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DEFINITIONS

“Affiliate Hospital” means Greene Memorial Hospital.

“Allied Health Professional” or "AHP" means an individual other than a licensed Physician (allopathic or osteopathic), Podiatrist, Dentist, or Psychologist who functions in a medical support role or who exercises independent judgment within the area of his or her professional competence and is qualified to render direct or indirect medical, surgical, nursing, dental, pediatric, or psychological care under the supervision of or in collaboration with a Practitioner who has been accorded privileges for such care in the Hospital. These AHPs may include, but are not limited to, physician's assistants, advanced nurse Practitioners, or other individuals whose scope of practice has been recognized by the Hospital.

“Appointee” means a Practitioner who has been granted membership to the Medical Staff as defined by the assigned staff category.

“Board of Directors” or “Board” means the board of directors of the Hospital which is the Hospital’s governing body which holds ultimate responsibility for the Hospital.

“Bylaws” or “Medical Staff Bylaws” mean these Amended and Restated Bylaws of Greene Memorial Hospital, Inc., unless otherwise specifically stated, and consist of the document or group of documents adopted by the voting members of the organized Medical Staff and approved by the Board that constitute the basic governing documents of the Medical Staff, as may be amended from time to time.

“Centralized Credentialing Office” or “CCO” mean the Kettering Health Network Centralized Credentialing Office that acts as agent of the Credentials Committee to conduct certain credentialing functions for the Hospital as referenced in the Bylaws.

“Chief Executive Officer/President/CEO” or “President/CEO” means the individual appointed by the Board of Directors to act on its behalf in the overall management of the Hospital. The Medical Staff may rely upon all actions of the President/CEO as being authorized by the Board of Directors.

“Chief of Staff” means the individual elected by the Medical Staff to be the spokesperson for the Medical Staff and chair of the Medical Executive Committee.

“Clinical Privileges” or “Privileges” means the authorization granted by the Board of Directors pursuant to the Bylaws to a Practitioner or AHP to provide specific patient care services at the Hospital within defined limits.

“Department Chief” or “Section Chief” means the Practitioner elected in accordance with the Bylaws and Manuals to manage the day-to-day affairs of a designated Department or Section.

“Dentist” means an individual who has received a doctor of dental medicine or doctor of dental surgery degree and is currently licensed to practice dentistry and whose practice is in the area of oral and maxillofacial surgery or the area of general dentistry or a specialty thereof.
“Department” means a clinical division of the Medical Staff as set forth in the Bylaws.

"Emergency Department Call" means a process whereby, except for honorary and retired Staff, the ongoing responsibilities of each member of the Medical Staff shall include participating in emergency service coverage or consultation, when scheduled, as may be determined by the Medical Staff. The ED physicians are provided with a list of specialists with knowledge and training beyond that of the ED physician. The on-call physicians are to be available to provide consultation in their areas of expertise when requested by the ED physician and without regard either of payor class or to pre-existing physician-patient relationships. If the ED physician believes that a prior physician-patient relationship would best facilitate prompt care of the patient, the ED physician may choose to consult that prior physician, but this does not remove the responsibility of the on-call physician to provide further expertise in his/her subspecialty and admit patients consistent with his/her privileges as needed. ER call is not intended for the sole purpose of providing physicians for unassigned patients, although such is a component of the above responsibilities.

“Ex Officio” means appointment to a body by virtue of an office or position held. Ex Officio members shall not be counted for purposes of determining a quorum nor shall they have voting rights unless a specific provision provides otherwise.

“Federal Health Program” means Medicare, Medicaid, TriCare, or any other federal or state program providing health care benefits that is funded directly or indirectly by the United States government.

“Good Standing” means a Practitioner, who, during the current term of appointment, with or without privileges, has maintained qualifications for Professional Staff Membership and assigned staff category and has no corrective actions.

“Hospital” means Greene Memorial Hospital, Inc.

“Joint Conference Committee” means an ad hoc committee of officers of the Medical Staff and officers of the Board of Directors whose function is to address issues of direct or potential conflict between the hospital board and the medical staff, and to facilitate communication between the Board and the Medical Staff.

“KHN” means Kettering Health Network.

“Manual” means those documents approved by the Medical Executive Committee and the Board which serve to implement and supplement the Medical Staff Bylaws including, but not limited to, the Medical Staff Credentials Policy Manual, the Medical Staff Organization Manual, and the Rules and Regulations.

“Medical Executive Committee” or “MEC” means the executive committee of the Medical Staff.

“Medical Staff” means all allopathic Physicians, osteopathic Physicians, Dentists (including Oral Surgeons), Podiatrists, and Psychologists who have obtained appointment status at the Hospital with such responsibilities, Prerogatives, and Privileges as defined in the category to which each has been appointed.
“Medical Staff Bylaws” or “Bylaws” means the articles and amendments that constitute the basic governing documents of the Medical Staff.

“Medical Staff Year” means the period from January 1 to December 31 each year.

“Oral Surgeon” or “Maxillofacial Surgeon” means a Practitioner who has successfully completed an accredited post-graduate/residency program in oral/maxillofacial surgery.

“Patient Encounter” means (a) in the inpatient setting, an inpatient admission, consultation, (resulting in not less than a progress note), or surgery/invasive procedure; (b) in the outpatient setting, treatment or consultation resulting in not less than a progress note, or surgery/invasive procedure; or (c) treatment in the Emergency Department resulting in not less than a progress note.

“Physician” means an individual who has received a doctor of allopathy degree or doctor of osteopathy degree.

“Podiatrist” means an individual who has received a doctor of podiatric medicine (D.P.M.) degree.

“Practitioner” means, unless otherwise expressly provided, a Physician, Dentist, Podiatrist, or Psychologist.

“Prerogative” means the right to participate, by virtue of Medical Staff category or otherwise, granted to an Appointee or Allied Health Professional, and subject to the ultimate authority of the Board, and the conditions and limitations imposed in these Bylaws, Manuals, and in other Hospital and Medical Staff policies.

“Professional Liability Insurance” means insurance coverage acceptable to the Board as the Board may determine from time to time by an insurance company licensed in the United States or having coverage by a company who has an underwriting agreement with a licensed U.S. insurance company to assure adequate reserves for payment of claims.

“Professional Review Activity” means an activity of a health care entity (as defined in the Health Care Quality Improvement Act of 1986 (“HCQIA”) and Ohio Revised Code §§ 2305.25, et seq. with respect to a Practitioner to determine whether such Practitioner may have Privileges with respect to, or appointment to, the Hospital; or to determine the scope or conditions of such Privileges or appointment; or to change or modify such Privileges or appointment; or for purposes as otherwise set forth in the Ohio Revised Code.

“Professional Review Body” means the Hospital, its Board, and any committee of the Hospital or the Medical Staff and the governing body or any committee of a health care entity that conducts Professional Review Activities and includes, but is not limited to, any committee of the medical staff of such an entity when assisting the governing body in a professional review activity, and other committees as defined by Ohio Revised code §§2305.25, et seq.
“Psychologist” means an individual with a doctoral degree in psychology or a doctoral degree deemed equivalent by the Ohio State Board of Psychology who is currently licensed to practice psychology.

“Section” means a clinical division of the Department as defined in these Bylaws and Manuals.

“Special Notice” means written notification (a) sent by certified mail, return receipt requested; or (b) delivered personally with the affected individual either signing as proof of receipt or other written documentation from the individual delivering the notice as to why signature was not obtained.

“Telemedicine” means the use of medical information exchanged from one site to another via electronic communication or other communications technologies for the health and education of the patient or healthcare provider, and for the purpose of providing, supporting, or improving patient care.

“Unassigned Patient” means any individual who comes to the Hospital for care and treatment who does not have an attending Practitioner; or whose attending Practitioner or designated alternate is unavailable to attend to the patient; or who does not want the prior attending Practitioner to provide care during the current Hospital encounter.

“Vice President of Medical Affairs (VPMA) or Chief Medical Officer (CMO)” means the Practitioner as may be appointed by the Board or designee, in conjunction with the medical staff, to act in this capacity.

Words used in these Bylaws shall be read as the singular or plural, as the content requires. The captions or headings are for convenience only and are not intended to limit or define the scope or effect of any provision of these Bylaws.

Whenever an individual is authorized to perform a duty by virtue of his or her position, then the term shall also include the individual’s designee.

In computing any period of time set forth in the Medical Staff governing documents, the date of the act from which the designated period of time begins to run shall not be included. The last day of the period shall be included unless it is a Saturday, Sunday, or legal holiday, in which event the period runs until the end of the next day which is not a Saturday, Sunday, or legal holiday. When the period of time is less than seven (7) days, intermediate Saturdays, Sundays, and legal holidays shall be excluded.
ARTICLE 1.
PREAMBLE & PURPOSES

These Bylaws, as adopted or amended, create a system of mutual rights and responsibilities between Practitioners and the Hospital, and are subject to the corporate authority of the Board in those matters where the Board has ultimate legal responsibility. These Bylaws are not intended to be and are not to be construed as a contract.

The purposes of this Medical Staff are to:

a. Provide a mechanism for accountability to the Board through defined organizational components and positions for the appropriateness of patient care services and the professional and ethical conduct of each Practitioner appointed to the Medical Staff and each Practitioner/AHP granted Privileges at the Hospital, to the end that patient care provided at the Hospital is maintained at that level of quality and efficiency which is commensurate with, or superior to, professionally accepted standards of care.

b. To serve as the collegial body through which Practitioners and AHPs may, as applicable, obtain Prerogatives and Privileges at the Hospital, fulfill their obligations of Medical Staff appointment and/or Privileges, and practice in an environment that promotes quality and efficient patient care.

c. To provide on behalf of the Hospital an appropriate educational setting and to maintain high scientific and educational standards for continuing medical education programs for Practitioners.

d. To provide an orderly and systematic means by which Appointees can give input to the Board and President/CEO on medico-administrative problems and on the Hospital's policy-making and planning processes.

e. To initiate, maintain, and enforce the Medical Staff Bylaws, other related medical staff governance documents and policies for self-governing of the Medical Staff.

f. Assume accountability to the Board for the quality of medical care provided by an Appointee to the patients, which may include the following:

- Acting on reports of Departments and committees of the Medical Staff;
- Provide reports to the Board regarding medical staff appointments, reappointments, and privilege delineations;
- Provide reports to the Board regarding medical staff behaviors that result in suspension or other corrective action, and any fair hearing results;
- Provide reports to the Board of organizational proposals including, Bylaws and other related manuals of the Medical Staff and Medical Staff Officers;
• Accountability to the Board for findings from ongoing competency review and professional practice evaluations of the clinical work of the Medical Staff; and

• Collaborating with administration and the Board regarding institutional planning, budgeting and appropriate utilization of available resources.

g. To fulfill professional and institutional obligations with respect to education of patients, staff, students, and our community.

h. To carry out the responsibilities delegated to it by the Board within the framework, principals and procedures set forth in the Bylaws and Manuals.
ARTICLE 2.
MEDICAL STAFF APPOINTMENT

SECTION 2.1. NATURE OF MEDICAL STAFF APPOINTMENT

Appointment to the Medical Staff and/or granting of Privileges at the Hospital is a privilege that shall be extended only to professionally competent Practitioners who continuously meet the qualifications, standards, and requirements set forth in these Bylaws. Appointment to the Medical Staff is separate and distinct from a grant of Privileges. A Practitioner can be a Medical Staff Appointee with Privileges; a Medical Staff Appointee without Privileges; or be granted Privileges without a Medical Staff appointment. A Practitioner who is granted Medical Staff appointment is entitled to such Prerogatives and is responsible for fulfilling such obligations as set forth in these Bylaws and the Medical Staff category to which the Practitioner is appointed. Medical Staff appointment shall confer only such Privileges as are granted in accordance with these Bylaws. A Practitioner who is granted Privileges at the Hospital is entitled to exercise such Privileges and is responsible for fulfilling such obligations as set forth in these Bylaws and the applicable Privilege set.

