or clinical privileges. The underlying grounds for termination of the contract may themselves be cause for initiating adverse action under these Bylaws.

#### **3.15 Leave of Absence**

A Medical Staff member or AHP may request a voluntary leave of absence from the Staff by submitting a written notice to the Medical Executive Committee. The request must state the approximate period of leave desired, which may not exceed one year, and include the reasons for the request. During the period of leave, the Practitioner shall not exercise clinical privileges at the Hospital, and membership prerogatives and responsibilities shall be in abeyance. When the reasons for the leave of absence indicate that the leave is optional, the request shall be granted at the discretion of the Medical Executive Committee based on their evaluation of the abilities of the Medical Staff to fulfill the patient care needs that may be created in the Hospital by the absence of the member requesting the leave. A leave of absence shall be granted for members, provided all incomplete medical records and Medical Staff and Hospital matters have been concluded. Exceptions shall be allowed only in the event that a member has a physical or psychological condition that prevents him/her from completing records or concluding other Medical Staff or Hospital matters. A leave of absence may be granted for the following reasons:

##### **3.15.1 Medical Leave of Absence**

A Medical Staff member or AHP may request and be granted a leave of absence for the purpose of obtaining treatment for a medical or psychological condition, disability, or impairment. If a member is unable to request a medical leave of absence because of a physical or psychological condition, the Chief of Staff or Chairperson of the Practitioner's Department may submit the written notice on his/her behalf. A certified letter will be sent to the Practitioner informing him/her of this action. Reinstatement of membership status and clinical privileges may be subject to production of evidence by the Practitioner that he/she has the ability to perform the clinical privileges requested.

##### **3.15.2 Military Leave of Absence**

A Medical Staff member or AHP may request and be granted a leave of absence to fulfill military service obligations.

##### **3.15.3 Educational Leave of Absence**

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

##### **3.15.4 Personal/Family Leave of Absence**

A Medical Staff member or AHP may request and be granted a leave of absence for a variety of personal reasons (e.g., to pursue a volunteer endeavor such as contributing work to "Doctors without Borders/USA") or family reasons (e.g., maternity leave).

##### **3.15.5 Termination of Leave**

At least thirty (30) days prior to the termination of the leave of absence, or at any earlier time, the Medical Staff member or AHP may request reinstatement of Medical Staff membership and clinical privileges by submitting a written notice to the Chief of Staff. The written request for reinstatement shall include an attestation that no changes have occurred in the status of any of the credentials listed in Article Three, Sections 3.8.2.1 – 3.8.2.24, or if changes have occurred, a detailed description of the nature of the changes.

If so requested, the Staff member shall submit a summary of relevant activities during the leave, which may include, but is not limited to the scope and nature of professional practice during the leave period and any professional training completed. If the leave of absence has extended past the Practitioner's reappointment time, he/she will be required to submit an application for appointment in accordance with Article Three of these Bylaws. The Chief of Staff will forward the request for reinstatement to the member's Department Chairperson for a recommendation. The Department Chairperson shall forward his/her recommendation to the Credentials Committee. The Credentials Committee shall make a recommendation and forward it to the Medical Executive Committee. The Medical Executive Committee shall forward a recommendation to the Board for approval. An adverse decision regarding reinstatement of Staff membership or renewal of any clinical privileges held prior to the leave shall entitle the Practitioner to a fair hearing and appeal as provided in these Bylaws.

#### **3.15.6 Failure to Request Reinstatement**

Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the Medical Staff. A request for Medical Staff membership subsequently received from a member deemed to have voluntarily resigned shall be submitted and processed in the manner specified for applications for initial appointment.

#### **3.16 RESIGNATION**

Resignations from the Medical Staff should be submitted in writing and should state the date the resignation becomes effective. Resignations shall be submitted to the Medical Staff Office. The Practitioner's Department Chairperson, the Medical Executive Committee, and the Board are informed of resignations. Upon acceptance of the resignation by the Board, the Practitioner will be notified in writing. When a resignation is accepted or clinical privileges are relinquished during the course of an investigation regarding improper conduct or incompetence, a report shall be submitted to the state professional licensing board and reported to the NPDB, as required by federal law.

#### **3.17 Actions Involving an impaired Practitioner OR Other IMPAIRED individual with Clinical Privileges**

The Medical Staff and Hospital leaders have a process to provide education about health issues related to Practitioners and others with clinical privileges. The process addresses physical, psychiatric, or emotional illness and facilitates confidential diagnosis, treatment, and rehabilitation of individuals who suffer from a potentially impairing condition. It is the policy of this Hospital to properly investigate and act upon concerns that an individual who is a member of the Medical Staff or who has clinical privileges is suffering from impairment. The Hospital will conduct its investigation and act in accordance with pertinent state and federal law, including, but not limited to, the Americans with Disabilities Act (ADA). An "Impaired Individual" is one who is unable to perform the clinical privileges that have been granted with reasonable skill and safety to patients or to perform other Medical Staff duties because of physical, mental, emotional or personality disorders, including deterioration through the aging process or loss of motor skill, or excessive use or abuse of drugs, including alcohol.

##### **3.17.1 Self-Reporting**

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

##### **3.17.2 Third Party Reports**

If a Medical Staff member, Allied Health Professional, or Hospital employee witnesses warning signs of impairment they should report the incident. Patients, family members, or others who witness warning signs of impairment shall be encouraged to report the incident to an appropriate patient care representative. The identity of any individual reporting signs of impairment shall be kept strictly confidential. Medical Staff members and others, as appropriate, shall be educated about illness and impairment recognition issues specific to physicians and others with clinical privileges, including education about warning signs.

Warning signs may include, but are not restricted to, perceived problems with judgment or speech, alcohol odor, emotional outbursts, behavior changes and mood swings, diminishment of motor skills, unexplained drowsiness or inattentiveness, progressive lack of attention to personal hygiene, or unexplained frequent illnesses.

3.17.2.1 When warning signs of impairment are observed and the practitioner's behavior may constitute an immediate threat to patient safety, an individual should contact the CEO, the Chief of Staff, or the Department Chairman for immediate assistance. The CEO, the Chief of Staff, and the Department Chairman shall have the authority to take immediate action to protect patient safety and shall have the authority to require that the practitioner submit to drug screening. The individual observing the behavior must prepare a written report.

3.17.2.2 When an individual observes warning signs that do not constitute an immediate threat to patient safety, a written report shall be given to the Chief Executive Officer, the Chief of Staff, and/or the Chairperson of the individual's Medical Staff Department.

3.17.2.3. Third party reports should be factual and include a description of the incident(s) that led to the belief that an individual may be impaired. The person making the report does not need to have proof of the impairment, but must state the facts leading to the concern.

3.17.2.4 The recipient of the report may:

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

3.18.2.4.2. Direct in writing that an investigation shall be instituted and a report thereof shall be rendered by the Medical Executive Committee

### **3.17.3 Investigation**

Following a written request to investigate, the Medical Executive Committee and/or Chief of Staff shall appoint an ad hoc committee of three (3) physicians to investigate the concerns raised and any and all incidents that led to the belief that the individual may be impaired within five (5) days of the receipt of the request. The Committee's investigation may include, but is not limited to, any of the following:

3.17.3.1 A review of any and all documents or other materials relevant to the investigation;

3.17.3.2 Interviews with any and all persons involved in the incidents or who may have information relevant to the investigation, provided that any specific inquiries made regarding the individual's health status are related to the performance of the individual's clinical privileges and Medical Staff duties and are consistent with proper patient care or the operations of the Hospital;

3.17.3.3 The Committee may meet with the individual under investigation as part of its investigation. This meeting does not constitute a hearing under the due process provisions of the Hospital's Medical Staff Bylaws or pertinent policies and thus may not be attended by such individual's legal counsel. At this meeting, the Committee may ask the individual under investigation health-related questions so long as they are related to the concerns related to performance of the individual's clinical privileges and Medical Staff duties, and are consistent with proper patient care and operations of the Hospital. In addition, if the Committee feels that the individual may have an impairment that significantly affects his/her ability to perform essential functions concerning patient care, it may discuss with the individual under investigation whether a reasonable accommodation is needed or could be made so that the individual could competently and safely exercise his/her clinical privileges and/or the duties and responsibilities of Medical Staff appointment.

3.17.3.4 At the conclusion of its investigation, the ad hoc committee will submit its findings to the Medical Executive Committee.

### **3.17.4 Outcome of Investigation**

Based on all of the information it receives from the ad hoc committee, the Medical Executive Committee shall determine:

- 3.17.4.1 If the individual under investigation should undergo a complete medical and/or psychological examination as directed by the Committee, so long as the exam is related to the performance of the individual's clinical privileges and Medical Staff duties and is consistent with proper patient care or the operations of the Hospital, with the results of the examination to be provided to the Committee;
- 3.17.4.2 If the individual under investigation should undergo urine drug screening, serum alcohol/drug level testing or other appropriate testing, with the results of the screening and/or testing to be provided to the Committee.
- 3.17.4.3 Based upon the findings from the ad hoc committee and any additional information obtained from testing and/or exams, the Medical Executive Committee shall determine:
  - 3.17.4.4 Whether or not the individual is impaired, or what other problem, if any, is affecting the individual under investigation;
  - 3.17.4.5 If the individual is impaired, the nature of the impairment and whether it is classified as a disability;
  - 3.17.4.6 If the individual's impairment is a disability, whether a reasonable accommodation can be made for the individual's impairment such that, with the reasonable accommodation, the impaired individual would be able to competently and safely perform his/her clinical privileges and the essential duties and responsibilities of Medical Staff appointment;
  - 3.17.4.7 Whether a reasonable accommodation would create an undue hardship upon the Hospital, such that the reasonable accommodation would be excessively costly, extensive, substantial or disruptive, or would fundamentally alter the nature of the Hospital's operations or the provision of patient care; and,
  - 3.17.4.8 Whether the impairment could negatively impact the quality of care or the health or safety of the impaired individual, patients, Hospital employees, physicians or others within the Hospital.
  - 3.17.4.9 If the Committee determines that there is a reasonable accommodation that can be made as described above, the Committee shall attempt to work out a voluntary agreement with the impaired individual, so long as that arrangement would neither impose an undue hardship upon the Hospital or create a direct threat, also as described above. The Chief Executive Officer shall be kept informed of attempts to work out a voluntary agreement before it becomes final and effective.
  - 3.17.4.10 If the Committee determines that there is no reasonable accommodation that can be made as described above, or if the Committee cannot reach a voluntary agreement with the impaired individual, the Medical Executive Committee shall make a recommendation and report to the Board of Director the appropriate action to be taken. If the Committee's recommendation would provide the impaired individual with a right to a hearing as described in the Medical Staff Bylaws, the impaired individual shall be promptly notified of the recommendation in writing, by certified mail, return receipt requested. The recommendation shall not be forwarded to the Board until the individual has exercised or has been deemed to waive the right to a hearing as provided under Article Seven of the Medical Staff Bylaws.
  - 3.17.4.11 The original report, documentation of the investigation, and a description of the actions taken shall be included in the individual's credentials file. If the initial or follow-up investigation reveals that there may be some merit to the report, but not enough to warrant immediate action, the report shall be included in a confidential portion of the individual's credentials file and further monitoring or other follow-up shall be at the discretion of the Medical Executive Committee.

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

### **3.17.5 Treatment/Rehabilitation and Reinstatement Guidelines**

If it is determined that the individual suffers from an impairment that could be reasonably accommodated through rehabilitation or medical/psychological treatment, the following are recommendations for rehabilitation or treatment and reinstatement:

3.17.5.1 An individual with an impairment shall not be reinstated until it is established, to the Medical Staff's satisfaction, that the individual has successfully completed a rehabilitation program in which the Medical Staff has confidence, or has received treatment for a medical or psychological impairment such that the condition is under sufficient control.

3.17.5.2 The Medical Staff is not required to extend membership or privileges to an individual who has an impairment, and may monitor, test or order any appropriate requirements of the individual in order to consider or grant privileges or membership to the individual.

3.17.5.3 Upon sufficient proof that the individual who has been found to be suffering from impairment has completed a program or received treatment as described above, the Medical Staff, in its discretion, may consider the impaired individual for reinstatement of Medical Staff membership or clinical privileges.

3.17.5.4 In considering an impaired individual for reinstatement, the Hospital and Medical Staff leadership must consider patient care interests paramount.

3.17.5.5 The Medical Staff must first obtain a letter from the physician director of the rehabilitation program where the impaired individual was treated, or the physician directing the impaired individual's medical or psychological treatment. The impaired individual must authorize the release of this information. The following information shall be requested in providing guidance to the physician director regarding the content of the letter:

3.17.5.5.1 *Whether or not the impaired individual is participating in the program or treatment;*

3.17.5.5.2 *Whether or not the impaired individual is in compliance with all of the terms of the program or treatment plan;*

3.17.5.5.3 *Whether or not the impaired individual attends AA/NA meetings regularly (if appropriate);*

3.17.5.5.4 *To what extent the impaired individual's behavior and conduct are monitored;*

3.17.5.5.5 *Whether or not, in the opinion of the treating physician, the impaired individual is rehabilitated or the medical/ psychological impairment is under control;*

3.17.5.5.6 *Whether or not an after-care program has been recommended to the impaired individual (if appropriate), and if so, a description of the after-care program; and,*

3.17.5.5.7 *Whether or not, in the opinion of the treating physician, the impaired individual is capable of resuming practice and providing continuous, competent care to patients.*

3.17.5.6 The Medical Staff has the right to require opinion(s) from other physician consultants of its choice.

3.17.5.7 Assuming all of the information received indicates that the individual is sufficiently in recovery or rehabilitated or the medical/psychological condition is under control, the Medical Staff shall take the following additional precautions when restoring clinical privileges:

- 3.17.5.7.1 *The impaired individual must identify a physician or peer who is willing to assume responsibility for the care of his/her patients in the event of his/her inability or unavailability;*
- 3.17.5.7.2 *The individual shall be required to obtain periodic reports for the Medical Staff from the rehabilitation program, after-care program, or treating physician – for a period of time specified by the Medical Executive Committee – stating that the individual is continuing treatment or therapy, as appropriate, and that his/her ability to treat and care for patients in the Hospital is not impaired.*
- 3.17.5.8 The individual must agree to submit to an alcohol or drug-screening test (if appropriate to the impairment) at the request of the Chief Executive Officer or designee, the Chief of Staff, or the pertinent Department Chairperson.
- 3.17.5.9 As a condition of reinstatement, the impaired individual's credentials shall be re-verified from the primary source and the verification documented, in accordance with the procedures of Article Three, Section 3.7.7 of these Bylaws. Minimally, licensure, DEA, and professional liability insurance shall be verified. Additionally, the Hospital shall query the National Practitioner Data Bank, the OIG Sanction Report and the GSA List. The Hospital may also re-verify any other qualification or competence if there is reasonable belief that it may have been adversely affected by the circumstances related to the impairment.
- 3.17.5.10 If at any point during the process of investigation, rehabilitation or treatment, or reinstatement the individual refuses or fails to comply with these procedures, he/she will be subject to a suspension from the Medical Staff and afforded due process as defined in the provisions of the Medical Staff Bylaws, unless the individual's contract with the Medical Executive Committee states otherwise, such as when automatic termination is the penalty stated in the contract.
- 3.17.5.11 If at any time during the diagnosis, treatment, or rehabilitation phase of this process it is determined that the individual is unable to safely perform the privileges he/she has been granted, the matter shall be forwarded to the Medical Executive Committee for appropriate corrective action that includes strict adherence to any state or federally mandated reporting requirements.
- 3.17.5.12 All requests for information concerning the impaired individual shall be forwarded to the Chief Executive Officer for response. Information concerning an individual seeking referral or referred for assistance shall be maintained with confidentiality, except as limited by law, ethical obligation or when the safety of a patient is threatened.