SECTION 2.2. QUALIFICATIONS FOR APPOINTMENT

2.2.1. In General. Only Physicians, Dentists, Psychologists, or Podiatrists, holding a license to practice in the State of Ohio(for military Practitioner’s on assignment at the Hospital pursuant to a contractual arrangement, such Practitioner’s current, unrestricted license to practice medicine issued by any jurisdiction accepted by the Department of Defense shall be deemed valid licensure in Ohio in accordance with Ohio’s statue found at O.R.C § 4731.36); who can document their background, licensure, experience, training/education, judgment, individual character, and demonstrated current competence; ability to exercise the privileges requested with or without a reasonable accommodation (health status); adherence to the ethics of their profession; and ability to work cooperatively with others with sufficient adequacy to assure the Medical Staff and the Board that any patient treated by them in the Hospital will be given a high quality of health care, shall be qualified for appointment to the Medical Staff. Any criminal records check that is performed must not evidence convictions of certain offenses that would act to disqualify an applicant from consideration for appointment or reappointment to the Medical Staff. No Practitioner, including those in a medico-administrative position by virtue of a contract with the Hospital, shall treat or otherwise provide medical care to a patient in the Hospital unless the Practitioner is an Appointee and has been granted privileges to do so. No Practitioner shall be entitled to appointment to the Medical Staff or to exercise privileges in the Hospital merely by virtue of the fact that the Practitioner is duly licensed to practice medicine, dentistry, psychology, or podiatry in this or any other state; or solely based upon certification, fellowship or membership in a specialty body or society; or that the Practitioner had in the past, or now has, such privileges at another hospital.

2.2.2. Eligibility.

a. Proof of Professional Liability Insurance consistent with the type and amount specified by the Board. For military Practitioner’s on assignment at the Hospital
pursuant to a contractual arrangement, the provisions of the Federal Torts Claims Act (28 U.S.C § 1346(b), 2671-2680 related to professional liability are accepted as adequate as to type and amount of professional liability coverage

b. Proof of current licensure or registration and verification of not currently being excluded for cause by the secretary of Health and Human Services from participation in any Federal Health Program as a provider, pursuant to §1128 (42 U.S.C. 1320a-7).

c. For appointment of a Physician or Podiatrist to the active or courtesy Medical Staff category, documentation of experience and training, including completion of a residency approved by Accreditation Council for Graduate Medical Education (ACGME”), American Board of Medical Specialties (“ABMS”), or American Osteopathic Association (“AOA”).

d. For appointment of a Physician or Podiatrist to the active or courtesy Medical Staff category, applicants must be currently board certified and/or subspecialty certified by a member board of the ABMS, a member board of the American Osteopathic Association Bureau of Osteopathic Specialists (“AOABS”), the American Board of Oral & Maxillofacial Surgery (“ABOMS”), the American Board of Podiatric Surgery (“ABPS”), or the American Board of Podiatric Orthopedics and Primary Podiatric Medicine (“ABPOPPM”); or an applicant must have within the last six (6) years completed a post-graduate training program which qualifies the applicant to seek certification by one of these certifying organizations. New post-graduate training program graduates are expected to become certified before six (6) years have transpired since the date of completion of their latest residency or fellowship training (or within such timeframe as may be required by the particular certifying board; excluding Dentists). All Members (excluding Dentists) and all Privilege holders who are required by these Bylaws to attain board certification and/or subspecialty certification by a member board of the ABMS, AOABS, ABOMS, ABPS, or ABPOPPM must also continuously maintain at least one current board certification and/or subspecialty certification for the duration of his/her medical staff membership.

e. All applicants must evidence good moral character as evidenced, in part, by the absence of convictions or pleas of no contest for certain criminal offenses.

SECTION 2.3. NONDISCRIMINATION

Neither the Hospital nor its Medical Staff will discriminate in granting Medical Staff appointment or privileges on the basis of sex, race, creed, national origin, and handicap or other considerations not impacting the applicant’s ability to discharge the Privileges for which he/she has applied.
SECTION 2.4. CONDITIONS AND DURATION OF APPOINTMENT

2.4.1. Appointment and Reappointment. Initial appointment and reappointment to the Medical Staff and the granting/regranting of Privileges shall be made by the Board of Directors and as otherwise provided in these Bylaws. The Board shall act on appointment, reappointment, and Privileges only after there has been a recommendation from the Medical Executive Committee or as otherwise provided in these Bylaws. All individuals and committees required to act on an application for Medical Staff appointment must do so in a timely manner and, except for good cause, each application should be processed within one hundred twenty (120) days from receipt of an application determined to be complete.

2.4.2. Term. Appointments to the Medical Staff and grants of privileges will be for no more than twenty-four (24) calendar months. Appointments and/or grants of Privileges for a period of less than twenty-four (24) calendar months shall not be deemed adverse.

2.4.3. Prerogatives. Appointment to the Medical Staff shall confer on the Appointee only Prerogatives as have been granted in accordance with these Bylaws.

SECTION 2.5. MEDICAL STAFF DUES

2.5.1. Dues. Annual Medical Staff dues shall be governed by the most recent action recommended by the Medical Executive Committee and adopted at a regular or special Medical Staff meeting. The Chief of Staff shall notify each Appointee, in writing, of any contemplated change in Medical Staff dues at least twenty-one (21) days before the meeting at which voting on such proposed change is to take place.

2.5.2. Exceptions. Consulting Peer Review, Retired, and Honorary Medical Staff Appointees are not required to pay dues.

2.5.3. Payment. Dues, if required, shall be due and payable within thirty (30) days of written request. A failure to pay Medical Staff dues shall result in an automatic suspension consistent with these Bylaws.

SECTION 2.6. ETHICAL REQUIREMENTS

A Practitioner who accepts appointment to the Medical Staff and/or Privileges agrees to act in an ethical, professional, and courteous manner consistent with the Hospital’s code of ethics as well as any applicable ethics of the Practitioner’s professional association and related Hospital and Medical Staff Bylaw provisions and policies.

No Appointee shall either receive from or pay to another Physician, either directly or indirectly, any part of a fee received for professional services that are in violation of applicable state and federal laws and regulations.

A medical history and physical must be completed and documented for each patient no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical
examination must be completed and documented by a Physician, Oral Maxillofacial Surgeon, or other qualified licensed individual in accordance with State law and hospital policy. An updated examination of the patient, including any changes in the patient’s condition, must be completed and documented within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination are completed within thirty (30) days before admission or registration. The updated examination of the patient, including any changes in the patient’s condition, must be completed and documented by a Physician, Oral Maxillofacial Surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

If other qualified Practitioners perform any part of the physical examination and medical history (other than a Podiatrist’s podiatric portion or a Dentist’s dental portion), the Physician shall sign for and assume full responsibility for this activity. See Organization Manual, Rules and Regulations for additional information.

SECTION 2.7. RESPONSIBILITIES OF APPOINTMENT & EXERCISE OF PRIVILEGES

Each Practitioner may independently direct the care of his/her patients within the scope of the Practitioner’s Privileges subject to the Medical Staff Bylaws, Organization Manual, Credentials Policy Manual, and any other applicable policies. Each Practitioner with Privileges is subject to review as a part of the Hospital’s performance improvement activities. No Practitioner is responsible for the actions of other Practitioners or AHPs unless the individual is practicing in collaboration with or under the supervision of such Practitioner. No Practitioner is responsible for the actions of Hospital employees unless the Practitioner contracts, in writing, to undertake such responsibility.

SECTION 2.8. QUALIFICATIONS/RESPONSIBILITIES FOR APPOINTMENT WITHOUT PRIVILEGES

Practitioners appointed to non-privileged Medical Staff categories shall meet such qualifications and fulfill such obligations as set forth in the applicable Medical Staff category and/or as otherwise recommended by the MEC and approved by the Board.
ARTICLE 3.
CATEGORIES OF THE MEDICAL STAFF

SECTION 3.1. ACTIVE MEDICAL STAFF

Appointment to the Active Medical Staff will be provisional for at least one (1) year pending satisfactory clinical performance and fulfillment of other Medical Staff requirements as determined by the Credentials Committee and Medical Executive Committee, and as approved by the Board. Active Appointees consist of those Physicians, Dentists, Podiatrists, and Psychologists who engage in significant clinical practice or at the Hospital. Hospital-based Practitioners who are either employed by the Hospital or have exclusive contracts for the provision of patient care at the Hospital must meet the qualifications for active Medical Staff. Practitioners who request “refer and follow” Privileges only have the option of requesting appointment to the Active Medical Staff or to the Associate Medical Staff.

3.1.1. Qualifications. Appointees to this category must:
   a. Meet all qualifications for Medical Staff appointment as set forth in Section 2.2.
   b. Actively participate in Medical Staff activities and responsibilities, such as committee and Department assignments.
   c. Provide evidence of clinical performance at all other hospitals in which they practice in such form as the Hospital may reasonably request. In addition, they shall provide other information as the Hospital may reasonably require in order to be able to appropriately evaluate the Appointee’s qualifications.

3.1.2. Prerogatives. Appointees to this category may:
   a. Admit, treat and consult on patients without limitation, in accordance with the Privileges granted, except as otherwise provided in the Medical Staff Bylaws, Manuals, or by specific privilege restriction.
   b. Attend meetings of the Medical Staff and of the Department or Section of which the Practitioner is member as well as Medical Staff or Hospital education programs.
   c. Vote on all matters presented at general and special meetings of the Medical Staff, and of the Department or Section and committee(s) of which the Practitioner is a member.
   d. Hold Medical Staff office, serve as a Department Chief, and sit on or be the chair of any committee, unless otherwise specified in these Bylaws.
   e. Participate in Hospital and Medical Staff education programs as appropriate.
3.1.3. **Responsibilities.** Appointees to this category must:

   a. Contribute to the organization and administrative affairs of the Medical Staff.
   
   b. Actively participate in recognized functions of Medical Staff appointment, including performance improvement, peer review, and other monitoring activities; proctor Appointees during their provisional period or when new privileges are granted; and discharge other Medical Staff functions as may be required from time to time.
   
   c. Participate in the care of unassigned patients, Emergency Department Call, consultation and other specialty coverage programs, as requested by the Medical Staff, Administration, or Board. Practitioners with unique or scarce expertise are expected to collegially assist other Practitioners when urgent patient care needs arise. This assistance is not intended to be unreasonably burdensome. Active Appointees who request and are granted “refer and follow” Privileges only shall not be required to comply with this requirement.
   
   d. Attend applicable meetings.
   
   e. Serve on Medical Staff committees, as assigned.
   
   f. Faithfully perform the duties of any office or position to which elected or appointed.
   
   g. Pay all application fees, dues, and assessments that may be enacted by the Medical Executive Committee.

**SECTION 3.2. COURTESY MEDICAL STAFF**

Appointment to the Courtesy Medical Staff will be provisional for at least one (1) year pending satisfactory clinical performance and fulfillment of other Medical Staff requirements as determined by the Credentials Committee and Medical Executive Committee, and approved by the Board.

3.2.1. **Qualifications.** Appointees to this category must:

   a. Meet all qualifications for Medical Staff appointment as set forth Article II, Section 2.
   
   b. Have not more than fifty (50) Patient Encounters in a consecutive twenty-four (24) month period (not including referrals to the Hospital's diagnostic facilities, access to which is unlimited). Practitioners who have more than fifty (50) Patient Encounters will automatically be transferred to the active Medical Staff.
   
   c. Provide evidence of clinical performance at all other hospitals in which they practice, in such form as the Hospital may reasonably request. In addition, they
shall provide other information as the Hospital may reasonably require in order to be able to appropriately evaluate the Appointee’s qualifications.

3.2.2. **Prerogatives.** Appointees to this category:

a. May admit, treat, and consult on patients without limitation, based on applicable Privileges, except as otherwise provided in the Medical Staff Bylaws, Manuals, or by specific Privilege restriction.

b. May attend Medical Staff meetings (without vote).

c. May attend applicable Department/Section meetings (without vote).

d. May be invited to serve on committees (with vote).

e. May not hold office or serve as a Department Chief or committee chair.

f. Are excused from the care of unassigned patients and from Emergency Department Call (unless there is a determination by the applicable Department or Section Chief, Medical Executive Committee, Administration, and/or the Board that courtesy Medical Staff Appointees of a particular Department or Section must participate in these responsibilities).

g. Must participate in performance improvement, monitoring, and peer review activities, including responding fully and timely to any inquiries regarding the care of patients.

h. Must pay all application fees, dues and assessments, which may be enacted upon by the Medical Executive Committee.