**3.18** *actions in response to DISRUPTIVE conduct*

- 3.18.1 It is the policy of the Hospital for all individuals working in the Hospital to treat others with respect, courtesy, and dignity and to conduct themselves in a professional and cooperative manner. In dealing with incidents of disruptive conduct, the protection of patients, employees, physicians, and others in the Hospital and the orderly operation of the Hospital are paramount concerns.
- 3.18.2 Disruptive conduct or behavior is defined as that which adversely affects or impacts the Hospital operations or the ability of others to perform their jobs competently, or interferes or tends to interfere with the provision of safe, quality patient care at the Hospital. For the purposes of these Bylaws, examples of "disruptive conduct" include, but are not limited to:
  - 3.18.2.1 Rude or abusive behavior or comments to Hospital personnel, Allied Health Professionals, patients, or Practitioners.
  - 3.18.2.2 Negative comments to patients about other Practitioners, nurses or other Hospital personnel, or Medical Staff members or about their care and treatment in the Hospital.
  - 3.18.2.3 Verbal attacks, which are personal, irrelevant or go beyond fair, professional conduct, and that are directed to Hospital personnel, Medical Staff, Allied Health Professionals, contracted staff, or patients.



- 3.18.2.4 Irrelevant or inappropriate comments, drawings, or illustrations made in a patient's medical records or other Hospital business records, impugning the quality of care in the Hospital, or attacking particular Practitioners, Allied Health Professionals, nurses, other Hospital personnel, or Hospital policies.
- 3.18.2.5 Criticism that is addressed to a recipient in such a manner as to intimidate, undermine confidence, belittle or imply stupidity or incompetence or some other type of public humiliation.
- 3.18.2.6 Disruption of Hospital operations, Hospital or Medical Staff committee(s), or departmental affairs.
- 3.18.2.7 Lying, cheating, and knowingly making false accusations, altering, or falsifying any patient's medical records or Hospital documents.
- 3.18.2.8 Verbal or physical maltreatment of another individual, including physical or sexual assault.
- 3.18.2.9 Harassment, including words, gestures and actions, verbal or physical, which interfere with a person's ability to competently perform his or her job.
- 3.18.2.10 Conduct or behavior that causes a hostile or offensive work environment, including sexual harassment.
  - 3.18.2.10.1 *Such conduct has the purpose or effect of creating an intimidating, hostile, or offensive work environment. Behaviors that engender a hostile or offensive work environment may include, without limitation, offensive comments, jokes, innuendos and other sexually oriented statements, printed material, material distributed through electronic media, or items posted on walls or bulletin boards.*
  - 3.18.2.10.2 *Sexual harassment includes unwelcome sexual advances, requests for sexual favors, and all other verbal or physical conduct of a sexual or otherwise offensive nature. Sexual harassment can also include making or threatening reprisal following a negative response to the verbal or physical sexual conduct or behavior, and any other such behavior or conduct as defined by state and federal law and regulations.*
- 3.18.3 Conduct of a criminal nature, including but not limited to assault and battery, rape, or theft shall be handled through local law enforcement officials in accordance with Hospital policy, local and State laws.
- 3.18.4 Disruptive conduct resulting from an impairment as defined in Section 3.17 of these Bylaws should be dealt with using either 3.18 or 3.19, whichever Section is most appropriate for the conduct in question.
- 3.18.5 In the event of any apparent or actual conflict between these Bylaws and the Rules and Regulations, policies of the Medical Staff, or other policies, the provisions of these Bylaws shall control.
- 3.18.6 This section of the Bylaws outlines initial collegial steps (i.e., warnings and meetings with a Practitioner) that may be taken in an attempt to resolve complaints about disruptive conduct exhibited by a Practitioner. However, there may be a single incident of disruptive conduct, or a continuation of conduct, that is so unacceptable as to make such collegial steps inappropriate and that requires immediate disciplinary action. Therefore, nothing in these Bylaws precludes immediate referral to the Medical Executive Committee or to the Board, summary suspension, the filing of criminal charges, or the elimination of any particular step in dealing with a complaint regarding disruptive conduct.
- 3.18.7 Nurses, other Hospital employees, or other individuals who observe, or are subjected to disruptive conduct by a Practitioner shall notify their supervisor or another member of management about the incident. Upon learning of the occurrence of an incident of disruptive conduct, the CEO (or designee) shall be notified. Any Practitioner who observes such behavior shall notify the CEO directly.

- 3.18.8 If a reporting individual is unwilling or uncomfortable with reporting disruptive conduct using the procedure described in Section 3.18.7, then a report of the incident may be made to the Hospital's Compliance Officer or the Compliance Hotline.

The CEO (or designee) shall interview the individual subjected to the conduct and shall document or request that the individual document:

- 3.18.8.1 The date and time of the questionable behavior;
  - 3.18.8.2 A factual description of the questionable behavior;
  - 3.18.8.3 The name of any patient or patient's family members who were involved in the incident, including any patient or family member who witnessed the incident;
  - 3.18.8.4 The circumstances which precipitated the incident;
  - 3.18.8.5 The names of other witnesses to the incident;
  - 3.18.8.6 Consequences, if any, of the disruptive conduct as it relates to patient care, personnel, or Hospital operations; and,
  - 3.18.8.7 Any action taken to intervene in, or remedy, the incident.
- 3.18.9 The Chief of staff shall be notified and shall review the report and may meet with the individual who prepared it and/or any witnesses to the incident to ascertain the details of the incident.
- 3.18.10 After a determination that the incident of disruptive conduct has occurred, the Chief of Staff and/or CEO (or their respective designees) shall meet with the Practitioner. If appropriate, this initial meeting should be collegial. During the meeting, the Practitioner shall be advised of the nature of the incident that was reported and shall be requested to provide his/her response and/or perspective concerning the incident. The identity of the individual preparing the report of disruptive conduct shall not be disclosed at this time, unless the CEO and Chief of Staff agree in advance that it is appropriate to do so. In this case, the Practitioner shall be advised that any retaliation against the person reporting the incident will be grounds for immediate exclusion from all Hospital facilities.
- 3.18.11 This initial meeting may also be used to educate the Practitioner about administrative channels that are available for registering complaints or concerns about quality or services. Other sources of support or counseling may also be identified for the Practitioner, as appropriate.
- 3.18.12 The Practitioner shall be advised that a summary of the meeting shall be prepared and a copy provided to him or her. The Practitioner may prepare a written response to the summary. The Chief of Staff shall cause the summary, and any response that is received, to be kept in the confidential portion of the Practitioner's credentials file. The CEO shall cause the written report(s) of the incident, summary of the meeting, and any other records regarding the incident or the meeting to be kept as a privileged peer review record.
- 3.18.13 The Medical Executive Committee shall be fully apprised of any action taken with respect to disruptive conduct and the actions taken to address the concerns.
- 3.18.14 When, despite prior warning, the Practitioner continues to engage in disruptive conduct, the Practitioner may be subject to summary suspension and initiation of a formal investigation process pursuant to the Bylaws and any related hearing and appeal that may result. The action should be taken to protect patients, employees, physicians, and others on the Hospital's premises from disruptive conduct and to emphasize to the Practitioner the most serious nature of the problem created by such conduct.

### **3.19 PHYSICIAN RESPONSIBILITY FOR COMPLETION OF HISTORY & PHYSICAL**

- 3.19.1 A physician shall be responsible for a complete admission history and physical examination which shall be recorded no more than thirty **(30)** days prior to and within twenty-four (24) hours after admission. All inpatients including obstetrical patients and surgical patients whose procedure will be performed under general or regional anesthesia shall have a history and physical examination (H&P) completed and recorded in the patient's medical record.
- 3.19.2 The content of an H&P generally includes the following elements:

- Chief complaint
- Description of the present illness
- Past medical history, as appropriate
- Past surgical history, as appropriate
- Family history, as appropriate
- Psychological and social status, as appropriate
- Allergies
- A physical examination and review of systems
- Impression
- Plan

3.19.3 History and physical may be recorded in any format sufficient to meet the content requirements of the scope of assessment defined in this rule. Examples of acceptable formats:

- 3.19.3.1 A handwritten history and physical on a form provided by the hospital or by the physician; or within the body of the progress notes;
- 3.19.3.2.1 A dictated history and physical using a format which meets the content requirements;
- 3.19.3.2.2 An obstetrics history and physical which specifically addresses the content requirements and provides additional assessment data specific to the care of obstetrical patients;
- 3.19.3.2.3 A Short Stay Form for inpatient procedures with discharge anticipated on or before the third calendar day, vaginal deliveries, medical observation patients, or outpatient procedures or
- 3.19.3.2.4 A newborn history and physical examination

3.19.4 When the required history and physical are not in the medical record prior to a surgical procedure, the procedure shall not be performed until the practitioner records the history and physical. Exception: See Surgical Care, Rule #1

3.19.5 If an H&P has been performed within thirty **(30)** days before admission or before the start of a procedure, a durable, legible copy of the report may be used in the patient's medical record. The physician must note H&P was reviewed and patient was examined, the patient's current status and any changes on the history and physical or on an addendum incorporated by reference to the H&P if the H&P was completed prior to admission or surgery.

3.19.6 The extent of the H&P for specified invasive procedures, including but not limited to endoscopy procedures, invasive radiology, cardioversion, and breast biopsy, performed as an outpatient, should contain at least the following:

- 3.19.6.1 History
- 3.19.6.2 Exam appropriate to the procedure
- 3.19.6.3 Plan of care

3.19.7 Assessment requirements for podiatry patients: Patients receiving podiatric care in any setting shall receive the same basic medical appraisal as patients for any other service.

- 3.19.7.1 The podiatric physician is responsible for that part of the history and physical examination that is related to podiatry.
- 3.19.7.2 All inpatients shall have a history and physical recorded by a Doctor of Medicine (MD) or Doctor of Osteopathy (DO).
- 3.19.7.3 Podiatric physicians granted the clinical privilege based on training and experience may perform the H&P for their outpatients without medical risk or comorbidity. If the patient is determined to have significant medical or anesthetic risks associated with the

procedure, an MD or DO shall conduct a history and physical examination.

- 3.19.7.4 When a H&P has been recorded by a podiatric physician and an additional H&P is required to fulfill these standards, the MD or DO is responsible to integrate all findings from the assessments and develop the appropriate plan of care relative to the medical problem(s).
- 3.19.8 Assessment requirements for oral surgery patients: Patients receiving oral surgery care in an inpatient setting shall receive the same basic medical appraisal as patients admitted for any other service.
  - 3.19.8.1 The oral surgeon is responsible for providing a detailed dental history and description of the examination of the oral cavity and a pre-operative diagnosis.
  - 3.19.8.2 All inpatients shall have a history and physical recorded by a Doctor of Medicine (MD) or Doctor of Osteopathy (DO).
  - 3.19.8.3 Qualified oral surgeons may be delineated the privilege to perform the complete medical history and physical examination at the discretion of the Executive Committee.
- 3.19.9 The attending practitioner must sign or must read, edit and countersign the history and physical examination recorded by a physician's assistant.

## **4. Article Four: Categories of the Medical Staff**

### **4.1 Categories**

The Staff shall include active and affiliate categories. At the time of appointment and at the time of each reappointment, the Medical Staff member's staff category shall be recommended by the Medical Executive Committee and approved by the Board.

### **4.2 limitations on prerogatives**

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

### **4.3 active staff**

#### **4.3.1 Requirements for Active Status**

The active staff category shall consist of Practitioners who actively support the Medical Staff and the Hospital by contributing to efforts to fulfill Medical Staff functions. The Active Staff category of Practitioners shall be responsible for oversight of care, treatment and services provided by the Medical Staff, and members in the Active Staff category shall have the requisite skills for providing such oversight.

Requirements for Active Status include, but are not limited to, the following:

- Timely response to on-call duties when on-call;
- Timely response to requests for consults;
- Timely completion of medical records;
- Complete and legible documentation in the medical record.

To qualify for the Active Staff category, the Medical Staff member shall have contributed to fulfilling medical staff functions by completing at least two of the following types of activities during the last term of appointment, as determined by the Department Chairperson and approved by the Board of Director, including during provisional status during an initial appointment:

- Actively involved in patient care at the hospital;
- Term of office as a Medical Staff Officer or Department Chairman;
- Membership on the Board of Director;
- Medical Staff committee chairman;
- Medical Staff committee member;
- Faculty member;
- Primary Care practitioners (general internal medicine and family medicine) who do not admit patients but who regularly utilize the inpatient hospitalists or family medicine residency program for the care of their patients may be members of the active Medical Staff;
- Serving as a physician advisor or peer reviewer
- Serving on a Hospital committee or team/task group;
- Supervisory duties, e.g., serving as the Chief Medical Officer of a Hospital department, or supervision of a Limited Licensure Practitioner;
- Active participation and attendance at Medical Staff meetings
- Providing education to fellow Medical Staff members, e.g., grand rounds, formal educational presentation, author of a medical staff newsletter article.

#### **4.3.2 Prerogatives of Active Status**

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

#### **4.3.3 Obligations of Active Status**

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

### **4.4 COURTESY STAFF**

#### **4.4.1 Requirements for Courtesy Status**

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

Requirements for Active Status include, but are not limited to, the following:

- Timely response to on-call duties when on-call, if applicable;
- Timely response to requests for consults;
- Timely completion of medical records;
- Complete and legible documentation in the medical record.

#### **4.4.2 Prerogatives of Courtesy Status**

A Courtesy Staff member may serve on committees of the Medical Staff or Hospital and may attend Medical Staff and Department meetings. Courtesy Staff members completing at least two of the activities required for Active Staff during a current term of appointment are eligible for Active Staff and may request a change of category.

Limitations on Prerogatives

4.4.2 Courtesy Staff can not admit more than 12 patients a year (admissions include inpatient, observation patients, Emergency Department patients if required to attend, day surgery or other procedural outpatient settings requiring the attending). Members of the Courtesy Staff shall not be eligible to vote or hold office within the Medical Staff organization nor serve as chair of a medical staff committee.

#### **4.4.3 Obligations of Courtesy Status**

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

### **4.5 TELEMEDICINE STAFF**

#### **4.5.1 Requirements for Telemedicine Status**

Each member of the Telemedicine Staff must be sponsored by an active member in the same specialty. Telemedicine physicians serve as consultants only. The sponsoring active staff member is ultimately responsible for the care and treatment of their patients.