3.2.3. **Responsibilities.** Appointees to this category have the same responsibilities as active Medical Staff, if requested.

**SECTION 3.3. ASSOCIATE MEDICAL STAFF**

**Appointment Only**

3.3.1. **Qualifications.** Appointees to the Associate Medical Staff category shall consist of those Practitioners who desire to be affiliated with the Hospital, but who do not intend to provide patient care at the Hospital. The primary purpose of the Associate Medical Staff category is to promote professional and educational opportunities, including continuing medical education endeavors, and to allow such Practitioners to refer patients to other Practitioners for admission, evaluation, and/or care and treatment. Appointees to this category must meet the general qualifications for appointment but shall not be required to maintain Professional Liability Insurance or to otherwise provide documentation establishing current clinical competence.

3.3.2. **Prerogatives.** Appointees to this category:
a. May attend meetings of the Medical Staff and appropriate Department or Section (without vote).

b. Have no Medical Staff committee responsibilities, but may be assigned to special committees (with vote).

c. May attend educational programs of the Medical Staff.

d. May refer patients to Appointees of the active and courtesy Medical Staff for admission and/or treatment.

e. May visit their patients when hospitalized and review their medical records (provided the patient consents), but may not write orders, make medical record entries, or otherwise actively participate in the provision or management of care to patients.

f. May refer patients to the Hospital's diagnostic and treatment facilities.

g. May not be granted Privileges and may not admit or treat patients at the Hospital.

3.3.3. Responsibilities. Appointees to this category:

a. Must pay all application fees, dues and assessments that are enacted by the Medical Executive Committee.

SECTION 3.4. AFFILIATE MEDICAL STAFF

Appointment to the Affiliate Medical Staff is for Practitioners who are appointed to the active medical staff at an Affiliate Hospital. Appointments to this category will be automatic upon appointment to the active medical staff at an Affiliate Hospital and shall be without Privileges. The primary purpose of this category is to provide for broad collaboration between affiliate medical staffs to promote and further effective peer review and quality of care to patients. Practitioners automatically appointed to this category may apply for Medical Staff appointment in a different category if they qualify and desire to be so appointed or seek Clinical Privileges.

3.4.1. Qualifications. An Affiliate Medical Staff Appointee must meet the following criteria:

a. Have an active appointment with Privileges at an Affiliate Hospital.

3.4.2. Prerogatives.

a. May attend meetings of the Medical Staff and appropriate Department or Section (without vote).

b. Have no Medical Staff committee responsibilities, but may be assigned to special committees (with vote).

c. May attend educational programs of the Medical Staff.
d. May refer patients to Appointees of the active and courtesy Medical Staff for admission and/or treatment.

e. May visit their patients when hospitalized and review their medical records (provided the patient consents), but may not write orders, make medical record entries, or otherwise actively participate in the provision or management of care to patients.

f. May refer patients to the Hospital's diagnostic and treatment facilities.

g. May not be granted Privileges and may not admit or treat patients at the Hospital.

h. May not hold Medical Staff office or serve as a Department or Section Chief, except that they may serve as Vice-Chief at Large.

3.4.3. Responsibilities

a. If requested, serve on committees (including acting as committee chair) with vote.

SECTION 3.5. CONSULTING PEER REVIEW MEDICAL STAFF

3.5.1. Qualifications. A Consulting Peer Review Medical Staff Appointee must meet the following criteria:

a. Practice either locally or in another city and state in which he or she has a valid license to practice.

b. Possess specialized skills needed at the Hospital for a specific project or on an occasional basis when requested by Hospital administration, Chief of Staff, Medical Staff committee, or the Board.

c. Demonstrate active participation on the active medical staff at another hospital requiring performance improvement/quality assessment activities similar to those of this Hospital unless the nature of the services being requested do not require that the Practitioner have such experience.

3.5.2. Prerogatives. Appointees to this category:

a. May review selected medical record components, organization information, and peer review materials retained by the Hospital for the purpose of rendering an opinion on the quality of health care rendered to patients at the Hospital or otherwise perform related peer review services as specifically requested.

b. May be requested to attend Medical Staff meetings or attend certain committee or Department meetings.

c. May not be granted Privileges and may not admit or treat patients to the Hospital.

d. May not be permitted to hold office or to vote.
3.5.3. **Responsibilities.** A Consulting Peer Review Medical Staff Appointee shall perform such duties as are requested and which he or she agrees to perform.

**SECTION 3.6. PROBATIONARY MEDICAL STAFF STATUS**

The Medical Executive Committee may impose a probationary Medical Staff status (different than the provisional period required for the first year of active and courtesy Medical Staff categories) for corrective action issues related to privileges and/or for non-clinical reasons. Probationary status shall not constitute a limitation on Privileges, Prerogatives, or obligations of appointment. The Medical Executive Committee shall define the time period (not longer than one (1) year) and the expected requirements of a successful probationary period. If the Appointee does not successfully fulfill the requirements of the probationary period as determined by the Medical Executive Committee, the Medical Executive Committee may initiate corrective action in accordance with these Bylaws.

**SECTION 3.7. EMERITUS MEDICAL STAFF**

3.7.1. **Qualifications.** The Retired Medical Staff shall consist of Practitioners who have retired from active practice and who, at the time of their retirement, were Appointees in Good Standing to the Medical Staff, and who continue to adhere to appropriate professional and ethical standards. They shall have no Privileges and shall be exempt from all Medical Staff qualifications and requirements. Requests for appointment to the Retired Staff will be directed to the MEC and shall be a lifetime appointment.

3.7.2. **Prerogatives.** Appointees to this category:

   a. Shall not be eligible to have Privileges, to vote, to hold office, or to serve on standing Medical Staff Committees.

   b. May attend educational programs at the Hospital.

   c. May be requested to sit on an ad hoc committee of the Medical Staff. If so appointed, they may participate on such committee with vote.

3.7.3. **Responsibilities.** Appointees to this category shall have no responsibilities other than, if appointed to a committee, to act consistent with that committee’s responsibilities.

**SECTION 3.8. CLINICAL PRIVILEGES ONLY**

3.8.1. **Qualifications.** Practitioners to the Clinical Privileges Only category shall consist of those Practitioners who desire to have Clinical Privileges at the Hospital, but who do not desire Medical Staff appointment. Clinical Privileges only is limited to those Practitioners who provide health care services to patients in either a locum tenens, telemedicine, and/or proctoring capacity or residents who desire an opportunity to obtain Privileges to moonlight in the Emergency Services Department, or military Practitioners who are officially assigned to perform authorized duties for the Department of Defense at the Hospital pursuant to a contractual arrangement.
a. Meet all qualifications for Medical Staff appointment as set forth in Article II, Section 2 with the exception of residents who will not have yet fulfilled the criteria in Article II, Section 2.2.2 (c) and (d).

b. Provide evidence of clinical performance at all other hospitals and healthcare organizations in which they practice, in such form as the Hospital may reasonable request. In addition, they shall provide other information as the Hospital may reasonably require in order to be able to appropriately evaluate the Practitioner’s qualifications.

3.8.2. **Prerogatives.** Practitioners in this non-appointment category:

a. May admit and consult on patients without limitation, except as otherwise provided in the Medical Staff Organization Manual or by specific privilege restriction.

b. May participate in Hospital and Medical Staff education programs as appropriate.

c. Have no Medical Staff committee responsibilities, but may be assigned to special committees (with vote).

d. May refer patients to Appointees of the active and courtesy Medical Staff for admission and/or treatment.

e. Have no procedural due process rights pursuant to the Medical Staff Bylaws.

3.8.3. **Responsibilities.** Practitioners in this non-appointment category:

a. May participate in the care of unassigned patients, Emergency Department Call, consultation and other specialty coverage programs, as requested by the Medical Staff, Administration, or Board. Practitioners with unique or scarce expertise are expected to collegially assist other Practitioners when urgent patient care needs arise. This assistance is not intended to be unreasonably burdensome.

b. May attend applicable meetings.

c. Must pay all application fees and assessments that may be enacted by the Medical Executive Committee.
ARTICLE 4.
OFFICERS

SECTION 4.1. OFFICERS OF THE MEDICAL STAFF

4.1.1. The officers of the Medical Staff shall be:

- Chief of Staff
- Chief of Staff-Elect
- Immediate Past Chief and Credentials Chair
- Secretary/Treasurer

SECTION 4.2. QUALIFICATION OF OFFICERS

4.2.1. Officers must:

   a. Be current Appointees to the Active Medical Staff.

   b. Have held a Medical Staff leadership position at this/or another hospital for at least two (2) years within the past previous five (5) consecutive years or been on the Active Medical Staff at the Hospital for at least the previous five (5) consecutive years.

   c. Be in Good Standing at the time of nomination and election.

   d. Remain Active Appointees in Good Standing during their terms of office.

   e. Be currently board certified (and maintain such current board certification during their terms of office) as specified by the American Board of Medical Specialties, the American Osteopathic Association, the American Board of Oral and Maxillofacial Surgery, the American Board of Podiatric Surgery, or the American Board of Primary Podiatric Medicine & Orthopedics.

   f. Have no pending adverse recommendations concerning Medical Staff appointment or Clinical Privileges.

   g. Have demonstrated an ability to work well with others, be in compliance with the KHN Code of Ethics and the Hospital Code of Conduct, and have demonstrated administrative and communication skills.

The authority and responsibilities including specific functions and tasks of Medical Staff officers are set forth in the Medical Staff Organization Manual. The general duties of the Medical Staff officers are outlined in this Article 4. Except for holding a leadership position at another KHN hospital and/or KHN facility, Medical Staff officers may not simultaneously hold a leadership position on any other hospital’s medical staff or at a facility that directly competes with the Hospital. Noncompliance with this requirement will result in the officer being automatically removed from office unless the Board determines that allowing the officer to maintain the
position is in the Hospital’s best interest. The board shall have the discretion to determine what constitutes a leadership position at another hospital or facility.

SECTION 4.3. ELECTION OF OFFICERS

4.3.1. General. Officers shall be elected bi-annually, according to the process described in this section with results announced and confirmed at a meeting of the Medical Staff. Only active Appointees shall be eligible to vote. Upon completion of the Chief of Staff term, the Chief of Staff-Elect automatically becomes Chief of Staff, the Chief of Staff will automatically become the Credentials Chair and the Secretary/Treasurer will advance to Chief of Staff Elect.

4.3.2. Nominating Committee. The nominating committee shall be appointed by the MEC and shall consist of the Chief of Staff, the Chief of Staff-Elect, two (2) other members of the Medical Executive Committee, and two (2) other active Appointees who are not then members of the MEC. The nominating committee will review qualification and will present a panel of candidates to the MEC for approval no later than two (2) months prior to the meeting at which confirmation will occur. When approved, the names of the nominees will be distributed to all active Appointees.

4.3.3. Additional Nominations. Within thirty (30) days of distribution, additional nominations may also be made by petition signed by ten percent (10%) of active Appointees. Such petition must be submitted to the Chief of Staff who shall then include these nominations on the distributed ballot.

4.3.4. Ballots. Ballots will be provided by mail or electronic means to active Appointees no later than thirty (30) days prior to the annual meeting. Ballots must be received by the Medical Staff Office no later than seven (7) days prior to the meeting at which the election is to be held.

4.3.5. Disclosure of Conflicts. All nominees for election or appointment to Medical Staff offices at the time of nomination shall disclose in writing to the MEC and nominating committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware that could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff. Such disclosures will be provided with the ballot.

SECTION 4.4. TERM OF OFFICE

All elected officers will serve a term of two (2) years. Officers shall take office on the first day of the calendar year. Anticipated progression will occur unless extenuating circumstances make that unfeasible. An officer may serve an unlimited number of consecutive terms, if circumstances warrant
SECTION 4.5. VACANCIES IN OFFICE

Vacancies in office during the Medical Staff year, except the office of the Chief of Staff, shall be filled by the MEC. If there is a vacancy in the office of the Chief of Staff, the Chief of Staff-Elect shall serve the remainder of the term, and then may serve his/her own term as Chief of Staff.

SECTION 4.6. DUTIES OF OFFICERS

4.6.1. Chief of Staff. The purpose of this position is to provide overall leadership and guidance to the Medical Staff. Additionally, it is essential that the Chief of Staff promote effective communications among the Medical Staff, Medical Executive Committee, Administration, and the Board. The Appointee occupying this position will be responsible for Medical Staff Bylaws implementation, Medical Staff involvement in securing and maintaining Hospital accreditation, providing information to the Board concerning matters that pertain to the care and treatment of patients, and generally facilitating positive relationships among administration, the Medical Staff, and other support services of the Hospital.

4.6.2. Chief of Staff-Elect. The purpose of this position is to provide continuity in leadership during times when the Chief of Staff is absent or otherwise unable to perform his/her assigned functions. The Chief of Staff-Elect will be expected to remain knowledgeable about all Medical Staff issues of current Medical Staff interest. At the conclusion of the term of the Chief of Staff, the Chief of Staff-Elect will succeed as Chief of Staff.

4.6.3. Immediate Past Chief and Credentials Chair. To provide oversight for the Hospital’s credentials program and direction to the Board in credentialing Practitioners and Allied Health Professionals, and to maintain compliance with the credentialing policies of the Hospital, applicable accrediting body, and applicable law.

4.6.4. Secretary/Treasurer. The purpose of this office is to serve as Secretary/Treasurer for the Medical Staff as well as other duties that may be assigned by the Chief of Staff.

Please refer to the Organization Manual for details as to the position requirements, accountabilities, and functions.

SECTION 4.7. REMOVAL FROM OFFICE

Any officer of the Medical Staff may resign at any time by giving written notice to the Medical Executive Committee. Such resignation shall take effect on the date of receipt or at any later time specified therein.

Any officer of the Medical Staff may be removed from office for conduct detrimental to the interests of the Medical Staff (malfeasance in office) or for failure to fulfill the duties of the office. A request for the removal of any officer must be made in writing by the Board, the Medical Executive Committee, or twenty-five percent (25%) of the active Appointees to the Medical Staff Services Department. The request for removal shall state the basis for the request and shall be signed by an appropriate member of the Board, the Medical Executive Committee,
or a petition signed by each of active Appointee requesting the removal. The Medical Staff Services Department shall deliver a copy of the written request to the officer. Within thirty (30) days of receiving said request, a special meeting of the active Medical Staff shall be held at which time the affected officer may present his/her position as to why he/she should remain in office. No officer shall be removed from office without a majority vote in favor of removal by active Appointees. Vote may be taken at the meeting or for such additional period of time, by written ballot, as determined by the Chief of Staff. Any removal from such office shall in no way affect the officer’s Clinical Privileges, nor would the officer be afforded any procedural rights set forth in Article 9 on account of such removal.
ARTICLE 5.
MEDICAL STAFF STRUCTURE

SECTION 5.1. ORGANIZATION OF THE MEDICAL STAFF

5.1.1. Medical Executive Committee. The MEC shall be responsible for the promotion of quality of care at the Hospital and reviewing the professional performance of Practitioners and AHPs rendering care at the Hospital. The MEC shall constitute the governing body of the Medical Staff as described in these Bylaws.

5.1.2. Departments. The following groups of Practitioners have been organized into Departments:

- Anesthesiology
- Cardiology
- Emergency Medicine
- Primary Care
  - (1) Family Medicine
  - (2) Pediatrics
- Diagnostic Radiology
- Internal Medicine
- Orthopedics
- Obstetrics and Gynecology
- Pathology
- Surgery

Other groups may elect to organize in the future with the approval of the Medical Executive Committee.

5.1.3. Organization. Organized Departments must select a Department Chief and an Assistant Department Chief (“Assistant Chief”), each to serve for a two (2) year term (which may be repeated for an unlimited number of terms). Should the Department be unable to elect a Chief or Assistant Chief, then the MEC will appoint an Appointee to fulfill these positions.

5.1.4. Election Process

   a. The Chief will be elected by majority vote of the active members of the Department participating in the vote.

   b. Six (6) months prior to completion of the term of the Department Chief, the current Department Chief will put forth a communication (i.e. memo, email, agenda item, etc.) calling for nominations.

   c. Thirty (30) days prior to the next scheduled Department meeting, a ballot will be distributed to all active Appointees within the Department for vote.

   d. The results of the election will be announced at the next Department meeting.
SECTION 5.2. MEDICAL STAFF DEPARTMENT CHIEFS

5.2.1. Qualifications. Appointees occupying this position must:

- Be a current Appointee to the Active Medical Staff.
- Have been an active Appointee at another hospital for at least the prior three (3) consecutive years; provided, however, that at such time as Hospital has been in existence for four (4) years, the Appointee must have been an Active Appointee in Good Standing at the Hospital for at least the prior three (3) consecutive years.
- Remain an Active Appointee in Good Standing during the term of office.
- Be currently board certified within his/her respective specialty, and/or subspecialty certified by a member board of the ABMS, AOABS, ABOMS, ABPS, or ABPOPPM, and retain such current certification while serving in this position.
- Have no pending adverse recommendations concerning Medical Staff appointment or Clinical Privileges.
- Have demonstrated an ability to work well with others, be in compliance with the KHN Code of Ethics and Hospital Code of Conduct, and have demonstrated administrative and communication skills.

5.2.2. Responsibilities. A Department Chief has the following responsibilities:

a. Overseeing all clinically related activities of the Department, including the development of applicable sections within the Department.

The Department Chief may, on his/her own initiative, organize a clinical sub-specialty service. The purpose of this sub-specialty service is to assist the Department Chief in meeting his/her responsibilities as they relate to that particular sub-specialty. If so organized, the Department Chief shall appoint a chair. Such individual shall be an active Appointee and board certified within the sub-specialty. The clinical sub-specialty chair shall have the authority, upon consultation with the Department Chief, to convene and chair meetings of such sub-specialty providers to discuss specialty-specific matters as they relate to the responsibilities of the Department Chief.

b. Making recommendations to the Chief of Staff, as requested, on appointments of Department members to committees.

c. Recommending to the Medical Staff professional criteria for privileges that are relevant to the quality care provided in the Department.

d. Reviewing applications for initial appointment and reappointment as well as requested Privileges for each Practitioner and AHP assigned to the Department and for providing opinions to the Credentials Committee as to what action should be taken on the application.

e. Integrating the Department into the primary function of the Hospital.
f. Providing orientation and monitoring of the continuing education of all Practitioners and AHPs in the Department.

g. Coordinating and integrating services within the Department with other Departments.

h. Overseeing all administratively related activities of the Department, unless otherwise provided for by the Hospital or the Medical Staff.

i. In conjunction with the Chief of Staff, accessing and recommending to the relevant Hospital authority off-site sources for needed patient care services not provided by the Department or the Hospital.

j. In conjunction with the Chief of Staff, developing and implementing policies and procedures that guide and support the provision of care, treatment and services.

k. In conjunction with the Chief of Staff, making recommendations for a sufficient number of qualified and competent persons to provide care, treatment or services.

l. In conjunction with the Chief of Staff, determining qualifications and competence of Hospital department and Department personnel who are not licensed independent Practitioners and who provide patient care, treatment and services.

m. In conjunction with the Chief of Staff, making recommendations for space, capital equipment, personnel, and other resources needed by the Department.

n. In conjunction with the Chief of Staff, providing continuing surveillance of the professional performance of all Practitioners and AHPs in the Department.

o. In conjunction with the Chief of Staff, providing continuous assessment and improvement of the quality of care, treatment and services.

p. In conjunction with the Chief of Staff, assuring the maintenance of quality control programs, as appropriate.

SECTION 5.3. ASSISTANT CLINICAL DEPARTMENT CHIEF

5.3.1. Qualifications. Appointees occupying this position must:

- Be a current Appointee to the Active Medical Staff.
- Have been an active Appointee at another hospital for at least the prior three (3) consecutive years; provided, however, that at such time as Hospital has been in existence for four (4) years, the Appointee must have been an Active Appointee in Good Standing at the Hospital for at least the prior three (3) consecutive years.
- Remain an Active Appointee in Good Standing during the term of office.
- Be currently board certified within his/her respective specialty, and/or subspecialty certified by a member board of the ABMS, AOABS, ABOMS,
ABPS, or ABPOPPM, and retain such current certification while serving in this position.

- Have no pending adverse recommendations concerning Medical Staff appointment or Clinical Privileges.
- Have demonstrated an ability to work well with others, be in compliance with the KHN Code of Ethics and Hospital Code of Conduct, and have demonstrated administrative and communication skills.

5.3.2. Responsibilities. The Assistant Chief is responsible for (a) working with the Department Chief, for all clinically related activities of the Department; and (b) fulfilling the duties and responsibilities of the Department Chief in his/her absence.

SECTION 5.4. REMOVAL OF DEPARTMENT CHIEF/ASSISTANT CHIEF

Department Chiefs and Assistant Chiefs may resign at any time by giving written notice to MEC. Such resignation shall take effect on the date of receipt, or at such later time as specified in the written notice. Department Chief/Assistant Chiefs may be removed from their position by the MEC upon receipt of a recommendation of the majority of the active Appointees of the Department. In the absence of such recommendation, the MEC may remove a Department Chief/Assistant Chief on its own by a majority vote, of members present, if any of the following occurs:

- The Department Chief/Assistant Chief ceases to be an active Appointee in Good Standing of the Medical Staff or to otherwise meet the qualifications for the position (e.g., failure to maintain board certification).
- The Department Chief/Assistant Chief suffers an involuntary loss or significant limitation of Privileges.
- The Department Chief/Assistant Chief fails, in the opinion of the MEC, to demonstrate to the satisfaction of the MEC or Board that he/she is effectively carrying out the responsibilities of the position.

If removal and/or vacancy of the Department Chief is required, the Assistant Chief automatically assumes the responsibilities of the Department Chief until a new election can be held or an appointment made by the MEC. If removal and/or vacancy of the Assistant Chief occurs, then a new election can be held or an appointment made by the MEC. Any removal from such position shall in no way affect the Appointee’s Clinical Privileges, nor would the Appointee be afforded any procedural rights set forth in Article 9 on account of such removal.
ARTICLE 6.
COMMITTEES OF THE MEDICAL STAFF

SECTION 6.1. DESIGNATION

There will be a Medical Executive Committee (MEC) and the following standing committees/councils shall report to the MEC: Credentials Committee, Performance Improvement Council, and Wellness Committee. The following committees will submit minutes to the Chief of Staff who will submit these reports to MEC as appropriate: the Performance Improvement Council, Pharmacy & Therapeutics, Utilization Review Committee, Clinical Quality Review, Perioperative Services Governance Council, Osteopathic Methods & Concepts, and the Infection Prevention & Control Committee (to the extent such committees are established). The Chief of Staff shall provide Medical Staff oversight for these committees and/or functions and will report to the MEC on an as needed basis regarding issues identified that directly affect the Medical Staff. The Chief of Staff shall appoint the chair (except for Credentials Committee, which is an elected position) and members of Medical Staff committees/councils and recommend Appointees for membership in Hospital and joint Medical Staff/Hospital committees/councils. Nothing in these Bylaws shall preclude joint meetings of Affiliate Hospitals Medical Staff committees to the extent that such meetings will assist in assuring quality patient care and effective peer review.

SECTION 6.2. MEDICAL EXECUTIVE COMMITTEE

6.2.1. Purpose and Composition. The Medical Executive Committee (MEC) supervises overall Medical Staff compliance with accreditation and other regulatory requirements applicable to the Medical Staff or any of its Departments as well as conducts periodic review of Medical Staff Bylaws, Manuals, and policies, and makes recommendations for changes to the Medical Staff and to the Board of Directors as outlined in the Medical Staff Bylaws.