#### 4.5.2 Prerogatives of Telemedicine Status

Members of the Telemedicine Staff may provide recommendations to the organization or clinical department on strategies to improve care and services.

#### 4.5.3 Limitations of Telemedicine Status

Members of the Telemedicine Staff shall not be allowed to prescribe, treat or admit; nor be eligible to vote, hold office, or serve on committees within the Medical Staff organization.

#### 4.5.4 Obligations of the Telemedicine Status

Each member of the Telemedicine Staff shall discharge the basic obligations of staff members as required in these Bylaws.

### 4.6 *Honorary STATUS*

#### 4.6.1 **Requirements for Honorary Status**

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

#### 4.6.2 **Prerogatives of Honorary Status**

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

### 4.7 *CHANGE IN STAFF CATEGORY*

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

### 4.8 *RESIDENT STAFF*

The Resident staff shall consist of physicians who are participants in accredited educational and/or training programs which are approved by the institution and are conducted partially or wholly by the institution.

Residents shall not be eligible to hold office on the Medical Staff and shall not be eligible to vote at Medical Staff committee meetings. Residents are encouraged to attend any and all meetings of the staff, services and committees to which they are invited. Medical Staff officers may appoint members of the Resident Staff to committees as non-voting members.

The clinical and ethical performance of the Resident Staff will be monitored by the Director(s) of the program(s) respectively, in which the Resident Staff physicians are participants.

Members of the Resident Staff shall remain in this category until their training has been completed or until they are no longer members of the training program, at which time their Resident Staff privileges shall automatically terminate.

Resident staff shall have hospital admitting privileges only under the supervision of the faculty of the educational and/or training program involved. Attending physicians to whom each Resident Staff member is assigned shall be primarily responsible for medical care and surgical procedures of patients who are treated by Resident Staff members. It is also the responsibility of the attending physician to document in the progress notes that he has seen the patient and has participated in the patient's care. All patient care shall be subject to these Bylaws.

The attending physician shall be responsible for all medical record requirements pertaining to the care of the patient. Resident Staff members shall be responsible for completion of those portions of the patient's record pertaining to the Resident Staff members assigned responsibilities for the care of the patients. The attending physician shall be responsible for the delinquencies in the patient's record attributable to the Resident Staff members. Since Resident Staff members are jointly responsible for completion of assigned portions of the medical record, they shall be subject to the disciplinary protocol of the hospital and medical teaching programs involved.

#### 4.9 *Allied health professionals*

4.9.1 The term, "Allied Health Professional" (AHP) refers to individuals who provide direct patient care services in the Hospital under a defined degree of supervision, exercising judgment within the areas of documented professional competence and consistent with applicable law. AHPs are designated by the Board to be credentialed through the Medical Staff system and are granted clinical privileges or clinical functions as either a dependent or independent healthcare professional as defined by State laws and in these Bylaws. Although AHPs are credentialed as provided in these Bylaws, in Article Three, they are not eligible for Medical Staff membership. They may provide patient care services only to the extent of the clinical privileges/functions that have been granted. The Board has determined the categories of individuals eligible for clinical privileges/functions as an AHP are physician assistants (PA), pathologist's assistants, certified registered nurse anesthetists (CRNA), radiology practitioner assistants, clinical psychologists (Ph.D., PsyD.), licensed professional counselors (LPC), and advanced practice registered nurses (APRN). Allied Health Professionals do not include:

4.9.1.1 Medical Staff Members;

4.9.1.2 Hospital employees acting within the scope of their employment by the Hospital;

4.9.1.3 Certain health care personnel determined by the hospital who do not need to be credentialed through the procedures described in these Bylaws or by medical staff policies and procedures such as:

4.9.1.2.1 Non-employee nurses hired by the hospital on a short-term basis;

4.9.1.2.2 Private duty nurses or sitters employed by patients;

4.9.1.2.3 Individuals providing services through a contractual agreement with the hospital.

4.9.1.3.4 Surgical technicians, Surgical First Assistants and Registered Nurses

4.9.2 Clinical Functions mean the duty or permission granted to an Allied Health Professional to provide one or more direct patient care services at the Hospital at the request or direction and under the supervision of a Medical Staff Member.

4.9.3 Categories - There are two categories of Allied Health Professionals: "Dependent Affiliates," and "Independent Affiliates."

4.9.3.1 Dependent Affiliate means an individual who: is licensed, registered or certified in the State of Texas to specialize in one or more areas of healthcare delivery and is required by the law or by the Board of Director to function under the supervision and responsibility of a physician or dental surgeon. Dependent Affiliates shall not be eligible for Medical Staff Membership and may not exercise clinical privileges, but may provide certain direct patient care services and perform Clinical Functions in the Hospital as provided in these Bylaws. Only those non-physician practitioners who meet the following defined minimum criteria shall be deemed Dependent Affiliates entitled to apply for Clinical Functions:

4.9.3.1.1 Signed Statement by the Sponsoring Physician: The Dependent Affiliate must submit a statement signed by the Sponsoring Physician and any alternative supervising physicians, acknowledging responsibility for supervision of the Dependent Affiliate in the performance of Clinical Functions and which also acknowledges that failure to properly supervise the Dependent Affiliate may serve as the basis for corrective action against the Sponsoring Physician in accordance with Medical Staff Bylaws.



- 4.9.3.1.2 Medical Supervision: Dependent Affiliates must be under the direction of a member of the Medical Staff of Wadley Regional Medical Center who possess clinical privileges in the area in which the Dependent Affiliate will practice and who provide a Signed Statement as provided in (1) above. Furthermore, it is the responsibility of both the applicant and the Sponsoring Physician to notify the Medical Staff Office at Wadley Regional Medical Center, in writing, of any changes in physician sponsorship which occur at any time during his/her exercise of Clinical Functions at Wadley Regional Medical Center. Failure to provide such notification shall constitute grounds for termination of access to patients at the Hospital.
  - 4.9.3.1.3 Competency Assessment: A competency assessment and evaluation of the quality of the services provided by the Dependent Affiliate must be completed by the Sponsoring Physician at least annually, on a form furnished by the Hospital's Medical Staff Office. In instances where the Hospital employs persons who perform clinical functions under the same job description as a dependent affiliate, the dependent affiliate shall be required to undergo the same competency assessment on an annual basis.
  - 4.9.3.1.4 Change in Sponsoring Physician: Dependent Affiliate must notify the Medical Staff Office following a change in the Sponsoring Physician(s).
- 4.9.3.2 Independent Affiliate means a non-physician practitioner who is licensed in the State of Texas to specialize in one or more areas of independent health care delivery and who is authorized by the Board to practice independently in the Hospital. Independent Affiliates shall not be eligible for Medical Staff Membership, but, to the extent authorized by the Board, may apply for and exercise Clinical Privileges as may be granted pursuant to these Bylaws.
- Only those non-physician practitioners who meet the following minimum criteria shall be deemed Independent Affiliates entitled to apply for Clinical Privileges:
- 4.9.3.2.1 Members of the profession must be licensed to provide a defined body of health services by the State of Texas or compact state license.
  - 4.9.3.2.2 Members of the profession must have authority, by virtue of licensure, to receive and examine patients, diagnose conditions, and prescribe and implement a plan for the treatment of conditions and diagnoses within the professional's area of practice, independent of review, supervision or prescription by another practitioner.
  - 4.9.3.2.3 Members of the profession must be legally authorized to give binding orders to nurses and other persons providing patient care.
  - 4.9.3.2.4 Members of the profession must have received training in a hospital setting, if appropriate.
  - 4.9.3.2.5 There must be sufficient Hospital resources, including, but not limited to, staff, equipment, and operating or treatment room facilities, to accommodate members of the profession, without significantly adversely affecting the availability of those resources to individuals currently providing services within the Hospital.
  - 4.9.3.2.6 Third party reimbursement must be generally available for Hospital services ordered by the professional or rendered in connection with services rendered by the professional, including, but not limited to, equipment and supply charges and laboratory fees.
  - 4.9.3.2.7 Services provided by members of the profession must be subject to objective monitoring criteria established through the Hospital's Quality Improvement Plan.
  - 4.9.3.2.8 The profession and services rendered by members of the profession

must be consistent with the treatment philosophy, mission and goals of the Hospital.

- 4.9.4 Department Criteria for Clinical Privileges: Each Department of the Medical Staff shall prepare written criteria for the delineation of Clinical Privileges for Independent Affiliates and defined clinical functions for Dependent Affiliates practicing within that Department. The criteria shall be approved by the Medical Staff Executive Committee and the Board and, once approved, shall be considered by the Executive Committee in recommending the granting or denying of Clinical Privileges for Independent Affiliates. Departmental criteria shall be evaluated at least every two (2) years, in light of changes in regulatory standards, practice patterns and Hospital experience with Independent Affiliates.
- 4.9.5 Compliance with Bylaws, Rules and Regulations: Allied Health Professionals shall comply with all requirements and responsibilities established in the Medical Staff Bylaws and Rules and Regulations, Departmental rules and regulations, and Hospital and Medical Staff policies. Each Allied Health Professional must agree in writing prior to the exercise of Clinical Functions or Clinical Privileges to comply with such Bylaws, Rules and Regulations, and Hospital and Medical Staff Policies and Procedures.
- 4.9.6 Indemnification: The practitioner under whose supervision or direction an Allied Health Professional provides patient care, shall indemnify the hospital and hold the hospital harmless from and against all actions, cause of actions, claims, damages, cost, and expenses including reasonable attorney fees resulting from, caused by, or arising from the negligence of such Allied Health Professional or the failure of such Allied Health Professional to satisfy the standards of proper care of patients.

## **5. Article FIVE: Clinical privileges**

### **5.1 EXERCISE OF PRIVILEGES**

Every Practitioner or Independent Allied Health Professional providing direct clinical services at this Hospital, by virtue of Medical Staff membership or otherwise, shall, in connection with such practice and except as provided in Sections 5.3 and 5.4 below, be entitled to exercise only those clinical privileges specifically granted to him/her by the Board. Clinical privileges may be granted, continued, modified, or terminated by the Board upon the recommendation of the Medical Staff, for reasons directly related to quality of patient care and other provisions of the Bylaws, and following the procedures outlined in these Bylaws. Each Practitioner must obtain consultation with another Practitioner who possesses appropriate clinical privileges in any case when the clinical needs of the patient exceed the clinical privileges of the Practitioner(s) currently attending the patient. Additionally, consultation must be obtained when required by these Bylaws or the Medical Staff Rules and Regulations, and other policies of the Medical Staff and the Hospital, which set forth criteria to determine which clinical procedures or treatments, or medical, surgical or psychiatric conditions require consultation.

### **5.2 DELINEATION OF PRIVILEGES**

#### **5.2.1 Application**

Clinical privileges may be granted only upon formal request on forms provided by the Hospital with subsequent processing and approval. Except for Honorary members who by virtue of their category are not eligible for clinical privileges, and dependent Allied Health Professionals who function within the scope of defined clinical functions, every application for appointment and reappointment must contain a request for the specific clinical privileges desired by the applicant. An application for clinical privileges without a request for Medical Staff membership shall contain the same information as an application for Staff membership. An applicant for clinical privileges shall be subject to the same obligations as are imposed upon an applicant for Staff appointment, as provided in Article Three, Section 3.5. Only those clinical privileges supported by evidence of competence and proof that the applicant meets the criteria for each privilege will be processed through the application process. The responsibility for producing a complete application and request for clinical privileges shall be the applicant's.

#### **5.2.2 Admitting Privileges**

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

#### **5.2.3 Basis for Privilege Determination**

There shall be criteria for granting, renewing or revising clinical privileges that are directly related to the quality of healthcare and pertain to the evidence of current competence and ability to perform the privileges requested. Applications and requests for clinical privileges shall be evaluated on the basis of the applicant's education, training, current competence, the ability to perform the clinical privileges requested, professional references, information from the applicant's current or past facility affiliations, professional liability experience and insurance coverage, and other relevant information, including an evaluation by the Chairperson of the Clinical Department in which the privileges have been sought. The criteria for granting clinical privileges shall also include the ability of the Hospital to provide supportive services for the applicant and his/her patients. Clinical privileges that are granted, renewed, or revised shall be setting-specific, meaning that in approving privileges, considerations shall include not only the applicant's qualifications, but also the availability of equipment, the number, type and qualifications of staff, and/or the appropriateness of the physical environment and resources in a particular Hospital setting, and clinical privileges may be restricted by the Board of Director to only certain settings within the Hospital, as appropriate to each setting.

The basis for privilege determinations for continuation of privileges shall include, in addition to the above listed information, the results of professional practice evaluation, or performance profiling, as provided for in Article Three of these Bylaws. Additionally, all individuals with delineated clinical privileges are required to participate in continuing

education as related to their privileges, and the applicant's participation in continuing education shall be considered when renewing or revising such privileges. Before clinical privileges are granted, renewed, or revised by the Board of Director, the Medical Staff shall evaluate each applicant with regard to the following information and make a recommendation based on the following information:

- 5.2.3.1 For applicants in fields performing operative and other procedures, the types of operative procedures performed as the surgeon of records, the handling of complicated deliveries, or the skill demonstrated in performing invasive procedures, including information about appropriateness and outcomes of the procedures;
- 5.2.3.2 For applicants in non-surgical fields, the types and outcomes of medical conditions managed by the applicant as the responsible physician;
- 5.2.3.3 The applicant's clinical judgment and technical skills;
- 5.2.3.4 Any evidence of unusual patterns of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant;
- 5.2.3.5 Information from quality assessment and performance improvement, including but not limited to review of operative and other procedures, use of blood and blood products, use of medications, review of medical records, utilization management/medical necessity review, risk management data, and patient safety data;
- 5.2.3.6 Relevant practitioner-specific data that are compared to aggregate data;
- 5.2.3.7 Morbidity and mortality data, when available.

Additionally, in considering any request to grant, continue, modify, or increase clinical privileges, the Hospital, including any committee of the Medical Staff, or the Board may, in its discretion, obtain assistance with their evaluation, as provided for in Article Three of these Bylaws.

#### **5.2.4 Additions to Clinical Privileges**

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

- 5.2.4.1 Training, continuing education, and experience related to the new clinical privileges requested shall be verified.
- 5.2.4.2 Evidence of current competence related to the new clinical privileges requested shall be verified.
- 5.2.4.3 Information provided by peers of the applicant shall be included in deliberations when increasing privileges.
- 5.2.4.4 Applicants are required to report malpractice insurance coverage information for the new privileges requested.
- 5.2.4.5 When revising clinical privileges, the applicant shall be required to respond to queries regarding whether there have been any:
  - 5.2.4.5.1 *Previously successful or currently pending challenges, or voluntary relinquishment of licensure or registration.*
  - 5.2.4.5.2 *Voluntary or involuntary reduction in privileges or termination of privileges or membership.*
  - 5.2.4.5.3 *Involvement in any liability actions, including all final judgments or settlements.*

### **5.2.5 Delineation**

Requests for clinical privileges shall be processed pursuant to the procedures outlined in Article Three of these Bylaws. Clinical privileges shall be delineated on an individual basis. The delineation of an individual's privileges shall include the limitations, if any, on the individual's privileges to admit or treat patients or direct the course of treatment of the patients whom have been admitted.