It is the responsibility of the MEC to initiate, investigate, review, and report on corrective action, and on any other matters involving clinical, ethical, or professional conduct of any individual Practitioner. This responsibility may be delegated to the Clinical Quality Review Committee or a focused professional practice quality improvement panel selected by the Chief of Staff with the intent to improve the Practitioner's performance. The panel shall conduct the review as peers following the time frames set for that focused review by the MEC.

The MEC consists of the Chief of Staff, Chief of Staff-Elect, immediate past Chief of Staff, Vice-Chief of Credentials, Vice-Chief at Large, and the Department Chiefs for a two (2) year term). The President/CEO, Vice President Medical Affairs/Chief Medical Officer, Vice President/Patient Care Services, Director of Medical Education, and a member representing the Board of Directors will be members Ex Officio. The Chief of Staff serves as chair of the committee. All active Appointees, of any discipline or specialty, are eligible for membership on the MEC; provided, however, that, at all times, Physician Appointees of the active Medical Staff shall comprise at least a majority of the voting members of the MEC.
6.2.2. **Duties.** The duties of the Medical Executive Committee shall be to:

a. Represent and to act on behalf of the Medical Staff, in the intervals between general Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws.

b. Receive and act upon reports and recommendations from Medical Staff committees, joint Hospital/Medical Staff committees, Departments, and assigned activities groups, and to make recommendation to the Board regarding the same, including the following Quality Assurance Performance Improvement (“QAPI”) functions which flow from the assigned committee and report to PIC/MEC for action and dissemination of information to clinical providers and Board.

- Medication therapy, including antibiotic and non-antibiotics for all service types (inpatient, outpatient, ambulatory, and emergency care) of patients;
- Infection control, including community acquired and healthcare acquired infections in patients and health care workers;
- Surgical/invasive and manipulative procedures, including tissues and non-tissue producing cases, with and without anesthesia and/or moderate sedation;
- Blood (including component) product usage;
- Data management (accuracy, currency, transferability) with emphasis on medical record pertinence and timeliness;
- Discharge planning and utilization review;
- Complaints regarding medical staff related issues;
- Restraint/seclusion usage; and
- Mortality review. Coordinate, provide leadership, and implement the professional, clinical, performance improvement (including customer satisfaction and patient safety), and organization activities and policies of the Medical Staff including peer review, which helps to create and maintain a culture of safety and quality throughout the Hospital.

c. Act as liaison between the Medical Staff and the Chief of Staff.

d. Recommend action to the Chief of Staff on matters of a medico-administrative nature and to recommend the Medical Staff organization structure to the Board.

e. Make recommendations on Hospital management matters to the Board through its Professional Practice Committee.
f. Ensure that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation and licensure status of the Hospital.

g. Fulfill the Medical Staff’s accountability to the Board for the medical care rendered to patients in the Hospital.

h. Design a mechanism to ensure that the same level of appropriate quality of patient care is provided by all Practitioners and AHP with Privileges, within and across the Departments and/or Sections, and between Practitioners and AHPs who have Privileges during the patient’s entire stay at the Hospital.

i. Oversee the quality of patient care, treatment, and services provided by Practitioners and AHPs.

j. Review the qualifications, credentials, performance, professional competence, and character of applicants, Appointees, Practitioners, and AHPs, and to make recommendations to the Board regarding, appointment, reappointment, termination, assignments to Departments and Sections, Privileges, and corrective action.

k. Request evaluations of a Practitioner's or AHP’s Privileges through the Medical Staff process in instances where there is doubt as to an applicant's, Appointee’s, or AHP’s ability to perform the Privileges requested.

l. Take all reasonable steps to ensure ethical professional conduct and competent clinical performance on the part of Practitioners and AHPs with Privileges.

m. Conduct such other functions as are necessary for the effective operation of the Medical Staff.

n. Direct mechanisms for corrective action, including indications and procedures for automatic and summary suspension of a Practitioner’s appointment and/or privileges.

o. Establish mechanisms to provide effective communications among the Medical Staff, Hospital administration, Board, and all levels of governance involved in policy decisions affecting patient care services in the Hospital.

p. Report at each general Medical Staff meeting.

q. Access and recommend to the relevant Hospital authority off-site sources for needed patient care services not provided by the Hospital.

r. Make recommendations for the position of Vice President Medical Affairs/Chief Medical Officer to the Board of Directors from among nominees.

t. Provide oversight with respect to appropriate completion of medical records including implementation of action plans to repair deficiencies and assisting in the
development of policies regarding (i) maintenance and proper recording of sufficient data to evaluate patients; (ii) confidentiality; (iii) access; and (iv) as otherwise necessary to the appropriate completion and maintenance of such documents.

6.2.3. **Meetings.** The Medical Executive Committee shall meet at least ten (10) times per year and maintain a permanent record of its proceedings and actions.

6.2.4. **Audience.** Any active Appointee has the right to an audience with the Medical Executive Committee. In the event a Practitioner is unable to resolve an issue by working with his/her Department Chief, the Appointee may, upon presentation of at least two (2) week written notice, meet with the Medical Executive Committee at its next regularly scheduled meeting to discuss any unresolved issues.

**SECTION 6.3. CREDENTIALS COMMITTEE**

6.3.1. **Composition.** The Credentials Committee shall be composed of the Credentials Chair, the immediate past Vice Chief, the immediate past Chief of Staff, the Vice President/Chief Medical Officer, a Board member (Ex Officio). In addition, reasonable efforts should be made to have Practitioners from the various Departments to reflect appropriate representation. The immediate Chief of Staff will advance to the Credentials Chair position. The officers will be ratified in a bi-annually election process outlined in the Bylaws. Member appointments shall be for a term of two (2) years and may be for unlimited consecutive terms. The Chief of Staff shall appoint new Department representatives after receipt of nominations from the Department Chiefs.

6.3.2. **Duties.** The Credentials Committee shall investigate the qualifications of all applicants for appointment and/or Privileges, and shall review the Departments assignments and the Medical Staff category and/or Privileges requested.

At an interval no greater than every twenty-four (24) months, the committee shall review all information available on each Practitioner and privileged AHP, including recommendation from the Department Chiefs. This information shall be used for the purpose of determining its recommendations for appointment/reappointment to the Medical Staff, assignment/reassignment to the Department, and the granting/regranting of Clinical Privileges. The committee shall transmit its recommendations in writing, which may be reflected by its minutes, to the Medical Executive Committee. Where non-appointment/reappointment/grant/regrant of Privileges, or a change in appointment category, Department, or Privileges is recommended, the reason(s) for such recommendation shall be stated and documented.

The Credentials Committee shall review qualifications of all privileged AHPs, subject to recommendation of the AHP Committee and Department Chief. The committee shall establish processes as necessary to accomplish this review.

The Credentials Committee shall establish criteria for new procedures provided such procedures are approved to be performed at the Hospital. The committee shall also evaluate the qualifications of any Practitioner applying for these Privileges.
The Credentials Chair shall be available to meet with the Board or its applicable committee on all recommendations that the Credentials Committee makes. The Credentials Committee may also create an ad hoc committee to deal with specific concerns.

6.3.3. Meetings, Reports and Recommendations. The Credentials Committee shall meet as often as necessary to accomplish its duties but at least six (6) times a year. The committee shall maintain a permanent record of its proceedings and actions, and report its recommendations to the Medical Executive Committee with a copy to the Board.

SECTION 6.4. WELLNESS COMMITTEE

6.4.1. Purpose. The Wellness Committee is a Medical Staff oversight committee whose primary purpose is not to discipline, but rather, to identify, assist, and foster rehabilitation of impaired Medical Staff Appointees and AHPs. The Wellness Committee's processes are separate from the Medical Staff corrective action function. An impaired Practitioner/AHP is one who is unable, or potentially unable, to exercise his/her Privileges with reasonable skill and safety to patients because of physical or mental illness, including deterioration through the aging process or loss of motor skills, or excessive use or abuse of drugs including alcohol.

The committee serves to educate the Medical Staff and Hospital staff about health, addressing prevention of physical, psychiatric or emotional illness, and impairment recognition issues specific to Practitioners and AHPS including facilitation of confidential diagnosis, treatment and rehabilitation from potentially impairing conditions.

The committee will encourage self-referral and referral by other Practitioners, AHPs, and Hospital staff.

The committee will examine the evidence for impairment of Practitioners and AHPS including evaluation of the credibility of a complaint, allegation, or concern.

The committee will facilitate referral of the affected Practitioner/AHP, if indicated, to the appropriate professional internal or external resources for diagnosis and treatment of the condition or concern.

Committee members will seek to maintain confidentiality of the Practitioner/AHP seeking referral or referred for assistance, except as limited by law, ethical obligation, or when safety of a patient or other is threatened.

The committee will provide support to Practitioners/AHPs with an impairment while monitoring recovery, including safety of patients, until the rehabilitation or corrective action process is completed.

The committee will report to the Medical Staff leadership instances in which a recovering Practitioner/AHP is providing unsafe treatment to patients.
The functions of the committee include: (i) reviewing concerns in an orderly and expeditious fashion that have been received by the Chief of Staff or otherwise referred to the committee in accordance with the Practitioner Wellness Policy; (ii) monitoring current cases of impairment of Practitioners/AHPs; and (iii) fulfilling its responsibilities under the Practitioner Wellness Policy which is incorporated herein. Concerns about impairment of Practitioners/AHPs will be taken to the next scheduled meeting, or addressed sooner at the discretion of the chair or as otherwise stated in the Practitioner Wellness Policy. When problems are presented, documentation will be obtained in a timely fashion. Suggestions or allegations of impairment of Practitioners/AHPs will be investigated in a thorough manner.

When the committee finds that a formal, professional evaluation is necessary to determine whether a problem exists, the committee will carry out an intervention in confidence, encouraging the suspected impaired Practitioner/AHP to voluntarily submit to the evaluation. If necessary, the committee may seek the help of the Greene County Medical Society Physician's Effectiveness Committee, if any, and/or the Ohio State Medical Association Physician's Effectiveness Program to do an intervention. The Chief of Staff will attend all interventions and will make an executive decision as to action to be taken (e.g., requirement of a formal evaluation). The impaired Practitioner/AHP will be encouraged to take a voluntary leave of absence and advised of the potential of a suspension of Privileges if he/she does not do so. The immediacy of response for evaluation will depend on the magnitude of the perceived problem. If the Practitioner/AHP declines to voluntarily participate in the process, the Practitioner/AHP will be reported to the Ohio State Medical Board, or other applicable licensing entity, and to the MEC.

When Practitioner/AHP is acutely impaired, the Chief of Staff and Department or Section Chief will be notified promptly and, if appropriate, will take the necessary actions to prevent risk to patient safety or care. The Wellness Committee will be notified of this action and shall investigate and determine whether additional action is required.

The committee is delegated the responsibility of establishing protocols for the evaluation and treatment of Practitioners/AHP whose physical or mental capacity is questioned. Any physical or mental condition, that would reasonably be expected to impair the Practitioner/AHP could subject the Practitioner/AHP to investigation. Such investigations are to be conducted in a confidential and impartial manner.

6.4.2. **Composition.** The membership of the committee shall consist of not less than three (3) members. One (1) of the members shall be the Chief of Staff. At least two (2) of the remaining members shall be Appointees and preferably not a Clinical Department or Section Chief or MEC member.

6.4.3. **Meetings, Reports and Recommendations.** The Wellness Committee shall meet as often as necessary to accomplish its duties but at least annually. The committee shall maintain a permanent record of its proceedings and actions, and report its recommendations to the MEC.
SECTION 6.5. PERFORMANCE IMPROVEMENT COUNCIL

6.5.1. **Purpose.** The Performance Improvement Council ("PIC") is a joint committee of the Hospital and Medical Staff that establishes the quality assessment and performance improvement ("QAPI") priorities and receives and provides formal information sharing between the Clinical Quality Department and the leadership of the Hospital and Medical Staff. The PIC has the responsibility to charter, oversee, and regularly evaluate QAPI programs and activities of the Hospital and its Medical Staff. The PIC receives and acts on summary reports from clinical and administrative committees as well as functions that track and trend information on clinical and other monitoring activities. The PIC makes recommendations for QAPI and effectively communicates those recommendations to the Medical Staff and Hospital groups with related responsibilities as specified in the Hospital's Performance Improvement Plan ("PI Plan").

The PIC oversees organization efforts to measure, assess, and improve clinical activities outcomes, the quality and appropriateness of selected service, and identify problem in care and performance at the various levels of organization leadership, functional areas, and Departments. The PIC is responsible for coordinating efforts to evaluate and monitor resource consumption and utilization management. Clinical review activities include appropriates of selected services/activities and management of the same in the following processes: (i) medication therapy; (ii) infection prevention and control; (iii) surgical management; (iv) blood products; (v) data management; (vi) discharge planning and utilization review; (vii) utilization management; (viii) complaints regarding Medical Staff related issues; (ix) restraint/seclusion usage; (x) mortality review; and (xi) "Never" events promulgated by CMS. Clinical review activities may be delegated to other committees and subcommittees that report through the PIC.

The PIC coordinates, prioritizes, and monitors the Medical Staff, Hospital, and medical education data gathering and analysis components of the quality review program, of QAPI activities using "Plan, Do, Check Act ("PDCA") methodology, or such other methodology as is adopted from time to time, and coordinates the Medical Staff activities in these areas with those of the other professional and support services in the Hospital. Individualized Practitioner/AHP/resident data identified through QAPI processes will be delegated for handling to the Chief of Staff and/or Clinical Quality Review Committee, as needed, for further evaluation according to Medical Staff peer review process.

The PIC annually evaluates the Hospital's overall QAPI program for its comprehensiveness, integration, effectiveness and cost efficiency, and revises the PI Plan as needed. The PI Plan includes evaluation mechanisms for every contracted patient care service and ensures that the list of all contracted services is maintained inclusive of the scope and nature of the services provided.

The PIC reviews clinical risk management events, including root cause analyses of sentinel events, morbidity concerns, and aggregate data on significant high risk events to identify possible patterns and communicate that information to the Medical Staff and Hospital groups with related responsibilities.
The PIC periodically oversees the development and implementation of Hospital safety programs and an emergency preparedness plan that addresses disasters, both Hospital and community.

The PIC annually reviews the Hospital Hazard Vulnerability Analysis ("HVA") objectives and scope of the Emergency Operations Plan, Environment of Care, Staffing Effectiveness, Plan for Patient Care, Patient Safety Plan, and the PI Plan.

The PIC establishes formats for the aggregation, display, and reporting of data and findings, as well as a system of follow-up to determine that recommended actions are implemented. The PIC formats and schedules submissions of data and findings, committee minutes, and special reports such that the entire clinical performance of the Hospital is monitored, the data is reported in a structured and comprehensive manner, and appropriate recommendations can be made based on that data to provide care within the Hospital of the highest quality.

The PIC oversees quality assessment, performance improvement, and peer review functions.

6.5.2. **Composition.** The composition of the PIC will include the Medical Director of Quality (co-chair), the Chief of Staff (co-chair), the Chief of Staff-elect, the Hospital Vice-Presidents, and such other Practitioners and members of Administration (in equal numbers) as are deemed necessary to accomplish the council's objectives. Practitioners shall be chosen by the Chief of Staff. Members of Hospital administration shall be chosen by the President/CEO.

6.5.3. **Meetings, Reports and Recommendations.** The PIC shall meet as often as necessary to accomplish its duties but at least quarterly. Medical Staff QAPI reviews that focus on clinical assessments, diagnostic procedures, and therapeutic interventions are reported at least semi-annually. The council shall maintain a permanent record of its proceedings and actions, and report its recommendations and findings to the Medical Executive Committee and the Board, as deemed appropriate. QAPI data and findings are used to develop continuing education activities, provide annual evaluations of improvement in clinical care, and assist in the credentialing process.

**SECTION 6.6. UTILIZATION REVIEW COUNCIL**

6.6.1. **Purpose.** The Utilization Review Council is a joint committee of the Hospital and Medical Staff that develops and annually amends a utilization review plan for approval by the MEC, Hospital Executive Council and, ultimately, the Board. The plan applies to all patients regardless of payment source, outlines the confidentiality and conflict of interest policy, and includes provision for:

a. Reviewing admissions and medical necessity of admissions, continued hospitalization, and extended stays;
b. Discharge planning, including referral for appropriate post-hospitalization care and Practitioner follow-up;

(c) Reviewing medical necessity of professional services, such as, but not limited to, high cost procedures, drugs and biologicals, data collection and reporting requirements;

(d) Identifying Practitioner/case variations from evidence-based care.

The council engages in review of ongoing issues, including case-specific utilization, Practitioner and Practitioner group profiling, and department and clinical service line trending to insure high quality medical care and effective utilization of resources.

The council assists the Hospital with decision-making and tracking of high volume, high risk, high cost, and/or problem prone diseases or DRGs and recommending measures to improve outcomes. The council reviews cost and quality trends on a continuous basis as a means to improve clinical effectiveness and resource allocation.

The council reviews, approves, and recommends to the MEC all new Practitioner order sets and protocols and significant revisions to existing orders/protocols, as the need arises.

6.6.2. Composition. The composition of the council will include the Medical Director of Quality, a Physician, two (2) additional Practitioners (one (1) of whom may be the Chief of Staff), and two (2) additional members of administration. Practitioners shall be chosen by the Chief of Staff. Members of Hospital administration shall be chosen by the President/CEO.

Members should be experienced in utilization review functions. No council member may participate in the review of any case in which he/she was professionally involved in the care of the patient. No person serving on the council may hold any financial interest in any hospital.

6.6.3. Meetings, Reports and Recommendations. The council shall meet as often as necessary to accomplish its duties but at least quarterly. The council shall maintain a permanent record of its proceedings and actions, and report its recommendations to the MEC and the PIC as deemed appropriate.

SECTION 6.7. LEADERSHIP COMMITTEE

6.7.1. Purpose. Leadership Committee is a subcommittee of the MEC responsible for receiving and/or identifying and determining initial peer review issues and coordinating, tracking, and trending clinical quality patterns and/or concerns as well as death reviews at the Hospital. The Leadership Committee may delegate certain peer review activities to the Departments but their activities must be reported to the Leadership Committee.

The Leadership Committee:
(a) Conducts review of surgical/invasive and manipulative procedures including tissue and non-tissue producing cases, with and without anesthesia and/or moderate sedation, and cases that fail to meet predetermined criteria. These criteria may include: documentation, tissue examination, indications for surgery, and post operative care. Define the scope and types of cases to be reviewed and provide tissue and audit review including cases with minimum or no pathology to determine the justification for all surgical procedures performed, scrutinize the relationship between preoperative diagnosis, and the final postoperative diagnoses.

(b) Reviews and evaluates internal and external data as necessary to understand the care that is being examined by the committee.

(c) Monitors and assesses utilization of blood and blood components for all types of patients, including evaluation of appropriateness of all blood component transfusions; reviews all confirmed transfusion reactions in a timely manner; reviews ordering practices for, and distributing, handling, dispensing, and administering of, blood and blood products; and, monitors blood and blood component effects on patients. The committee establishes policies governing all transfusions of blood and blood derivations, systems for reporting transfusion reactions, and evaluates such policies and practices at regular intervals. Transfusion reactions will be considered adverse medical events and will be reported through the QAPI process. The committee investigates all transfusion reactions occurring in the Hospital and recommends improvement in transfusion procedures. The committee develops policies and procedures regarding transfusions of potentially HIV/HCV infectious blood and blood products and defines the relationship and responsibilities of outside blood banks with appropriate notification procedures.

(d) Monitors mortality review and complaints with quality concerns regarding Medical Staff related issues. Mortality review considers the awareness of the critical nature of the cases, analyzes opportunities for early recognition of clinical deterioration, correct diagnosis, and educational reporting of interesting cases for potential instructional use by the Medical Staff and Hospital staff.

Reports will uphold confidentiality by using Hospital case numbers and Practitioner numbers.

6.7.2. Composition. The members of the Leadership Committee will be appointed by the Chief of Staff and include, among others, appropriate Clinical Department Chiefs.

No committee member may participate in the review of any case in which he/she was professionally involved in the care of the patient.

6.7.3. Meetings, Reports and Recommendations. The committee shall meet as often as necessary to accomplish its duties but at least quarterly. The committee shall maintain a permanent record of its proceedings and actions, and report its recommendations to either
the appropriate surgical clinical service and the Medical Executive Committee as deemed appropriate.

**SECTION 6.8. PHARMACY & THERAPEUTICS COUNCIL**

6.8.1. **Purpose.** The Pharmacy and Therapeutics (P&T) Council is a joint committee of the Hospital and Medical Staff that serves as a regulatory and advisory committee in all matters pertaining to the evaluation, selection, and utilization of medications, including equipment used to prepare and administer medications.

The P&T Council:

a. Recommends and/or assists in the formulation of education programs designed to meet the needs of Practitioners, AHPs, nurses, pharmacists, and other health care providers on matters related to the selection, administration, and monitoring of medication use.

b. Develops and maintains a formulary of drugs accepted for use in the Hospital and provides for its appropriate revisions. The selection and review of these drugs is based on objective evaluation of their relative merit, safety and cost.

c. Establishes programs and procedures that help ensure cost effective drug therapy using indicators of patient outcome in their assessment.

d. Reviews adverse drug reactions and errors and develops programs and policies to minimize their occurrence and formulates procedures for reporting such reactions and errors; and assists the Medical Staff in investigating such issues and implementing corrective actions.

e. Collects data and monitors and recommends process improvement to the Hospital and the Medical Staff regarding procurement, storage and distribution; prescribing or ordering; preparing and dispensing; administering and monitoring the effects on patients of medications used in the Hospital and enteral nutrition products in the Hospital.

f. Reviews medication errors and determine actions that should be taken to minimize their occurrence.

g. Develops a medication safety program for the Hospital that promotes safe medication administration and reduces preventable medication errors.

h. Recommends to the Medical Staff and Hospital policies regarding nutrition care issues.

i. Establishes priorities for ongoing assessment of medication used in the Hospital.

j. Monitors the anticoagulation management program for efficiency and effectiveness.
k. Recommends drugs that are stocked on nursing units.

l. Evaluates clinical data concerning new drugs requested for use in the Hospital, and advises the Medical Staff and pharmacists on the choice or use of drugs.

(m) Reviews P&T related policies at least every three (3) years and updates more frequently as necessary.

6.8.2 Composition. The P&T Council consists of representatives from the Medical Staff, nursing, pharmacy, nutrition services, and other health care providers. Members are appointed jointly by the Chief of Staff and the Hospital executive committee. The chair shall be appointed by the Chief of Staff. The number of members may not exceed twenty (20).

6.8.3 Meetings, Reports and Recommendations. The council shall meet as often as necessary to accomplish its duties but at least quarterly. The council shall maintain a permanent record of its proceedings and actions, and report its recommendations to the PIC and the MEC as deemed appropriate.

SECTION 6.9. PERI-OPERATIVE SERVICES GOVERNANCE COUNCIL

6.9.1 Purpose. The Peri-operative Services Governance Council is a joint committee of the Hospital and Medical Staff for the following: the Operating Rooms ("OR"), the Post Anesthesia Care Units ("PACU"), the Ambulatory Surgery Center ("ASC") (pre and post operative care) (if any), and the Pre-Admission Testing ("PAT") services (including the Pre-Operative Clinic, Endoscopy Services ("GI") Outpatient Surgery Center, and Central Sterile Processing).

The Council:

a. Reviews, revises, and develops policies and procedures for Peri-operative Services.

b. Recommends policy revisions to the MEC for approval.

c. Monitors compliance with Peri-operative services policies.

d. Monitors and evaluates effectiveness of Peri-operative Services, including patient safety issues and performance improvement activities.

e. Upon request, provides comments to the Credentials Committee or other appropriate Medical Staff committee regarding Practitioners' use of Peri-operative Services.

f. Reviews and prioritizes requests for capital equipment, instruments, and medical supplies.

g. Reviews and complies with regulatory and accrediting agency requirements.
In urgent situations, the co-chairs of the Peri-operative Services Committee may:

(i) Discuss team interactions.