### **5.2.6 New/Transpecialty Privileges**

Any request for clinical privileges that are either new to the Hospital or that overlap more than one Department shall initially be reviewed by each appropriate Department Chairperson. The Department Chairperson(s) shall review the need for, and appropriateness of a new procedure or service. The Department Chairperson(s) shall facilitate the establishment of hospital-wide credentialing criteria for the new or transpecialty procedure, with the input of all appropriate Departments, with a mechanism designed to ensure that the same level of quality of patient care is provided by all individuals with such clinical privilege. In establishing the criteria for such clinical privileges, the Department Chairperson(s) may establish an ad-hoc committee with representation from all appropriate Departments or the Department Chairperson(s) may undertake the process himself/herself. Information may be requested from one or more Practitioners or Departments, or from outside sources such as professional literature or specialty associations. The recommendation of the Department Chairperson(s) shall be forwarded to the Credentials Committee for its review. The Credentials Committee shall forward its recommendation to the Medical Executive Committee for its review. The recommendation of the Medical Executive Committee and the approval of the Board shall be based in part on whether the new procedure or service is appropriate to the Hospital.

### **5.2.7 Telemedicine Privileges**

Practitioners who wish to provide telemedicine services, as defined in these Bylaws, in prescribing, rendering a diagnosis, or otherwise providing clinical treatment to a Hospital patient, without clinical supervision or direction from a Medical Staff member, shall be required to apply for and be granted clinical privileges for these services as provided in these Bylaws. The Medical Staff shall recommend to the governing body which clinical services are appropriately delivered through a telemedicine medium, according to commonly accepted quality standards. Consideration of appropriate utilization of telemedicine equipment by the telemedicine practitioner shall be encompassed in clinical privileging decisions.

### **5.2.8 Limited Licensure Practitioners**

Requests for clinical privileges from limited licensure Practitioners (e.g., Licensed Independent Practitioners who are not physicians) shall be processed in the manner and based on the same conditions as for any applicant for clinical privileges. Due to the limitations imposed by the Practitioner's license, a Medical Staff member who is a qualified physician is required to be responsible for the care of a patient admitted by a limited licensure Practitioner with respect to any medical or psychiatric problem that is present on admission or develops during hospitalization and that is not specifically within the scope of practice of the limited licensure Practitioner, as defined by the Medical Staff and permitted by state law. All patients admitted by a limited licensure Practitioner should have a history and physical examination by a qualified physician as defined in these Bylaws, who shall also agree to provide any needed medical or psychiatric care to the patient during the hospitalization, should the need arise. The limited licensure Practitioner shall be responsible for securing the services of such physician prior to the admission of the patient and shall supply the name of the physician to the Hospital. The limited licensure Practitioner shall be responsible for performing the part of the history and physical examination related to the care he/she will provide:

5.2.8.1 Dentists are responsible for the part of their patients' history and physical examination that relates to dentistry. Other responsibilities of Dentists include: 1) a detailed dental history justifying hospital admission; 2) a detailed description of the examination of the oral cavity and a pre-operative diagnosis; 3) a complete operative report, describing the findings and techniques; in cases of extraction of

teeth and fragments removed, all tissue including teeth and fragments shall be sent to the hospital pathologist for examination, or accurately counted and described in the operative report; 4) the dentist is totally responsible for the oral or dental care; 5) progress notes as are pertinent to the oral condition; and 6) discharge summary.

5.2.8.2 Podiatrists are responsible for the part of their patient's history and physical examination that relates to podiatry. Podiatric physicians granted the clinical privilege based on training and experience may perform the H&P for their outpatients without medical risk or comorbidity without further requirement of an additional H&P.

5.2.8.3 An oral and maxillofacial surgeon who has successfully completed a postgraduate program in oral and maxillofacial surgery accredited by a nationally recognized accrediting body approved by the U. S. Department of Education, and who has been determined by the Medical Staff to be currently competent to perform a history and physical examination, may be granted the clinical privilege to perform the medical history and physical examination.

### **5.2.9 Unavailable Clinical Privileges**

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

## **5.3 TEMPORARY PRIVILEGES**

Temporary clinical privileges shall be granted only to individuals defined as Practitioners in these Bylaws, to fulfill an important patient care, treatment, and service need or when a new applicant with a complete application that raises no concerns is awaiting review and approval of the Medical Executive Committee and the Board of Directors. In granting temporary privileges, special requirements may be imposed in order to monitor and assess the quality of care rendered by the Practitioner exercising such privileges. A Practitioner shall not be entitled to the procedural rights afforded by these Bylaws because of his/her inability to obtain temporary privileges or because of any termination of temporary privileges.

### **5.3.1 Qualifications**

Temporary privileges may be granted upon receipt of a complete application and primary source verification of the following:

- Current state unrestricted licensure
- Current and unrestricted DEA registration, and DPS (if the practitioner will be prescribing or administering controlled substances)
- Documentation of current professional liability insurance coverage as required by the Board, except as specified in Section 5.3.2.4 in this Article
- Relevant training and/or experience
- Explanation of any gap in work history
- Current competence related to the privileges requested
- Ability to perform the privileges requested
- A query and evaluation of the NPDB information
- No sanctions or exclusions – The Medical Staff Office shall check the OIG Sanction Report, the GSA list, and verify that the applicant is not an Ineligible Person. If the applicant is an Ineligible Person, temporary privileges shall not be granted. Any exclusion subsequent to having been granted temporary privileges shall result in immediate termination of such privileges.
- No current or previously successful challenge to licensure or registration

- No subjection to involuntary termination of medical staff membership at another organization
- No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges

Applicants for temporary privileges shall agree to be bound by the Medical Staff Bylaws, Rules and Regulations, and applicable Hospital policies.

### **5.3.2 Conditions and Authority for Granting Temporary Privileges**

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

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

5.3.2.2 Care of Specific Patient(s): Temporary privileges may be granted on a case-by-case basis when an important patient care need justifies the authorization to practice, for a limited period of time as defined herein. After receipt of a written request for temporary privileges, a Practitioner qualified as described in Article Five, Section 5.3.1 may be granted temporary privileges for care of a specific patient. Authorization may be granted to provide care for that specific patient. Temporary privileges granted under this condition shall not exceed the length of stay of the specific patient or one hundred and twenty (120) consecutive days, whichever is less. A Practitioner may be granted temporary privileges under this condition for no more than four (4) patients in a twelve-month period.

5.3.2.3 Locum Tenens: A Practitioner qualified as described in Article Five, Section 5.3.1, who has been hired to substitute for a member of the Medical Staff who is temporarily unable to provide services, may be granted temporary privileges in order to fulfill an important patient care need that would be created by the Medical Staff member's absence and could not otherwise be met by the existing members of the Medical Staff. The locum tenens Practitioner shall not be granted temporary privileges that are in excess of those granted to the Medical Staff member being temporarily replaced. Temporary privileges granted under this condition shall not exceed one hundred and twenty (120) consecutive days or the term of absence of the Medical Staff member, whichever is less. Locum Tenens who return more than once shall complete a short application as approved by the Medical Executive Committee at each occurrence. The original application is good for 24 months. Consideration may be given to grant him/her privileges for a 2 year period, then at reappointment determine whether to reappoint or end his privileges due to lack of participation.

5.3.2.4 Disaster Response and Recovery: Potential disaster situations shall be described in the Hospital Emergency Management Plan and are defined as any occurrence that inflicts destruction or distress and that creates demands exceeding the capacities or capabilities of the Hospital to handle in a normal or routine way. Such occurrence may be due to a natural disaster or a man-made disaster. Upon activation of the Hospital's Emergency Management Plan, temporary disaster privileges may be granted to an appropriately qualified Practitioner as described in Article Five, Section 5.3.1, based upon the needs of the Hospital to augment staffing due to the disaster situation. Privileges should be approved by the

Hospital Emergency Incident Commander (CEO/designee) or the Operations Chief, if that position is activated as part of the Hospital Emergency Incident Command System (HEICS), upon recommendation by the Chief of Staff or the HEICS-designated Medical Staff Director. All decisions to grant temporary disaster privileges are at the discretion of the Hospital Emergency Incident Commander or designees, and shall be evaluated on a case-by-case basis in accordance with the Hospital and patient care needs. Approvals shall be documented in writing. The Chief of Staff or the HEICS-designated Medical Staff Director shall also assign a member of the Medical Staff to responsibilities for supervising Practitioners granted temporary disaster privileges. Practitioners who are employees of any Federal agency, and Practitioners acting on behalf of a Federal agency in an official capacity, temporarily or permanently in the service of the United States government, whether with or without compensation, are immune from professional liability for malpractice committed within the scope of employment under the provisions of the Federal Tort Claims Act, and are therefore exempt from the requirement to have professional liability insurance coverage. Temporary privileges granted to Practitioners who are acting as agents of the Federal government shall be limited in their privileges at this Hospital to the scope of their Federal employment. Temporary privileges granted to anyone under a disaster situation shall not exceed the disaster response and recover period or one hundred and twenty (120) consecutive days, whichever is less. In the event that the disaster creates extreme urgencies as defined in Section 5.4, a Practitioner would be permitted to provide patient care using emergency privileges.

5.3.2.4.1 *Temporary disaster privileges may be granted upon presentation of a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport), and at least one of the following; and the qualifications required in Section 5.3.1 of this Article shall be verified as soon as the immediate disaster situation is under control and be completed within 72 hours from the time the volunteer practitioner presents to the organization (unless extraordinary circumstances prevent completion of primary source verification), using a process identical to granting temporary privileges for an immediate patient care need; and verification shall be given high priority:*

5.3.2.4.1.1 *A current picture hospital ID card that clearly identifies professional designation;*

5.3.2.4.1.2 *A current license to practice in the State of Texas, and a valid picture ID issued by a state, federal or regulatory agency;*

5.3.2.4.1.3 *Primary source verification of the license;*

5.3.2.4.1.4 *Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT) or MRC or ESAR-VHP or DMORT or other recognized state or federal organization;*

5.3.2.4.1.5 *Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances, such authority having been granted by a federal, state or municipal entity; or,*

5.3.2.4.1.6 *Identification by a current hospital or medical staff member(s) who possesses personal knowledge regarding the practitioner's*

5.3.2.4.1.7 *If possible, photocopies of the above-listed credentials should be made and retained as part of a credentials file.*



5.3.2.4.2 *Upon initial approval, the Practitioner should be issued appropriate Hospital security identification as required by the Hospital, and shall be assigned to a Medical Staff member who shall collaborate in the care of disaster victims and oversee the professional practice of the volunteer LIP.*

5.3.2.4.3 The Hospital shall make a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours related to the continuation of the disaster privileges initially granted.

5.3.2.4.4 *In the event that verification of information results in negative or unsubstantiated information about qualifications of the Practitioner, privileges should be immediately terminated. When the emergency situation no longer exists, or when Medical Staff members can adequately provide care, temporary disaster privileges terminate.*

#### **5.4 EMERGENCY PRIVILEGES**

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

## **6. ARTICLE SIX: CORRECTIVE ACTIONS**

### **6.1 CRITERIA FOR INITIATION**

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

### **6.2 ALTERNATIVES TO CORRECTIVE ACTION**

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

- 6.2.1 Informal discussions or formal meetings regarding the concerns raised about conduct or performance, including the actions outlined in Section 3.17 that may be taken to address disruptive conduct;
- 6.2.2 Written letters of guidance, reprimand or warning regarding the concerns about conduct or performance;
- 6.2.3 Notification that future conduct or performance shall be closely monitored and notification of expectations for improvement;
- 6.2.4 Suggestions or requirements that the individual seek continuing education, consultations, or other assistance in improving performance;
- 6.2.5 Warnings regarding the potential consequences of failure to improve conduct or performance; and/or,
- 6.2.6 Requirements to seek assistance for an impairment, as provided in these Bylaws.

### **6.3 SUMMARY SUSPENSION OR RESTRICTION**

Whenever a Staff member's conduct or the conduct of an individual with clinical privileges appears to require that immediate action be taken to protect the life or well-being of a patient(s) or to reduce a substantial and imminent likelihood of significant impairment of the health or safety of any patient, prospective patient, or other person, the Chief of Staff, appropriate Department Chairperson, or Chief Executive Officer may impose a summary suspension or restriction on the clinical privileges of the individual. Unless otherwise stated, such suspension or restriction shall become effective immediately upon imposition and the person responsible for imposing the suspension or restriction shall promptly give written notice to the Chief Executive Officer and the Medical Executive Committee. In addition, the affected individual shall be provided with a written notice of the action within one day of imposition. This initial notice shall include a summary of facts and issues regarding the individual's conduct that led to the summary suspension or restriction, and shall not substitute for the notice required in Article Seven. When the individual being suspended or restricted is a Practitioner, the Chief of Staff or the Chairperson of the Practitioner's Department shall arrange for alternative medical coverage of a suspended Practitioner's patients in the Hospital and for coverage of patient care subject to a restriction. The wishes of the patient shall be considered in the selection of an alternative Practitioner. When the individual being suspended or restricted is an Allied Health Professional, the sponsoring physician shall be responsible for arranging alternative coverage for the care normally provided by the individual.

### **6.3.1 Medical Executive Committee Action**

Upon notice of a summary suspension or restriction, the Medical Executive Committee shall direct that an investigation be conducted within twenty-nine (29) days as provided in Article Six, Section 6.3 of these Bylaws. The Medical Executive Committee shall also review the circumstances leading to the summary suspension or restriction and may determine, as a result of the review, to continue, modify, or terminate the summary suspension or restriction pending the outcome of the investigation.

### **6.4 INVESTIGATION/PEER REVIEW PROCESS**

Peer review may be initiated in response to the circumstances in a single case, or to investigate a pattern or trend in performance. The Medical Executive Committee or the Board of Director may request an investigation. Any Quality/Peer Review Committee or the Medical Executive Committee may conduct such an investigation, or the Medical Executive Committee may assign the task to a Medical Staff officer, Department, ad hoc committee or other organizational component. External third parties may be utilized in the investigation process as provided in these Bylaws. The investigation may involve an interview with the practitioner and/or an interview of other individuals or groups deemed appropriate by the investigating body. If the investigation is conducted by a group or individual other than the Medical Executive Committee, that group or individual must forward a written report of the investigation to the Medical Executive Committee as soon as practical after the assignment to investigate has been made. The Medical Executive Committee may at any time within its discretion, and shall at the request of the Board, terminate the investigation process and proceed with action as provided below. The investigation procedures do not constitute a hearing and need not be conducted in accordance with the formal procedures for a fair hearing. The investigation shall include:

- 6.4.1 Conformance to the peer review procedures outlined in Article Ten, Section 10.5.
- 6.4.2 As deemed necessary by the investigating body, a review of the medical record for specific cases, a review of aggregate performance data, a review of comparative data when available, a review of any verbal or written reports regarding any specific incidents, conduct or behavior, or any other information material to the matter being investigated;
- 6.4.3 A report of the investigation, including all material evidence, and a recommendation to the Medical Executive Committee.