(ii) Interpret and enforce Peri-operative Services policies, if necessary, between meetings of the Peri-operative Services Committee.

6.9.2. **Composition.** The council consists of the Chair of the Department of Surgery, the Administrative Director of Peri-operative Services (co-chair), and additional Practitioners and members of Hospital administration as necessary to accomplish the council's purposes. Practitioners shall be chosen by the Chief of Staff. Members of Hospital administration shall be chosen by the President/CEO.

6.9.3. **Meetings, Reports and Recommendations.** The council shall meet as often as necessary to accomplish its duties but at least quarterly. The committee shall maintain a permanent record of its proceedings and actions, and report its recommendations to the PIC, the Hospital Executive Council, and to the MEC as deemed appropriate.

**SECTION 6.10. OSTEOPATHIC METHODS & CONCEPTS COMMITTEE.**

6.10.1. **Purpose**

The committee:

(a) Makes recommendations to improve utilization of osteopathic principles and practice; records osteopathic findings, describes osteopathic manipulative treatment, and applies such modalities as part of the comprehensive care received by patients.

(b) Establishes and records retrospective and current audits of patient charts relating the application of osteopathic principles and practice to patient diagnosis and treatment.

(c) Inform osteopathic Physicians of the evaluations of patient charts reviewed by the committee to improve utilization of osteopathic principles and practices.

6.10.2. **Composition.** The committee shall consist of at least two (2) osteopathic Physicians on the active Medical Staff. The committee does not need to be established unless and until there are ten (10) osteopathic Physicians on the active Medical Staff.

6.10.3. **Meetings, Reports and Recommendations.** The committee shall meet as often as necessary to accomplish its duties but at least annually. The committee shall maintain a permanent record of its proceedings and actions, and report its recommendations to the PIC and the MEC as deemed appropriate.
SECTION 6.11. MEDICAL RECORDS COMMITTEE

6.11.1 Purpose

The Committee:

6.11.1.1. Using the Kettering Health Network definition for a complete medical record as standard for comparison, will review reporting of record reviews that substantiates compliance with the standard. Assures implementation of actions plans to repair such deficiencies as are identified.

6.11.1.3. Addresses concerns regarding records completions as brought forth to the committee from the administration or the medical staff.

6.11.1.4. Recommends any new use or any changes in the format of medical records.

6.11.1.5. Reports quarterly to the MEC and Performance Improvement Committee its findings and process evaluations.

6.11.1.6. Recommends policies regarding maintenance and proper recording of sufficient data to evaluate patient care, as well as matters of confidentiality, access, and legal release of information.

6.11.2. Composition

The Vice Chief at Large will serve as the Co-chair of the Medical Records Committee along with the Network Medical Records Administrator. It shall include as members the Chief Medical Officer, the Director of Medical Records for the hospital, the Medical Director of Clinical Quality, at least one additional medical staff member, as appointed by the Chief of Staff and one additional member from the medical records department.

6.11.3. Meetings, Reports and Recommendations

The Medical Records Committee shall meet as often as necessary to accomplish its duties but at least quarterly. The committee shall maintain a permanent record of its proceedings and actions, and report its recommendations to the Performance Improvement Committee and to the Medical Executive Committee as deemed appropriate.

SECTION 6.12. JOINT CONFERENCE COMMITTEE

6.12.1. Purpose. The Joint Conference Committee is an ad hoc committee of officers of the Medical Staff and officers of the Board of Director whose function is to address issues of direct or potential conflict between the Hospital Board and the Medical Staff and to facilitate communication between the Board and the Medical Staff.
The Joint Conference Committee shall:

(a) Be a forum for the discussion of matters involving Hospital Policy and Practice, especially those pertaining to patient care and shall provide medical administrative liaison with the Board.

(b) Monitor the correction of any cited deficiencies resulting from inspection by Hospital accrediting bodies and compliance with their directives.

(c) Perform such other duties as shall be delegated to it by the Board.

6.12.2. Composition:

The Joint Conference Committee shall be a Board committee. The chair of the committee shall be a member of the Board appointed, by the Chair of the Board. Membership shall include three (3) members of the Board nominated by the committee Chair and approved by the Chair of the Board, and three (3) active Medical Staff Appointees, usually the Chief of Staff, the Chief Elect, and one additional member appointed by the Chief of Staff.

6.12.3. Meetings, Reports and Recommendations

The Joint Conference Committee shall meet as often as necessary to accomplish its duties but at least Quarterly. The Committee shall maintain a permanent record of its proceedings and actions and shall report its recommendations to the MEC, the Hospital CEO and the Board.
ARTICLE 7.
MEDICAL STAFF FUNCTIONS

Provisions shall be made in these Bylaws, or by resolution of the Medical Executive Committee approved by the Board, either through assignment to Medical Staff committees, to Medical Staff officers, or to interdisciplinary Hospital committees, for the effective performance of the Medical Staff functions specified in this Section and described in other related Medical Staff governance documents, and of such other Medical Staff functions as the Medical Executive Committee or the Board shall reasonably require.

SECTION 7.1. FUNCTIONS

7.1.1. Credentialing and privileging of all eligible candidates for Medical Staff membership/Privileges in accordance with these Bylaws, Ohio law, and then-current accrediting standards to the Board regarding the credentialing and privileging of these candidates.

7.1.2. Monitor and assure provision of quality care.
   a. documentation of standards
   b. incident review

7.1.3. Provide formal and informal mechanisms to address interactions of concerns

7.1.4. Self governance
   a. Bylaws and documents
   b. officers
   c. meetings

7.1.5. Duties
   a. Monitoring and evaluating the care provided in and developing clinical policy for special care areas, such as intensive or coronary care units and all Hospital-based services.
   b. Conducting or coordinating quality and appropriateness and improvement activities, including invasive and non-invasive procedures, blood usage, drug usage reviews, medical record and other reviews.
   c. Conducting or coordinating utilization review activities.
   d. Conducting or coordinating credentials investigations regarding Medical Staff appointment and grants of Privileges and specified scopes of services.
e. Providing continuing education opportunities responsive to quality assessment/improvement activities, new state-of-the-art developments, and other perceived needs and supervise the Hospital’s professional library services.

f. Developing and maintaining surveillance over drug utilization policies and practices.

g. Investigating and controlling nosocomial infections and monitoring the Hospital’s infection control program.

h. Directing Medical Staff organization activities, including review and revision of Medical Staff Bylaws, Medical Staff officer and committee nominations, acting as liaison with the Board and Hospital administration, and review and maintenance of Hospital accreditation and licensure.

i. Coordinating the care, including patient and family education, provided by Practitioners with the care provided by the nursing service and with the activities of other Hospital patient care and administrative services.

j. Engaging in other functions reasonably requested by the Medical Executive Committee and Board.

SECTION 7.2. CREDENTIALING, PRIVILEGING, AND APPOINTMENT

Applications for appointment, reappointment and privileges shall be submitted to the Kettering Health Network Centralized Credentialing Office (“CCO”). The CCO shall review the application, collect the required information, and perform primary source verification. Upon completion of the collection and verification process, the application and all supporting documentation shall be submitted to the Hospital’s Medical Staff Services (“MSS”) Department. The MSS department will then be responsible for performing a comprehensive review, competency evaluation for the privileges requested, and shall query the NPDB. When the application is considered complete by the MSS personnel, it is forwarded for review and action upon by the applicable Department or Section Chief, Credentials Committee, and Medical Executive Committee. The final decision regarding initial appointments and reappointments to the Medical Staff and/or the granting of Privileges shall be made by the Board. The Board shall act on appointments, reappointments, and/or Privileges only after there has been a recommendation from the MEC. Temporary Privileges are time-limited. Temporary Privileges for a new applicant, new procedure, locum tenens, or to fulfill an important patient care need may be requested and granted under circumstances as outlined in the Credentials Policy Manual.

In the event of an emergency or a disaster, volunteer licensed Practitioners and AHPs, may be granted “emergency” or “disaster” privileges as outlined in the Credentials Policy Manual and in accordance with applicable Hospital policies and procedures.

Full details regarding the credentialing/re-credentialing, appointment/reappointment, and privileging/re-privileging processes are set forth in the Credentials Policy Manual.
Each applicant must attest as part of the application for appointment, reappointment, or privileges, that he/she has read the Bylaws, Manuals, applicable policies, and code of ethics, and will abide by the same.

A separate credentials record shall be maintained for each Practitioner requesting initial appointment, re-appointment and/or Privileges.

SECTION 7.3. MEETINGS

7.3.1. Medical Staff Meetings

The Medical Staff shall meet quarterly throughout the Medical Staff Year. One (1) of these meetings will be designated by the MEC as an annual meeting. Written notice of these meetings shall be sent at least seven (7) days in advance to all Appointees and shall also be conspicuously posted.

The primary objective of the meetings shall be to report on the activities of the Medical Staff and to conduct other business as may be on the agenda. Written minutes of all meetings shall be prepared and recorded.

7.3.2. Special Meetings

The Chief of Staff may call a special meeting of the Medical Staff at any time. The Chief of Staff shall call a special meeting within twenty (20) days after receipt of a written request signed by not less than ten percent (10%) of the active Appointees or upon resolution by the Medical Executive Committee. Such request or resolution shall state the purpose of the meeting. The Chief of Staff shall designate the time and place of any special meeting.

Written or printed notice stating the time, place, and purpose of any special meeting of the Medical Staff shall be conspicuously posted and shall be sent to each Appointee at least ten (10) days before the date of such meeting. The attendance of an Appointee at a meeting shall constitute a waiver of notice of such meeting. No business shall be transacted at any special meeting, except that stated in the notice of such meeting.

A special meeting of any committee or Department or Section may be called by the Chair, Department or Section Chief, or a Medical Staff officer.

7.3.3. Regular Meetings of Departments and Committees

Regular meetings shall be those Department meetings as well as Medical Staff and/or Hospital committees that are identified in the Bylaws and Manuals. Committees may, by resolution, provide the time for holding regular meeting without notice other than such resolution. Meetings may be held jointly for the Hospital system as deemed appropriate.

Each Department is required to have a minimum of two (2) meeting per year or such additional number as is necessary to process the business of the Department.
Each committee of the Medical Staff shall hold its first meeting of the Medical Staff Year at a time and place designated by the Chief of Staff subject to review by the Medical Executive Committee. Thereafter, the Chief of Staff or each committee chair shall establish a time for regular meetings, select a recorder to record minutes of meetings, and adopt such rules of procedure necessary to accomplish the purposes for which the committee was established.

7.3.4. **Quorum**

Medical Staff Meetings. Those Active Appointees present but not less than two (2).

Medical Executive Committee. Fifty percent (50%) of the voting members of the committee. Those members not meeting this requirement will receive a letter of reprimand from the Chief of Staff that outlines the requirements of said position, up to and including removal from the position.

Credentials Committee, Performance Improvement Council, and Utilization Review Council. Minimum of three (3) voting members at least two (2) of whom must be Practitioners.

All other committee/Department Meetings. Those active Appointees present but not less than two (2).

7.3.5. **Attendance Requirements**

Medical Staff Meeting Attendance. All Appointees are encouraged to attend meetings of the Medical Staff. Meeting attendance will be used by the Credentials Committee as one (1) parameter in evaluating Practitioners at the time of reappointment.

Attendance by members of the Medical Executive, Credentials, and Performance Improvement Committees. Members of the Medical Executive Committee, Credentials Committee, and Performance Improvement Council are expected to attend at least fifty percent (50%) of the meetings held. The Medical Executive Committee may require Medical Staff meeting attendance on any Medical Staff, joint Medical Staff/Hospital committee, or Department meetings. Those members not meeting this requirement will receive a letter of from the committee chair that outlines the requirements of said position, up to and including removal from the position.