### **6.5 ACTION ON INVESTIGATION REPORT**

As soon as practicable following receipt of the report, the Chief of Staff shall forward the report to the Executive Committee, which shall take action on the request. The action may include, without limitation, rejecting the request, issuing a warning, a letter of admonition or a letter of reprimand, recommending terms of probation or requirements of consultation or recommending reduction, suspension, or revocation of clinical privileges, recommending a change in staff category or limitation of staff prerogatives, recommending the suspension or revocation of staff appointments; or referring the matter to the Board of Director for any of such actions. Any adverse action as defined in Fair Hearing Plan shall entitle the practitioner to the procedural rights afforded in the Fair Hearing Plan, except as provided in the Fair Hearing Plan.

### **6.6 AUTOMATIC SUSPENSION OR TERMINATION**

If an individual fails to maintain a legal credential authorizing him/her to practice, or other qualification necessary for Medical Staff membership or clinical privileges, the individual shall be immediately and automatically suspended from practicing in the Hospital by the CEO, and his/her staff membership may be automatically terminated. The following circumstances shall constitute conditions for automatic suspension, and if indicated, automatic termination:

#### **6.6.1 Licensure**

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

#### **6.6.2 Controlled Substance Registration**

If an individual's DEA or State controlled substance registration is revoked, suspended, or restricted, or if an individual fails to maintain a current unrestricted registration, he/she

shall be automatically suspended from practicing in the Hospital and his/her staff membership may be automatically terminated.

**6.6.3 Liability Insurance**

If an individual's professional liability insurance is revoked or if the individual fails to maintain ongoing coverage as required in these Bylaws, he/she shall be immediately automatically suspended from practicing in the Hospital and his/her staff membership shall be automatically terminated, if individual professional liability is not reinstated within thirty (30) days.

**6.6.4 Eligibility to Participate in Federal Programs**

The occurrence of any of the following events shall result in immediate automatic termination of staff membership and clinical privileges:

**6.6.4.1 Becoming an Ineligible Person; or,**

**6.6.4.2 A criminal conviction.**

**6.6.5 Medical Records**

A medical record is considered to be delinquent when it has not been completed for any reason within thirty (30) calendar days following a patient's discharge. When a Medical Staff member or individual with clinical privileges has failed to complete a medical record and the record becomes delinquent, following notification, his/her clinical privileges shall be automatically suspended. The suspension shall continue until all of the individual's delinquent records are completed.

**6.6.6 Misrepresentation**

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

**6.6.7 Failure to Disclose Physician Ownership**

If it is determined that a referring physician owner has failed to disclose to a patient of his/her ownership and/or investment interest in the Hospital, as required in Section 3.1.13, his/her clinical privileges shall be automatically suspended. The suspension shall continue until the referring physician has signed an attestation that he/she has formally implemented a process to making such disclosures to patients.

**6.7 Criminal Arrest**

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

**6.8 AUTOMATIC RESIGNATION**

**6.8.1 Failure to Apply for Reappointment or Renewal of Privileges**

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

## **7. ARTICLE SEVEN: HEARING AND APPELLATE REVIEW PROCEDURES**

### **7.1 Overview**

Fair hearing and appellate review procedures shall be used in addressing adverse actions involving those who are applying for Medical Staff membership, for existing Medical Staff members, and for other individuals applying for or holding clinical privileges. The fair hearing and appeal process shall be the same for applicants for Medical Staff membership and existing Medical Staff members. Individuals with clinical privileges who are not applying for Medical Staff membership and who are not Medical Staff members are afforded a fair hearing and appeal process but that process shall be modified. The hearing and appeal procedures for individuals with clinical privileges who are not applying for Medical Staff membership and who are not Medical Staff members is described in Article Seven, Section 7.10.4 of these Bylaws.

### **7.2 ADVERSE RECOMMENDATIONS OR ACTIONS**

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

7.2.1.1 Denial of initial staff appointment;

7.2.1.2 Denial of reappointment;

7.2.1.3 Suspension of staff membership;

7.2.1.4 Revocation of staff membership;

7.2.1.5 Limitation of the right to admit patients other than limitations applicable to all individuals in a Staff category or a clinical specialty, or due to licensure limitations;

7.2.1.6 Denial of requested clinical privileges;

7.2.1.7 Involuntary reduction in clinical privileges;

7.2.1.8 Summary suspension or restriction of clinical privileges, as defined in Article Six, Section 6.3;

7.2.1.9 Revocation of clinical privileges; or,

7.2.1.10 Involuntary imposition of significant consultation requirements where the supervising Practitioner has the power to supervise, direct, or transfer care from the Practitioner under review (excluding monitoring incidental to provisional status or the granting of new privileges).

7.2.2 The following actions are not deemed to be adverse actions or recommendations:

#### **7.2.2.1 Availability of Facilities, Exclusive Contracts**

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

#### **7.2.2.2 Medico-Administrative Officer or Other Contract Practitioner**

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

#### **7.2.2.3 Automatic Suspension, Termination, or Relinquishment of Privileges**

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

**7.2.2.4 Removal from Emergency Call Panel**

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

**7.2.2.5 Hospital Policy Decision**

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

**7.3 HEARING RIGHTS**

**7.3.1 Notice of Adverse Recommendation or Action**

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

7.3.1.1 State the reasons for an adverse recommendation or action, with enough specifics to allow response;

7.3.1.2 Advise the Practitioner of his/her right to a hearing pursuant to the provisions of the Medical Staff Bylaws and of this Fair Hearing Plan.

7.3.1.3 Advise the Practitioner that the Practitioner has thirty (30) days following receipt of the notice to submit a written request for a hearing.

7.3.1.4 State that failure to request a hearing within thirty (30) days shall constitute a waiver of rights to a hearing and to an appellate review of the matter, and the recommendation for adverse action will become final upon approval by the Board of Director.

7.3.1.5 State a summary of the Practitioner's rights at the hearing.

7.3.1.6 State that upon receipt of his/her hearing request, the Practitioner will be notified of the date, time and place of the hearing.

**7.3.2 Request for Hearing**

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

**7.3.3 Failure to Request a Hearing**

A Practitioner who fails to request a hearing within the time and in the manner specified in Section 7.3.2 waives any right to such a hearing and to any appellate review to which he/she might otherwise have been entitled. Such waiver in connection with:

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

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

**7.4 HEARING PREREQUISITES**

**7.4.1 Special Written Notice**

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

7.4.1.1 The place, time, and date, of the hearing, which date shall not be less than 30 days after the date of the notice, unless both parties agree otherwise;

7.4.1.2 A list of the witnesses (if any) expected to testify at the hearing on behalf of the body whose action gave rise to the hearing request;

7.4.1.3 The Practitioner involved has the right:

7.4.1.3.1 *To be present at the hearing;*

7.4.1.3.2 *To representation by an attorney or other person of the Practitioner's choice;*

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

7.4.1.3.4 *To call, examine, and cross-examine witnesses;*

7.4.1.3.5 *To present evidence determined to be relevant by the chairman of the hearing committee, regardless of its admissibility in a court law; and,*

7.4.1.3.6 *To submit a written statement at the close of the hearing.*

7.4.1.4 Upon completion of the hearing, the Practitioner involved has the right:

7.4.1.4.1 *To receive the written recommendation of the hearing committee, including a statement of the basis for the recommendations; and,*

7.4.1.4.2 *To receive a written decision of the Board of Director, including a statement of the basis for the decision.*

7.4.1.5 The right to the hearing may be forfeited if the Practitioner fails, without good cause, to appear.

7.4.2 Appointment of Hearing Committee

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

7.4.2.2 By Board: A hearing occasioned by an adverse action of the Board shall be conducted by an ad hoc hearing committee appointed by the Chairman of Board.

7.4.2.3 Composition of Hearing Committee: The Hearing Committee shall be composed of at least three members. One of the members so appointed will be designated as the chairman. The chairman will preside over the hearing. No member may serve who has acted as accuser, investigator, fact finder, or initial decision maker in the matter. Knowledge of the matter shall not preclude a member from serving. No member shall be appointed who is in direct economic competition with the Practitioner, or is a member of the Medical Executive Committee or Board of Director.

## **7.5 HEARING PROCEDURE**

### **7.5.1 Personal Presence**

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

### **7.5.2 Presiding Officer**

The Chairman of the hearing committee shall be the presiding officer. The presiding officer shall act to maintain decorum and to assure that all participants in the hearing have a

reasonable opportunity to present relevant oral and documentary evidence. He/she shall be entitled to determine the order of procedure during the hearing and shall make all rulings on matters of law, procedure, and the admissibility of evidence.

#### **7.5.3 Appointment of a Hearing Officer or Legal Consultant**

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

#### **7.5.4 Representation**

7.5.4.1 The Practitioner who requested the hearing shall be entitled to be accompanied and represented at the hearing by an attorney or another person of his/her choice.

7.5.4.2 The MEC or the Board, depending on whose recommendation or action prompted the hearing, shall be entitled to be accompanied and represented by an attorney.

7.5.4.3 The hospital is entitled to a representative at the proceeding which shall be a member of Hospital Administration.

#### **7.5.5 Rights of Parties**

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

7.5.5.1 Call and examine witnesses;

7.5.5.2 Introduce exhibits;

7.5.5.3 Cross-examine any witness on any matter relevant to the issues;

7.5.5.4 Impeach any witness; and

7.5.5.5 Rebut any evidence.

#### **7.5.6 Procedure and Evidence**

The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be admitted, regardless of the admissibility of such evidence in a court of law. The concern of the hearing committee is with determining the truth of the matter, providing adequate safeguards for the rights of the parties and ultimate fairness to both parties. The committee shall also be entitled to consider all other information that can be considered, pursuant to these Bylaws, in connection with applications for appointment or reappointment to the Medical Staff and for clinical privileges. At the Chairman's discretion, each party shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of law or fact, and such memoranda shall become part of the hearing record.

#### **7.5.7 Burden of Proof**

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

#### **7.5.8 Record of Hearing**

A record of the hearing shall be kept that is of sufficient accuracy to permit a valid judgment to be made by any group that may later be called upon to review the record and render a recommendation or decision in the matter. The hearing committee may select the



method to be used for making the record, such as court reporter, electronic recording unit, detailed transcription, or minutes of the proceedings.

**7.5.9 Postponement**

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

**7.5.10 Presence of Hearing Committee Members and Vote**

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

**7.5.11 Recesses and Adjournment**

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

**7.6 HEARING COMMITTEE REPORT**

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

7.6.2. Effect of Favorable Result: If the Hearing Committee's recommendation is favorable to the Practitioner, the Chief Executive Officer shall promptly forward it, together with all supporting documentation, to the Board for its final action. The Board shall take action thereupon by adopting, rejecting, or modifying the recommendation in whole or in part, or by referring the matter back to the MEC for further reconsideration. Any such referral back shall state the reasons therefore, set a time limit within which a subsequent recommendation to the Board must be made, and may include a directive that an additional hearing be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, the Board shall within 31 days take final action. The Chief Executive Officer shall promptly send the Practitioner notice informing him/her of each action taken pursuant to this Section.

7.6.3 Effect of Adverse Result for Practitioner: If the Hearing Committee's recommendation continues to be adverse to the Practitioner in any of the respects listed in Section 7.2, the notice required by this Section shall inform the Practitioner of his/her right to request an appellate review by the Board as provided in Section 7.7.1.

**7.7 INITIATION AND PREREQUISITES OF APPELLATE REVIEW**

**7.7.1 Request for Appellate Review**

A Practitioner shall have thirty (30) days following his/her receipt of a notice pursuant to Section 7.6.2 or 7.6.3 to file a written request for an appellate review. Such request shall be delivered to the Chief Executive Officer either in person or by certified or registered mail and may include a request for a copy of the report and record of the hearing committee and all other material, favorable or unfavorable, that was considered in making the adverse action or result.

**7.7.2 Failure to Request Appellate Review**

A Practitioner who fails to request an appellate review within the time and in the manner specified in Section 7.7.1 above waives any right to such review. Such waiver shall constitute acceptance of the recommendation or action, which shall become immediately effective. The matter shall be considered closed.

**7.7.3 Notice of Time and Place for Appellate Review**

Upon receipt of a timely request for appellate review, the Chief Executive Officer shall deliver such request to the Board. As soon as practicable, the Board shall schedule and arrange for an appellate review which shall not be less than 30 days from the date of notice to the Practitioner of the time, place and date of the review. The time for the appellate review may be extended or expedited by the appellate review body for good cause.

#### **7.7.4 Appellate Review Body**

The appellate review shall be conducted by an appellate review committee of at least three (3) members of the Board appointed by the Chairman of the Board. If a committee is appointed, one of its members shall be designated as Chairman. No person shall serve on the appellate review committee if that person has served on the hearing committee in the same case or if that person is in direct economic competition with the Practitioner and at least one member of the appellate review committee must be an M.D..

### **7.8 APPELLATE REVIEW PROCEDURE**

#### **7.8.1 Nature of Proceedings**

The proceedings by the review committee shall be in the nature of an appellate review based upon the record of the hearing before the hearing committee, that committee's report, and all subsequent results and actions thereon. The proceedings shall be restricted to reviewing whether the Medical Staff Bylaws were followed and whether substantial evidence to support the recommendation is documented. The appellate review committee shall also consider the written statements, if any, submitted pursuant to Section 7.8.2 and such other material as may be presented and accepted under Sections 7.8.4 and 7.8.5.

#### **7.8.2 Written Statements**

The Practitioner seeking the review and the MEC may submit a written statement detailing the findings of fact, conclusions and procedural matters with which the party agrees or disagrees, and the reasons for such agreement or disagreement. This written statement may cover any matters raised at any step in the hearing process, and legal counsel may assist in its preparation. The statement shall be submitted to the appellate review committee through the Chief Executive Officer at least three (3) days prior to the scheduled date of the appellate review, except if such time limit is waived by the appellate review committee.

#### **7.8.3 Presiding Officer**

The Chairman of the appellate review committee shall be the presiding officer. He/she shall determine the order of procedure during the review, make all required rulings, and maintain decorum.

#### **7.8.4 Oral Statement**

The appellate review committee, in its sole discretion, may allow the parties or their representatives to appear and make oral statements in favor of their positions. Any party or representative so appearing may be requested to answer questions asked him/her by any member of the appellate review committee.

#### **7.8.5 Consideration of New or Additional Matters**

New or additional matters of evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in the record may be introduced at the appellate review only in the discretion of the appellate review committee, and, as the appellate review committee deems appropriate, only if the party requesting consideration of the matter or evidence demonstrates that it could not have been discovered in time for the initial hearing and that the new matter or evidence is relevant to a material issue. The requesting party shall provide, through the Chief Executive Officer, a written, substantive description of the matter or evidence to the appellate review committee and the other party at least three (3) days prior to the scheduled date of the review.

#### **7.8.6 Powers**

The appellate review committee shall have all the powers granted to the hearing committee, and such additional powers as are reasonably appropriate to the discharge of its responsibilities.

**7.8.7 Presence of Members and Vote**

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

**7.8.8 Recesses and Adjournment**

The appellate review committee may recess the review proceedings and reconvene the review proceedings at predetermined time for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon the conclusion of oral statements, if allowed, the appellate review shall be closed. The appellate review committee shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusion of those deliberations, the appellate review shall be declared finally adjourned.

**7.8.9 Action Taken**

The appellate review committee may, as decided by a majority vote of its members, affirm, modify or reverse the adverse result or action, or in its discretion, may refer the matter back to the hearing committee for further review and recommendation to be returned to it within 30 days in accordance with its instructions. Within 30 days after receipt of such recommendation after referral, the appellate review committee shall take action.

**7.8.9.1 Appellate Review Committee Decision: The appellate review committee's decision is the final decision in the matter and will become effective when ratified by the Board.**

**7.9 FINAL DECISION OF THE BOARD**

**7.9.1 Board Action**

Within seven (7) days after the conclusion of the appellate review, the Board shall render a final decision in the matter in writing and shall send notice thereof to the practitioner, to the Chief of Staff, and to the MEC.

**7.10 GENERAL PROVISIONS**

**7.10.1 Number of Hearings and Reviews**

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

**7.10.2 Release**

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

**7.10.3 Confidentiality**

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

**7.10.4 Hearing and Appeal Procedures for Allied Health Practitioners**

Individuals with clinical privileges who are not eligible for Medical Staff membership and who are not Medical Staff members (i.e., Allied Health Professionals - AHPs) are afforded a fair hearing and appeal process but that process shall be a modification of that for

Medical Staff members or applicants for Medical Staff membership.<sup>1</sup> The following procedures shall be used for AHPs:

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

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

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

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

*7.10.4.4.1 A determination favorable to the AHP shall be reported in writing to the body making the adverse recommendation or action.*

*7.10.4.4.2 A determination adverse to the AHP shall result in notice to the AHP of the right to appeal the decision to the Chairman of the Board.*

7.10.4.5 Final Decision: The decision of the Chairman of the Board shall be final.

#### **7.10.5 EXTERNAL REPORTING REQUIREMENTS**

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

## **8. article eight: MEDICAL staff officers**

### **8.1 elected officers of the staff**

#### **8.1.1 Identification**

The officers of the Medical Staff shall be the Chief of Staff, the Vice Chief of Staff and the Immediate Past Chief of Staff.

#### **8.1.2 Qualifications**

*Officers must be Board Certified doctors of medicine or doctors of osteopathy who, during the current term of appointment, has maintained qualifications for Medical Staff membership and assigned staff category, has met attendance and participation requirements, and has not received a restriction of membership or privileges. Once an officer is elected, he/she will be ineligible to serve as Department Chairman. Failure to maintain such status shall immediately create a vacancy in the office involved.*

### **8.2 term of office and eligibility for re-elections**

#### **8.2.1 Term of Office**

Officers shall be elected for a term of one year which shall begin upon approval by the Board of Directors and until their successors are duly elected and have qualified. The Executive Committee shall fill a vacant office for any unexpired portion of the term.

#### **8.2.2 Eligibility for Re-election**

No person may serve in the same position for more than two (2) consecutive terms.

### **8.3 attainment of office**

#### **8.3.1 Nomination**

At least forty-five (45) days before the Annual Medical Staff meeting of the calendar year, the Nominating Committee shall convene and submit to the Chief of Staff one or more qualified nominees for the offices of Chief of Staff, and Vice Chief of Staff. At least twenty-one (21) days before the Annual Medical Staff Meeting, the Medical Staff Coordinator shall report the names of the nominees to the Staff with the date and location of the Annual Medical Staff Meeting. Nominations may also be made by petition signed by at least twenty (20) percent of the appointees of the active staff, with a signed statement of willingness to serve by the nominee, filed with the Chief of Staff at least ten (10) days before the annual meeting. As soon thereafter as reasonably possible, the names of the additional nominees will be reported to the Staff. If, before the election, all nominees refuse or are disqualified or are otherwise unable to accept nomination, the Nominating Committee shall submit one or more additional nominees at the annual meeting and nominations may be accepted from the floor if the nominee is present at the meeting and consents to the nomination.

#### **8.3.2 Election**

Voting by proxy shall not be permitted. A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate for an office receives a majority vote, a runoff election between the two candidates receiving the highest number of votes shall be held at the meeting by secret written ballot. If a tie results, the majority vote of the Medical Executive Committee shall decide the election. The votes of Medical Executive Committee members shall be by secret written ballot at its next meeting or a special meeting called for that purpose. The election shall become effective upon approval of the Board.

#### **8.3.3 Board Approval/Indemnification**

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

assessment/performance improvement activities. Such activities shall have the following characteristics:

**8.3.3.1** The activities such leaders undertake shall be performed on behalf of the Hospital;

8.3.3.2 The activities shall be performed in good faith,

8.3.3.3 That any professional review action shall be taken:

8.3.3.3.1 *In the reasonable belief that the action was in the furtherance of quality health care;*

8.3.3.3.2 *After a reasonable effort to obtain the facts of the matter;*

8.3.3.3.3 *After adequate notice and hearing procedures are afforded to the individual involved or after such other procedures as are fair to the individual under the circumstances; and,*

8.3.3.3.4 *In the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting this Section.*

8.3.3.4 The activities shall follow procedures set forth in these Bylaws, rules and regulations, or policies;

8.3.3.5 Medical Staff leaders who are performing activities meeting the above listed criteria shall qualify for indemnification for those activities through the Hospital.

#### **8.4 VACANCIES**

Vacancies in office may occur from time to time, such as upon the death, disability, resignation, removal, or recall from office of an officer, or upon an officer's failure to maintain active staff status. The Executive Committee shall fill a vacant office for the unexpired term.

#### **8.5 resignation, removal, and recall from office**

##### **8.5.1 Resignation**

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

##### **8.5.2 Removal**

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

8.5.2.1 Failure to perform the duties of office;

8.5.2.2 Failure to comply with or support the enforcement of the hospital and Medical Staff Bylaws, Rules and Regulations, or policies;

8.5.2.3 Failure to support the compliance of the Hospital and the Medical Staff to applicable Federal and State laws and regulations, and the standards or other requirements of any regulatory or accrediting agency having jurisdiction over the Hospital or any of its services;

8.5.2.4 Failure to maintain qualifications for office, specifically, failure to maintain active staff status; and/or,

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

##### **8.5.3 Recall from Office**

Any Medical Staff officer may be recalled from office, with or without cause. Recall of a Medical Staff officer may be initiated by a majority of members of the Medical Executive

Committee or by a petition signed by at least one-third of the medical staff members eligible to vote in Medical Staff elections. Recall shall be considered by the Medical Staff at a special meeting of the Medical Staff called for that purpose. A recall shall require two-thirds of the votes of the Medical Staff members attending the specially called meeting who are eligible to vote. Sealed and authenticated votes mailed by Medical Staff members eligible to vote shall also be counted at the special meeting. The recall shall become effective upon approval of the Board.

## **8.6 responsibilities and authority of the officers**

### **8.6.1 Chief of Staff**

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

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

### **8.6.2 Vice Chief of Staff**

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

### **8.6.3 Immediate Past Chief of Staff**

As an individual with unique knowledge of Medical Staff affairs, the Immediate Past Chief of Staff shall serve as an advisor and mentor to the Chief of Staff, shall participate as a member of the Medical Executive Committee and other standing committees of the

Medical Staff as specified in these Bylaws, and shall perform other duties as requested by the Chief of Staff.

#### 8.7 Chief Medical Officer

The Chief Medical Officer shall be a physician who is under contract with the Hospital to perform administrative duties related to the medical staff affairs of the Hospital. The Chief Medical Officer is not elected by the Medical Staff and therefore is not one of the officers of the Medical Staff organization. The Chief Medical Officer is a Medico-Administrative Officer, and as such, the provisions of Article Three, Section 3.13 of these Bylaws apply.

##### 8.7.1 Qualifications

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

##### 8.7.2 Responsibilities and Authority

The Chief Medical Officer's duties and responsibilities are intended to provide administrative and oversight consulting services with respect to clinical case management and medical staff operations and to ensure that such operations are provided at a level of consistent medical quality. The Chief Medical Officer will recommend and facilitate the development and implementation of consistent policies, guidelines, procedures and protocols in the Hospital. The specific duties and responsibilities of the Chief Medical Officer shall include the following:

8.7.2.1 Continuing consulting oversight of the clinical operations, clinical quality issues, medical staff functions, and other administrative operations of the Hospital, as that structure and those functions, issues, and operations are reported to the Directors by designated physician and management representatives from the Hospital, all to promote the provision of quality and consistent health care services at the Hospital.

8.7.2.2 Attendance at regularly scheduled meetings of the Medical Executive Committee and attendance upon advance request at meetings of the governing body. Attendance at regularly scheduled meetings of the Quality Improvement Committees, Quality Council, Utilization Management (UM), Ethics Committee, Bylaws Committee, and Nominating Committee, or, alternatively, meeting with designated representatives of such committees on a periodic basis.

8.7.2.3 Review and evaluation of clinical pathways, protocols, procedures, and guidelines as they currently exist and are refined and developed by designated committee chairs or physician representatives, and comparison of such guidelines, pathways, protocols, and procedures to other facilities.

8.7.2.4 Attendance at regularly scheduled meetings with Hospital management to discuss current developments and needs, and future goals of the Hospital regarding clinical operations and medical staff functions and other such matters as may be appropriate, all in an effort to facilitate delivery of consistent and quality services.

8.7.2.5 Review, evaluation and oversight of the development and implementation of chronic disease management programs, including (where appropriate and possible) oversight of the standardization of treatment protocols and clinical pathways.

8.7.2.6 Facilitation and coordination of the Hospital's graduate medical education programs.

8.7.2.7 Review and evaluation of the Hospital's clinical case management and utilization monitoring programs, including review and evaluation of peer comparative profiling of medical staff performance

8.7.2.8 Monitoring and evaluation of the development and implementation of credentialing criteria and continuing medical education programs to promote consistency.



- 8.7.2.9 Maintenance of professional affiliations sufficient to keep current as to trends in clinical administration and the health care field in general.
- 8.7.2.10 Provision of consulting guidance, including knowledge of concurrent and retrospective review of medical resource consumption and appropriateness of clinical care, to administrative and clinical teams of the Hospital responsible for resource and case management programs and related utilization management activities at the Hospital.
- 8.7.2.11 Development and coordination of open lines of communication with the CEO of the Hospital in order to promote channels of communication between the physicians and hospital management.
- 8.7.2.12 Consultation with appropriate staff, physician leaders, and clinical departments prior to recommending new policies and procedures to promote the availability of support and resources.
- 8.7.2.13 Attendance at various meetings outside the hospital as requested by the Hospital CEO.

## **9. Article nine: clinical departments**

### **9.1 current clinical departments**

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

- 9.1.1 Emergency Department
- 9.1.2 Family Medicine Department
- 9.1.3 Medicine Department
- 9.1.4 Obstetrics/Gynecology/Pediatrics/Nursery/NICU Department
- 9.1.5 Radiology Department
- 9.1.6 Surgery / Anesthesia/Pathology Department

### **9.2 criteria to qualify as a department**

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

### **9.3 requirements for affiliation with departments**

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

### **9.4 functions of departments**

The primary function of each Department is to implement specific review and evaluation activities that contribute to the preservation and improvement of the quality and efficacy of patient care provided in the Department. To carry out this overall function, each Department shall:

- 9.4.1 Perform quality assessment/performance improvement and patient safety activities which include:
  - 9.4.1.1 Perform peer review and quality assessment activities relative to the performance of individuals with clinical privileges in the Department and report such activities to the Medical Executive Committee on a regular basis;
  - 9.4.1.2 Provide leadership for activities related to patient safety, including proactive risk assessments, root cause analysis in response to an unanticipated adverse event, addressing patient safety alerts, and implementing procedures to comply with patient safety goals;
  - 9.4.1.3 Ensure appropriate quality control is performed, if applicable to the Department;
  - 9.4.1.4 Receive reports regarding Hospital performance improvement results that are applicable to the performance of the Department and its members, and integrate the Department's performance improvement activities with that of the Hospital by taking a leadership and participatory role in such activities, as outlined in the Hospital Performance Improvement Plan.
- 9.4.2 Establish guidelines for granting of clinical privileges within the Department and submit with the recommendations required regarding these specific privileges for each staff member or applicant may exercise, and the specified services that each Allied Health Professional may provide. Recommend to the Medical Executive Committee and Board of

Directors which services, as well as associated clinical privileges, commonly provided by their department can be provided via telemedicine.

- 9.4.3 Conduct or participate in making recommendations regarding the need for continuing education programs pertinent to changes in medical practice.
- 9.4.4 Monitor on a continuing basis adherence to 1) staff and hospital policy and procedures; 2) requirements for alternative coverage and consultation; 3) sound principles of clinical practice; 4) fire and other regulations designed to promote patient safety.
- 9.4.5 Coordinate the patient care provided by the members of the Department with nursing and other non-physician patient care services and with administrative support services.
- 9.4.6 Foster an atmosphere of professional decorum within the Department appropriate to the practice of medicine.
- 9.4.7 Submit written reports and minutes of Department meetings to the Executive Committee on a regular and timely basis concerning 1) the findings of the Department's review and evaluation activities, actions taken thereon and the results of such actions; 2) recommendations for maintaining and approving the quality of care provided in the Department and the hospital; and 3) such other matters that may be requested from time to time by the Executive Committee.
- 9.4.8 Meet as needed as a department for the purposes of acting on reports from the functions indicated above and for receiving reports on other department and staff functions.
- 9.4.9 Establish such committees or other mechanisms as are necessary and desirable to properly perform the functions assigned to the Department.

## **9.5 FUNCTIONS OF DIVISIONS**

The Divisions shall meet as often as necessary to perform the following functions:

- 9.5.1 The Division meetings shall serve as a forum to discuss clinical aspects of care related to the Division;
- 9.5.2 The Division may be requested by the Department Chairperson or Medical Executive Committee to meet to discuss specific issues related to quality assessment, peer review, performance improvement, and/or credentialing. In such cases, the Division shall report their findings directly to the Department Chairperson or the Medical Executive Committee.

## **9.6 officers of departments and divisions**

### **9.6.1 IDENTIFICATION**

The officers of the Departments shall be the Department Chairperson and the Department Vice Chairperson. The officer of a Division shall be the Division Director.

### **9.6.2 QUALIFICATIONS**

The officers of the Departments and Divisions shall be active or provisional/active staff members. Each Department Chairperson and Vice Chairperson shall have demonstrated ability in at least one of the clinical areas of the Department. All officers of the Departments shall be certified by an appropriate specialty board.

### **9.6.3 ATTAINMENT OF OFFICE**

Department officers shall be elected by a majority vote of the Department members present at the meeting in which the election is held. The officers selected during the election shall be subject to approval by the Medical Executive Committee and ratification by the Board and shall take office at the beginning of the subsequent medical staff year. Division Directors shall be appointed by each respective Department Chairperson, subject to approval by the Medical Executive Committee.

### **9.6.4 TERM OF OFFICE AND ELIGIBILITY FOR REAPPOINTMENT TO POSITION**

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

### **9.6.5 RESIGNATION**

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

#### **9.6.6 REMOVAL**

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

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

#### **9.6.7 RECALL**

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

#### **9.6.8 VACANCY**

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

#### **9.6.9 RESPONSIBILITY AND AUTHORITY**

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

- 9.6.9.1.1 *Presiding at all meetings of the Department;*
- 9.6.9.1.2 *Appointing Department members to membership positions on Departmental committees, if any;*
- 9.6.9.1.3 *Serving as an ex-officio member of all departmental committees if any, without vote, unless specifically stated in the Bylaws or Rules and Regulations otherwise;*
- 9.6.9.1.4 *Serving as a member of the Medical Executive Committee and accountable to the Medical Executive Committee with regard to the activities and functioning of the Department, specifically to regularly*

*report the quality assessment and performance improvement activities of the Department to the Medical Executive Committee;*

- 9.6.9.1.5 Conducting all clinically related activities of the Department;*
- 9.6.9.1.6 Conducting all administratively related activities of the Department, unless otherwise provided by the Hospital;*
- 9.6.9.1.7 Continuing surveillance of the professional performance of all individuals in the Department who have delineated clinical privileges;*
- 9.6.9.1.8 Recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the Department;*
- 9.6.9.1.9 Recommending clinical privileges for each member of the Department;*
- 9.6.9.1.10 Assessing and/or recommending to the relevant Hospital authority off-site sources for needed patient care services not provided by the Department or the Hospital;*
- 9.6.9.1.11 Integrating the Department into the primary functions of the Hospital;*
- 9.6.9.1.12 Coordinating and integrating interdepartmental and intradepartmental services;*
- 9.6.9.1.13 Developing and implementing policies and procedures that guide and support the provision of services;*
- 9.6.9.1.14 Recommending a sufficient number of qualified and competent persons to provide care or services;*
- 9.5.8.1.15 Determining the qualifications and competence of department personnel who are not licensed independent practitioners and who provide patient care services;*
- 9.6.9.1.16 Ensuring the continuous assessment and improvement of the quality of care and services provided;*
- 9.6.9.1.17 Maintaining quality control programs, as appropriate;*
- 9.6.9.1.18 Ensuring the orientation and continuing education of all persons in the Department;*
- 9.6.9.1.19 Recommending appropriate space and other resources needed by the Department.*

9.6.9.2 Department Vice Chairperson: The Vice Chairperson shall assist the Department Chairperson in the performance of the Chairperson's duties, and shall assume the duties of the Chairperson in his/her **absence**.

## 10. ARTICLE TEN: FUNCTIONS AND COMMITTEES

### 10.1 Functions of the Staff

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

#### 10.1.1 Governance

Although the Medical Staff is an integral part of the Hospital and is not a separate legal entity, the Medical Staff is organized to perform its required functions. The Medical Staff organization shall:

10.1.1.1 Establish a framework for self-governance of Medical Staff activities and accountability to the Board

10.1.1.2 Establish a mechanism for the Medical Staff to communicate with all levels of governance involved in policy decisions affecting patient care services in the Hospital.

#### 10.1.2 Planning

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

10.1.2.1 Planning patient care services;

10.1.2.2 Planning and prioritizing performance improvement activities;

10.1.2.3 Budgeting;

10.1.2.4 Providing for uniform performance of patient care processes, including providing a mechanism to ensure that the same level of quality of patient care is provided by all individuals with delineated clinical privileges, within Medical Staff Departments, across Departments, and between members and non-members of the Medical Staff who have delineated clinical privileges;

10.1.2.5 Recruitment, retention, development, and continuing education of all staff;

10.1.2.6 Consideration and implementation of clinical practice guidelines as appropriate to the patient population.

#### 10.1.3 Credentialing

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

10.1.3.1 Establish specifically defined mechanisms for the process of appointment and reappointment to Medical Staff membership and for granting delineated clinical privileges to qualified applicants;

10.1.3.2 Establish professional criteria for membership and for clinical privileges;

10.1.3.3 Conduct an evaluation of the qualifications and competence of individuals applying for Medical Staff membership or clinical privileges;

- 10.1.3.4 Submit recommendations to the Board regarding the qualifications of an applicant for appointment, reappointment or clinical privileges;
- 10.1.3.5 Establish a mechanism for fair hearing and appellate review;
- 10.1.3.6 Establish a mechanism to ensure that the scope of practice of individuals with clinical privileges is limited to the clinical privileges granted.

10.1.4 Quality Assessment/Performance Improvement, Utilization Review and Patient Safety

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

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

- 10.1.4.1.1 That an ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained.
- 10.1.4.1.2 That the Hospital-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety; and that all improvement actions are evaluated.
- 10.1.4.1.3 That clear expectations for safety are established.
- 10.1.4.1.4 That adequate resources are allocated for measuring, assessing, improving, and sustaining the Hospital's performance and reducing risk to patients.
- 10.1.4.1.5 That the determination of the number of distinct improvement projects is conducted annually.

10.1.4.2 Medical Staff Leadership in Performance Improvement and Utilization Review: The Medical Staff shall perform a leadership role in the Hospital's quality assessment, performance improvement, utilization review and patient safety activities when the performance of a process is dependent primarily on the activities of one or more individuals with clinical privileges. Such activities shall include, but are not limited to a review of the following:

- 10.1.4.2.1 Use of patient safety data, proactive risk assessment and risk reduction activities, and implementation of procedures to respond to patient safety alerts and comply with patient safety goals;
- 10.1.4.2.2 Root cause analysis, investigation and response to any unanticipated adverse events;
- 10.1.4.2.3 Medical assessment and treatment of patients, including a review of all medical and surgical services for the appropriateness of diagnosis and treatment;

- 10.1.4.2.4 Review and analysis of performance based on the results of core measures;
  - 10.1.4.2.5 Use of information about adverse privileging decisions for any Practitioner privileged through the medical staff process;
  - 10.1.4.2.6 Use of medications, including the review of any significant adverse drug reactions or medication errors, and the use of experimental drugs and procedures;
  - 10.1.4.2.7 Use of blood and blood components, including the review of any significant transfusions reactions;
  - 10.1.4.2.8 Use of operative and other procedures, including tissues review and the review of any major discrepancy between pre-operative and post-operative (including pathological) diagnoses;
  - 10.1.4.2.9 Review of appropriateness, medical necessity, and efficiency of clinical practice patterns, including the review of surgical appropriateness, readmissions, appropriateness of discharge, and resource/utilization review;
  - 10.1.4.2.10 Significant departures from established patterns of clinical practice, including review of any sentinel events, risk management reports, and patient or staff complaints involving the Medical Staff; and
  - 10.1.4.2.11 Use of developed criteria for autopsies.
- 10.1.4.3 Medical Staff Participant Role in Performance Improvement: The Medical Staff shall participate in the measurement, assessment, and improvement of other patient care processes. Such activities shall include, but are not limited to a review of the following:
- 10.1.4.3.1 Analyzing and improving patient satisfaction;
  - 10.1.4.3.2 Education of patients and families;
  - 10.1.4.3.3 Coordination of care with other practitioners and hospital personnel, as relevant to the care of an individual patient;
  - 10.1.4.3.4 Accurate, timely, and legible completion of patients' medical records, including a review of medical record delinquency rates;
  - 10.1.4.3.5 The quality of history and physical exams;
  - 10.1.4.3.6 Surveillance of nosocomial infections.
- 10.1.4.4 Medical Staff Peer Review: Findings relevant to an individual are used in an ongoing evaluation of the individual's competence. When the findings of quality assessment or performance improvement activities are relevant to an individual's performance and the individual is a Medical Staff member or holds clinical privileges, the Medical Staff is responsible for determining the use of the findings in peer review or the ongoing evaluations of the individual's competence. In accordance with these Bylaws, clinical privileges are renewed or revised appropriately.
- 10.1.4.5 Continuing and Graduate Medical Education: Since the Medical Staff recognized continuing education as an adjunct to maintaining clinical skills and current competence, all individuals with clinical privileges shall participate in continuing education. The Medical Staff shall develop educational programs for Medical Staff members and others with clinical privileges related at least in part to:
- 10.1.4.5.1 The type and nature of care offered by the hospital; and



#### 10.1.4.5.2 The findings of performance improvement activities.

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

#### 10.1.6 Bylaws Review and Revision

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

- 10.1.6.1 Remain consistent with the Bylaws of the Board of Director;
- 10.1.6.2 Remain in compliance with all applicable Federal and State laws and regulations, and applicable accreditation standards;
- 10.1.6.3 Remain current with the Medical Staff's organization, structure, functions, responsibilities and accountabilities;
- 10.1.6.4 Remain consistent with Hospital policies.

#### 10.1.7 Nominating

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

### 10.2 Principles Governing Committees

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

### 10.3 Designation

The current standing committees of the Medical Staff are the Medical Executive Committee, the Credentials Committee, Quality Council, the Bylaws Committee, the Nominating Committee, the Graduate Medical Education Committee, the Ethics Committee, the Pharmacy and Therapeutics Committee, and the Infection Control Committee.

### 10.4 Operational Matters Relating to Committees

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

#### 10.4.2 Ex Officio Members

The Chief Executive Officer shall be ex-officio members of all Medical Staff committees. The Chief Executive Officer may designate another senior administrative member to attend any meeting in his/her place. At the prerogative of the Board of

Directors, Board member(s) may be appointed to serve as representative(s) of the Board of Director on any Medical Staff committee or Hospital committee. Other ex-officio members of specific standing committees may be designated by the CEO or Chief of Staff.

#### 10.4.3 Appointment of Chairperson and Members

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

#### 10.4.4 Term, Prior Removal and Vacancies

Unless specified otherwise, the term of office for a Medical Staff committee chairperson or committee member shall be two (2) years.

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

#### 10.4.5 Notice

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

#### 10.4.6 Quorum

A minimum of one (1) voting member of a committee present in person at a meeting shall constitute a quorum with the exception of the Medical Executive Committee. For the Medical Executive Committee a minimum of fifty (50) percent of voting members present in person or by interactive telecommunications, at a meeting shall constitute a quorum.

#### 10.4.7 Action through Subcommittees

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

#### 10.4.8 Minutes

The secretary of each committee shall cause to be prepared minutes or reports of each meeting and forward copies to the Chief of Staff.

#### 10.4.9 Reports

Each committee shall report its activities, findings, and recommendations to the Executive Committee. A copy of all reports, records, and evaluation of each committee shall be kept and maintained in the Minute Book of the committee and in the notebook of duties and responsibilities of staff committees maintained by the staff.

Where duties and responsibilities are to be determined, a written list thereof shall similarly be maintained.

#### 10.5 Committees and Departments with Peer Review Responsibilities

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

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

10.5.1.1 *To improve the quality of health care provided to patients;*

10.5.1.2 *To reduce morbidity and mortality at the Hospital;*

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

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

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

10.5.3 Hospital Committees or Functions: A peer review process includes any process, program or proceeding involving any or all of the following Hospital committees or functions: performance improvement, utilization management, credentialing, infection control, use of medications, use of blood and blood components, clinical risk management, quality assessment, and fair hearings conducted pursuant to the Medical Staff Fair Hearing Plan.

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

10.5.5 Credentialing Records: The credentialing record or file of each Practitioner or other individual with clinical privileges shall be segregated so that the documents that are subject to the peer review privilege are maintained separately and identified as peer review information. Generally, the documents that are not subject to the peer review privilege include the initial application, application for reappointment, request for privileges, and correspondence from the Practitioner or other individual with clinical privileges.

#### 10.6 Executive Committee

##### 10.6.1 Composition

The Executive Committee shall consist of the Chief of Staff, the Vice Chief of Staff, the Immediate Past Chief of Staff, the Chairpersons of each Medical Staff Department, Chairpersons of standing committees, one member at large appointed by the Chief of Staff, and one member at large appointed by the Chief Executive

Officer. The Chief of Staff shall serve as Chairman. In addition to the Chief Executive Officer, the Chief Nursing Officer, or other designated hospital officials, and the Medical Staff Coordinator shall serve as ex-officio members without vote.

#### 10.6.2 Duties and Authority

The Medical Executive Committee is empowered to represent and act for the Medical Staff in the interval between Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws. The Medical Executive Committee shall perform or direct the performance of the duties relative to the key functions of Governance and Planning, as described in these Bylaws and oversee the performance of other key functions. The following duties shall be performed by the Medical Executive Committee:

- 10.6.2.1 Providing for current Medical Staff Bylaws, rules and regulations, and Medical Staff policies, subject to the approval of the Board.
- 10.6.2.2 Providing liaison and communication with all levels of Hospital governance and administration with regard to policy decisions affecting patient care services.
- 10.6.2.3 Collaborate with other leaders of the organization in Hospital planning.
- 10.6.2.4 Review the qualifications, evidence of current competence, and the recommendations of a Department Chairperson and the Credentials Committee for each individual applying for Medical Staff membership or clinical privileges, and make recommendations for appointment, reappointment, staff category, assignment to Departments and Divisions, clinical privileges, and any disciplinary actions.
- 10.6.2.5 Organizing the Medical Staff's quality assessment and performance improvement activities and establishing a mechanism designed to conduct, evaluate, and revise such activities.
- 10.6.2.6 Conduct and supervise Medical Staff peer review activities.
- 10.6.2.7 Receive and act on reports and recommendations from Medical Staff committees, Departments, and assigned activity groups, specifically as related to Medical Staff quality assessment and performance improvement activities.
- 10.6.2.8 Make recommendations directly to the Board with regard to all of the following:
  - 10.6.2.8.1 *The Medical Staff structure;*
  - 10.6.2.8.2 *The mechanism used to review credentials and to delineate individual clinical privileges;*
  - 10.6.2.8.3 *Recommendations of individuals for Medical Staff membership;*
  - 10.6.2.8.4 *Recommendations for delineated clinical privileges for each eligible individual;*
  - 10.6.2.8.5 *The participation of the Medical Staff in organization quality assessment, performance improvement, and patient safety activities;*
  - 10.6.2.8.6 *Reports regarding the Medical Staff's evaluation of the quality of patient care services provided by the Medical Staff and the Hospital;*
  - 10.6.2.8.7 *The mechanism by which Medical Staff membership may be terminated; and,*
  - 10.6.2.8.8 *The mechanism for fair hearing procedures.*
- 10.6.2.9 Report at each Medical Staff meeting with regard to the actions taken by the Medical Executive Committee on behalf of the Medical Staff.

## 10.7 CREDENTIALS COMMITTEE

### 10.7.1 Composition

The Credentials Committee shall be composed of active staff members. The voting membership shall include the Vice Chief of Staff who shall chair the committee, the Chief Medical Officer, the Chairperson of the Quality Council, and up to four (4) active Medical Staff members appointed by the Chief of Staff. The Chief Executive Officer and the Medical Staff Coordinator shall be ex-officio members without vote.

### 10.7.2 Duties and Authority

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

10.7.2.1 Oversee a mechanism to ensure that all Medical Staff members and individuals with clinical privileges maintain required credentials ongoing;

10.7.2.2 Through making recommendations related to granting clinical privileges, ensure that the same level of quality of care is provided by all individuals with delineated clinical privileges, within Medical Staff Departments, across Departments, and between members and non-members of the Medical Staff who have delineated clinical privileges;

10.7.2.3 Oversee a mechanism to ensure that the scope of practice of individuals with clinical privileges is limited to the clinical privileges granted;

10.7.2.4 Make recommendations to the Medical Executive Committee with regard to any revisions in the process for appointment, reappointment or delineation of clinical privileges.

### 10.7.3 Meetings and Reporting

The Credentials Committee shall meet at least quarterly, and shall report their recommendations and activities to the Medical Executive Committee.

## 10.8 Quality Council

### 10.8.1 Composition

The Quality Council shall be composed of active staff members. The voting membership shall include the Chairperson designated by the Chief of Staff and up to four (4) members of the medical staff appointed by the Chief of Staff. In addition to the Chief Executive Officer and the Chief Medical Officer, the ex-officio members without vote shall also include the Chief Nursing Officer, the Director of Quality Services and the Director of Medical Staff Services. At least twice a year the Chairman of the Board, other board member(s) as appropriate along with the Chief of Staff will attend the meeting or participate in the committee via telecommunications system to allow direct communication to discuss matters related to the quality of medical care provided to the patients of the hospital. The Quality Council shall also have the option of calling upon any member of the Medical Staff or other individual with clinical privileges to serve on the committee on an ad hoc basis to provide clinical review and recommendations to the committee, their appointment subject to the approval of the Chief of Staff acting on behalf of the Medical Executive Committee and the Board in this singular capacity. Ad hoc members of the committee shall be bound by the confidentiality requirements of the committee and shall be provided indemnification while serving on the committee, subject to the provisions of Article 8, Section 8.3.3. Ad hoc members of the committee shall not have voting rights on the committee.

### 10.8.2 Duties and Authority

The Quality Council shall perform the key function of Quality Assessment/Performance Improvement, as described in these Bylaws in Section 10.1.4, under the oversight and

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

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

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

10.8.3 Meetings and Reporting

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

10.9 Bylaws Committee

10.9.1 Composition

The Bylaws Committee shall be composed of the Immediate Past Chief of Staff who shall chair the committee, the Chief of Staff, the Vice Chief of Staff, and up to three at-large members appointed by the Chief of Staff. In addition to the Chief Executive Officer and the Chief Medical Officer, the ex-officio members without vote shall also include the Medical Staff Coordinator.

10.9.2 Duties and Authority

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

10.9.3 Meetings and Reporting

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

10.10 Nominating Committee

10.10.1 Composition

The Nominating Committee shall consist of the Chief of Staff, who shall chair the meeting, the Past Chief of Staff, and the Vice Chief of Staff.

10.10.2 Duties and Authority

The Nominating Committee shall perform the key function of nominating, as described in these Bylaws, under the oversight and direction of the Medical Executive Committee. The Nominating Committee shall solicit and accept nominations for elected Medical Staff officer positions, consult with the nominees concerning their qualifications and willingness to serve, prepare ballots, and supervise election of officers.

### 10.10.3 Meetings and Reporting

The Nominating Committee shall meet annually and shall report their recommendations and activities to the Medical Executive Committee.

## 10.11 Graduate Medical Education Committee

### 10.11.1 Composition

The Graduate Medical Education Committee shall consist of the Residency Program Director as Chairman, a Vice-Chairman, and up to five members-at-large selected by the Chief of Staff and Residency Program Director.

### 10.11.2 Duties and Authority

The Graduate Medical Education Committee shall be responsible for safety and quality of patient care provided by, and the related educational and supervisory needs of, the participants in professional educational programs. The Committee will also submit a report of their findings and recommendations to the Medical Executive Committee on a quarterly basis regarding the education needs and performance of the participants in the program.

### 10.11.3 Meetings and Reporting

The Graduate Medical Education Committee will meet at least four times per year and will submit a report of their findings and recommendations to the Medical Executive Committee on a quarterly basis regarding the education needs and performance of the participants in the program.

## 10.12 Ethics Committee

### 10.12.1 Composition

The Ethics Committee shall be composed of at least three members of the active Medical Staff. The Chief of Staff shall appoint the members of the Ethics Committee and shall designate a Chairman. Administrative staff appointments shall be made after consultation with and approval of the Chief Executive Officer.

### 10.12.2 Duties and Authority

The Ethics Committee shall be assigned to oversee improvement efforts in the area of Patient Rights and Ethics; review applicable policies periodically; establish and maintain a mechanism to address ethical issues; determine staff educational needs in the area of Patient Rights/Ethics; and assess compliance periodically with TJC standards.

### 10.12.3 Meetings and Reporting

The Ethics Committee shall meet at least quarterly and shall report their recommendations and activities to the Medical Executive Committee.

## 10.13 Pharmacy and Therapeutics Committee

### 10.13.1 Composition

The Pharmacy and Therapeutics Committee shall be composed of six members of the active Medical Staff. The Chief of Staff shall appoint the members of the Pharmacy and Therapeutics Committee and shall designate a Chairman. Administrative staff appointments shall be made after consultation with and approval of the Chief Executive Officer.

### 10.13.2 Duties and Authority

The Pharmacy and Therapeutics Committee shall be assigned to oversee improvement efforts in medication use and nutrition care including responsibility for preventing, monitoring, and reporting medication errors; review applicable policies and procedures periodically; perform drug regimen reviews; maintain the hospital formulary; and assess compliance periodically with TJC standards.

### 10.13.3 Meetings and Reporting

The Pharmacy and Therapeutics Committee shall meet at least quarterly and shall report their recommendations and activities to the Medical Executive Committee.

#### 10.14 Infection Control Committee

##### 10.14.1 Composition

The Infection Control Committee is a multi-disciplinary committee and shall be composed of at least five (5) members of the medical staff. The Chief of Staff shall appoint the members and designate a Chairman. The Chief Executive Officer shall appoint representatives from Nursing (Surgical Services), Administration, Environmental Services, Laboratory, Cardiopulmonary, Material Management (Central Supply & Laundry), Nutritional Services, Engineering, Safety, Pharmacy, and the Infection Control Coordinator.

##### 10.14.2 Duties and Authority

The committee shall approve the type and scope of the infection surveillance activities; approve the actions to prevent or control infections; review and approve, as per hospital policy, all policies and procedures related to the infection surveillance, prevention and control activities within all departments; have the authority to institute any surveillance, prevention and control measures or studies if there is a reason to believe that any patient or personnel may be in danger.

##### 10.14.3 Meetings and Reporting

The Infection Control Committee shall meet at least quarterly and shall report their recommendations and activities to the Medical Executive Committee. Special meetings may be called by the committee chairman.



## 11. ARTICLE ELEVEN: MEETINGS

### 11.1 *Medical Staff year*

The Medical Staff year shall be the period from January 1 to December 31 of each year.

### 11.2 *Medical Staff meetings*

#### 11.2.1 Regular Meetings

The Medical Staff shall meet annually for the purpose of conducting business and shall also be for the purpose of electing officers.

#### 11.2.2 Special Meetings

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

### 11.3 *department meetings*

#### 11.3.1 Regular Meetings

Regular meetings of each Department shall be scheduled quarterly and held no less than two times a year as necessary to perform the functions of Departments as specified in Article Nine of these Bylaws.

#### 11.3.2 Special Meetings

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

### 11.4 *attendance requirements*

#### 11.4.1 Generally

Active staff members of the Medical Staff shall be encouraged to attend meetings of the Department to which they are assigned and quarterly general Medical Staff meetings.

#### 11.4.2 Special Appearances

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

### 11.5 *meeting procedures*

#### 11.5.1 Notice of Meetings

Notice of the date, time and place of the Annual Medical Staff meeting and regular Medical Staff meetings shall be given not less than fourteen (14) days prior to the meeting, and not less than seven (7) days prior to a special meeting of the general Medical Staff. Notice to a Medical Staff member or other individual with clinical privileges who is being required to attend a meeting for quality review purposes shall be considered proper and valid when a registered, return receipt letter is sent at least fourteen (14) days prior to the meeting.

### 11.6 *quorum*

#### 11.6.1 General Staff Meetings

The active staff members present in person shall constitute a quorum for the transaction of business at any Medical Staff meeting. Voting by proxy shall not be permitted.

#### 11.6.2 Department Meetings

The active staff members present in person shall constitute a quorum for the transaction of business at any Medical Staff Department meeting. Voting by proxy shall not be permitted.

#### 11.7 *manner of action*

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

#### 11.8 *voting RIGHTS*

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

#### 11.9 *Rights of ex-officio members*

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

#### 11.10 *minutes*

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

#### 11.11 *procedural rules*

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

## 12. article twelve: confidentiality, immunity and release

### 12.1 *authorizations and conditions*

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

### 12.2 *confidentiality of information*

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

### 12.3 *Breach of confidentiality*

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

### 12.4 *immunity from liability*

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

- 12.4.1 Applications for appointment to the Medical Staff or for clinical privileges;
- 12.4.2 Periodic appraisals or reviews for reappointment or for renewal or revisions to clinical privileges;
- 12.4.3 Corrective action or disciplinary action, including suspension or revocation of Medical Staff membership or clinical privileges;
- 12.4.4 Hearing and appellate review;
- 12.4.5 Medical care evaluations;
- 12.4.6 Peer review evaluations;

12.4.7 Utilization review and resource management; and,

12.4.8 Any other Hospital, departmental, service or committee activities related to quality patient care, professional conduct or professional relations. Such matters may concern, involve or relate to, without limitation, such person's professional qualifications, clinical competence, character, fitness to practice, physical and mental condition, ethical or moral standards or any other matter that may or might have an effect or bearing on patient care.

12.5 *releases*

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

12.6 *severability*

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

12.7 *NONEXCLUSIVITY*

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

### 13. article Thirteen: adoption and amendment and general provisions

#### 13.1 *Medical Staff authority and responsibility*

The Medical Staff Bylaws shall be adopted upon the approval of the Medical Staff and become effective upon approval by the Board. The Medical Staff Rules and Regulations shall be adopted upon the approval of the Medical Executive Committee, acting on behalf of the Medical Staff, and shall become effective upon approval by the Board. Neither the Board nor the Medical Staff may unilaterally amend the Medical Staff Bylaws or Rules and Regulations. Notwithstanding anything to the contrary contained herein, the Board shall maintain responsibility and authority over the operation of the Medical Staff. In the event the Medical Staff refuses to amend their Bylaws or Rules and Regulations to comply with local, state or federal laws and regulations or applicable accreditation standards, the Board retains the authority to unilaterally amend the Medical Staff Bylaws and Rules and Regulations to so comply.

#### 13.2 *exclusive mechanism*

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

#### 13.3 *methodology*

##### 13.3.1 Medical Staff Bylaws

These Bylaws, including the Rules and Regulations, shall be adopted when approved by the Board of Director. Any Department, committee or member of the staff may propose amendments, revisions, modifications and restatements of these Bylaws. Such proposals shall be referred to the Bylaws Committee for evaluation. Any proposal approved by the Bylaws Committee shall be submitted to the Executive Committee for approval. If approved, the amendment will be communicated to the organized medical staff for review and vote; if approved by the medical staff the amendment will be submitted to the Board of Director for final approval. The Board of Director shall act on the recommendation of the Executive Committee within sixty (60) days. If approved by the Board of Director, the proposal shall become effective. Board of Director approval shall not be unreasonably withheld, but any decision of the Board of Director shall be final. Amendments, revisions, modifications, and restatements of these Bylaws shall be communicated to the entire Medical Staff within an appropriate timeframe.

##### 13.3.2 Rules and Regulations

Subject to approval by the Board, the Medical Executive Committee shall adopt such Rules and Regulations as may be necessary to implement these Bylaws. Rules and Regulations proposed by the Medical Executive Committee will be communicated to the voting members of the medical staff prior to submission to the Board for approval. The Rules and Regulations shall relate to the proper conduct of Medical Staff organizational activities and shall embody the level of practice required of each Staff appointee and individuals with clinical privileges.

##### 13.3.3 Amendments Proposed Directly to the Board of Director

The organized medical staff has the ability to adopt medical staff bylaws, rules and regulations, and policies, and amendments thereto, and to propose them directly to the governing body. If the voting members of the organized medical staff propose to do so, they must first communicate the proposal to the Medical Executive Committee.

##### 13.3.4 Conflicts Between the Organized Medical Staff and Medical Executive Committee

Should a conflict arise regarding proposed amendments, the Conflict Management Policy will be implemented.

#### 13.4 *technical, editorial and regulatory amendments*

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

13.4.2 In cases of a documented need for an urgent amendment to Rules and Regulations necessary to comply with law or regulation, the Medical Executive Committee may

provisionally adopt and the Board may provisionally approve an urgent amendment without prior notification of the medical staff. In such cases, the medical staff will be immediately informed by the Medical Executive Committee. The medical staff has the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the organized medical staff and the Medical Executive Committee, the provisional amendment stands. If there is conflict over the provisional amendment, the Conflict Management Policy will be implemented.

### 13.5 *general provisions*

#### 13.5.1 Successor in Interest

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

#### 13.5.2 Affiliations

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

#### 13.5.3 No Implied Rights

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

#### 13.5.4 Notices

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

#### 13.5.5 No Contract Intended

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

Notwithstanding the forgoing, the provisions of Article Thirteen and other provisions containing undertakings in the nature of an agreement or an indemnity or a release shall be considered contractual in nature, and not a mere recital and shall be binding upon Medical Staff applicants and members and individuals applying for or those granted clinical privileges in the Hospital.

#### 13.5.6 Conflict of Interest

Individuals shall disclose any conflict of interest, as defined by the Board, or potential conflict of interest in any transaction, occurrence or circumstance which exists or may arise with respect to his/her participation on any committee or in his/her activities in Medical Staff affairs, including in departmental activities and in the review of cases. Where such a conflict of interest exists or may arise, the individual shall not participate in the activity, or as appropriate, shall abstain from voting, unless the circumstances clearly warrant otherwise. This provision does not prohibit any person from voting for

himself/herself nor from acting in matters where all others who may be significantly affected by the particular conflict of interest consent to such action.

13.5.7 No Agency

Physicians, other practitioners, and other individuals with clinical privileges shall not, by virtue of these Bylaws or Medical Staff appointment, be authorized to act on behalf of, or bind the Hospital, and shall not hold themselves out as agents, apparent agents or ostensible agents of the Hospital, except where specifically and expressly authorized in a separate written contract with the Hospital.

13.5.8 Conflict

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

13.5.9 Entire Bylaws

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

14. certification of adoption and approval

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Approved and Adopted by the Medical Staff of Wadley Regional Medical Center on November 18, 2014

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CHIEF OF STAFF

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Approved and Adopted by the Board of Wadley Regional Medical Center on December 4, 2014

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SECRETARY OF THE BOARD

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