7.3.6. **The Manner of Action:**

Except as otherwise specified in these Bylaws, the action of a majority of the Appointees entitled to vote shall be the action of the group. Voting may occur in any of the following ways as determined by the chair of the respective committee, Department, or Section; or for voting by the Medical Staff, as determined by the Chief of Staff:

a. Vote by hand ballot;

b. Vote by written ballot;
c. Vote without a meeting by written ballot or by electronic ballot provided such votes are received prior to the deadline date set forth in the notice advising of the purpose for which a vote is to be taken.

d. Absentee written ballots may also be accepted in any of the above situations provided the ballot(s) are received prior to the deadline date set forth in the notice advising of the purpose for which a vote is to be taken.

7.3.7. Rights of Ex Officio Members:

Except as otherwise provided in these Bylaws and Manuals, persons serving as Ex Officio members of a committee shall have all rights and privileges of regular members, except they shall not vote or be counted in determining the existence of a quorum.

7.3.8. Participation by President, Vice President Medical Affairs, Chief of Staff, and Past Chief of Staff:

The President, Vice President Medical Affairs, Chief of Staff, and Past Chief of Staff shall attend meetings of the Medical Staff, and any committee, Department, or Section meeting as Ex Officio without vote.

7.3.9. Minutes:

7.3.9.1. Minutes shall be prepared for any meeting held by the Medical Staff, Department, Section, or committee.

7.3.9.2. Minutes shall be prepared by the presiding officer of the meeting and shall include a record of attendance and the vote(s) taken on each matter. Copies of such minutes shall be, forwarded to the Medical Executive Committee and, when appropriate, made available to the Medical Staff. A permanent file of the minutes of all meetings shall be maintained in the Medical Staff Office or in other designated secure, confidential area(s).

7.3.10. Participation by Chief of Staff

The Chief of Staff and/or any representative assigned by the Chief of Staff may attend any committee or Department meetings of the Medical Staff.
ARTICLE 8.
CORRECTIVE ACTION

SECTION 8.1 INFORMAL INVESTIGATIONS FOR CORRECTIVE ACTION

Prior to initiating a formal corrective action against an Appointee for professional conduct or competency concerns, the Medical Staff leadership (officers of the Medical Staff or Department Chiefs) or the Board (through the Chief Executive Officer or the Vice President/CEO of Medical Affairs) may elect to attempt to resolve the concern(s) informally.

An informal investigation may be initiated by such individuals as stated in Subsection 8.1.1 whenever an Appointee engages in, makes, or exhibits acts, statements, demeanor, or professional conduct (either within or outside the Hospital), and the same is, or is reasonably likely to be, detrimental to the quality of patient care or safety, disruptive to the Hospital’s operations, or an impairment to the community’s confidence in the Hospital.

When initiating an informal investigation, the involved Appointee shall be invited to be interviewed by the Medical Staff leadership and by either/or both of the Chief Executive Officer, and/or the Vice President/CEO of Medical Affairs. At such interview, circumstances prompting the informal investigation should be discussed, and the Appointee asked to present relevant information on his/her own behalf.

8.1.1. Effect of Informal Investigation. If the involved Appointee’s action(s) is not subject to Section 8.2 (Automatic Suspension) or Section 8.3 (Summary Suspension), the individual conducting the informal investigation will recommend to the Chief of Staff that the matter in question be considered resolved or be referred to the MEC for further review or formal investigation. An informal investigation is a collegial inquiry that does not rise to the level of a formal investigation as contemplated by the National Practitioner Data Bank.

8.1.2. Written Record. A written summary shall be maintained for each informal investigation. The summary shall identify the persons conducting the informal investigation, a summary of the Appointee’s actions (including pertinent dates) that prompted the informal investigation, a summary of the interview with the Appointee (if so conducted), and the effect of the informal investigation. A designated member of the committee conducting the informal action shall provide the Appointee with a follow up letter detailing shall the occurrence and any future expectations.

8.1.3. Informal Investigations Relating to Hospital Employee Complaint. If the circumstances prompting an informal investigation arise out of a Hospital employee’s report or allegation of Appointee misconduct, the informal investigation may, at the discretion of the Vice President/CEO or Medical Affairs and/or Chief Executive Officer, also serve to satisfy certain Hospital administrative policies regarding an employee’s report or allegation of misconduct, unless otherwise stated in such policies. In such instance, the identity of such employee shall be protected to the extent accorded by applicable Hospital policies. If the Appointee knows or has a reasonable suspicion as to the identity of such
employee, and such applicable Hospital policies state otherwise, the Appointee is prohibited from contacting the employee regarding such report or allegation. It is the responsibility of the Vice President/CEO of Medical Affairs and/or the Chief Executive Officer to notify the Appointee of such prohibition.

8.1.4. **Statutory Protections.** Formal and informal investigations and all proceedings, information, and records in connection with such informal investigations are considered peer review activities and are subject to the protection of Ohio's peer review privilege statutes as set forth at Ohio Rev. Code §§2305.25, et seq.

Nothing in this §8.1 shall be construed as obligating the Medical Staff leadership or Hospital to engage in informal remediation prior to implementing a formal investigation or other corrective action. Section 1 does not confer a procedural right to the Appointee, and any interview conducted under §8.1 shall not be subject to the provisions of Article 9.

**SECTION 8.2. FORMAL INVESTIGATIONS FOR CORRECTIVE ACTION**

8.2.1. **Notice and Request.** A voting member of the Medical Executive Committee, Board Member, Chief of Staff, Vice President/CEO of Medical Affairs, Department Chief, or the President/CEO may request the Medical Executive Committee to initiate a formal investigation regarding the necessity or advisability of corrective action against an Appointee. All requests for a formal investigation must be in writing, which may be reflected by minutes submitted to or created by the Medical Executive Committee, and supported by reference to specific activities or conduct that constitute grounds for the request. The Chief of Staff shall promptly notify the President/CEO of all such requests.

8.2.2. **Criteria for Initiation of Formal Investigation.** Upon notice or request to the Medical Executive Committee in accordance with §8.2.2 that there is reliable information that an Appointee may have exhibited acts, demeanor, or conduct that is reasonably likely to be (a) detrimental to patient safety or to the delivery of quality patient care within the Hospital; (b) unethical; (c) contrary to the bylaws or policies of the Hospital or Medical Staff Bylaws, Policies, Rules or Regulations; (d) a felony conviction of any degree or serious misdemeanor; or (e) below applicable professional standards of behavior or clinical management, the Medical Executive Committee, by majority vote, shall initiate a formal investigation.

8.2.3. **Procedure for Formal Investigation.** The MEC shall meet as soon after receiving the request for formal investigation as is practicable and if, in the opinion of the MEC, the request for a formal investigation contains on its face sufficient information to warrant action or investigation, the Medical Executive Committee shall immediately appoint an investigating committee (“ad hoc committee”) to do so. The ad hoc committee shall consist of at least three (3) persons of equivalent credentialing who may or may not hold appointment to the Medical Staff and must have at least one (1) Medical Staff Officer. The ad hoc committee shall also include any other individuals (who may or may not be Appointees) as is required by, or may be prudent, in accordance with relevant Hospital policy. Non-members of the MEC may be utilized in the investigation process in accordance with relevant Hospital policy and so long as appropriate steps are taken to
assure that the activities of such a non-member (as related to the investigatory process) are protected by Ohio’s peer review privilege and other relevant law.

The ad hoc committee shall not include anyone that is a partner or associate of those members sitting on the Medical Executive Committee, who is in economic competition with the Appointee, or otherwise has a conflict of interest. The ad hoc committee shall have available the full resources of the Medical Staff and the Hospital to aid in its work, as well as the authority to use outside consultants as required. The Appointee being investigated will be promptly notified of the investigation and the reason for such investigation and shall be given an opportunity to meet with the ad hoc committee before it makes its report. Prior to this meeting, the Appointee shall be informed of the charge and the evidence supporting the requested formal investigation; shall be provided access to any medical records involved in the formal investigation; and shall be invited to discuss, explain or refute the basis of the formal investigation. The investigative process, including any interviews conducted, does not constitute a "hearing" as that term is used in Article 9 and shall not entitle the Appointee to the procedural rights provided in Article 9. A record of such interview with the affected Appointee shall be made by the ad hoc committee and included with its report to the Medical Executive Committee. The formal investigation shall be completed and the report submitted to the Medical Executive Committee within thirty (30) days unless, for good cause shown, the Medical Executive Committee authorizes additional time for completion of the formal investigation.

At any time during the formal investigation, the Medical Executive Committee may suspend all or any part of the Clinical Privileges of the affected Appointee. This suspension shall be deemed to be administrative in nature, for the protection of Hospital patients. It shall remain in effect during the formal investigation only, without appeal, but in no event for longer than fourteen (14) days, and shall not indicate the validity of the charges. If such a suspension is placed into effect, the formal investigation shall be completed within fourteen (14) days. Nothing in this section shall limit or preclude the imposition of a summary suspension pursuant to these Bylaws.

The Appointee is not entitled to be represented by an attorney or other representative at any interview, meeting, review, informal investigation, formal investigation, or other proceeding or process that takes place prior to a formal hearing as that term is used in Article 9.

Unless otherwise required by law or Hospital policy, during a formal investigation concerning alleged Appointee misconduct based upon a report of such conduct by a Hospital employee, the identity of such employee shall not be disclosed to the Appointee or any other person on behalf of the Appointee. Further, if the employee is a current employee of the Hospital, such employee shall not be contacted, directly or indirectly, by the Appointee or his/her attorney, or any other person on behalf of the Appointee. During such formal investigation, the Appointee shall be informed as to the general and specific allegations of any employee’s allegations, and the Appointee may contact the President/CEO to request assistance in clarifying any aspect of the employee’s report of alleged misconduct.
If the ad hoc committee has reason to believe that the Appointee's conduct giving rise to the request for corrective action was the result of a physical or mental impairment, the MEC may either refer the matter to the Medical Staff Wellness Committee or require the Appointee to undergo an impartial physical or mental evaluation within a specified time and pursuant to guidelines set forth in the Medical Staff Wellness Policy. The MEC shall provide names of qualified independent third party Practitioners who may be asked to conduct the examination at the Appointee's expense.

8.2.4. Medical Executive Committee Action. As soon as practicable after conclusion of the investigative process, but in any event at its next meeting unless deferred, the Medical Executive Committee must act upon the recommendation of such investigative action. Its action may include without limitation:

a. Determining that no corrective action be taken.

b. Deferring action for a reasonable time where circumstances warrant.

c. Issuing a letter of admonition, censure, reprimand, or warning. In the event such letter is issued, the affected Practitioner may make a written response that shall be placed in the Practitioner's file.

d. Imposition of a probationary period with retrospective review of cases and/or other review of professional behavior, but without a requirement of prior or concurrent consultation or direct supervision.

e. Recommending the imposition of prior or concurrent consultation, direct supervision, or other form of probation that limits the Appointee's ability to exercise Privileges for a specified time period.

f. Referring the matter to the Medical Staff Wellness Committee for evaluation and action as appropriate for the Practitioner's condition.

g. Recommending reduction, suspension, or revocation of all, or any part, of the Appointee's Privileges.

h. Recommending reduction of Medical Staff category or limitation of any Medical Staff Prerogatives directly related to the Appointee's delivery of patient care, or suspension or revocation of Medical Staff appointment.

i. Take other actions deemed appropriate under the circumstances including summary suspension.

8.2.5. Procedural Rights. A Medical Executive Committee recommendation pursuant to 8.2.4(e) through (i) above may be deemed adverse and entitle an affected Appointee to the procedural rights contained in Article 9 when such restriction or revocation lasts longer than fourteen (14) days. If adverse action is taken or recommended, the Appointee must exhaust the remedies afforded by these Bylaws before resorting to legal action.
8.2.6. **Board Notification.** A Medical Executive Committee recommendation or action shall be forwarded to the Board together with all supporting documentation for information purposes. A recommendation or action that does not limit the ability of an Appointee to exercise his/her Prerogatives of appointment or Privileges is not deemed adverse and shall be transmitted to the Board.

8.2.7. **Summary Suspension; Automatic Suspension/Termination.** The commencement of corrective action procedures against an Appointee shall not preclude the summary suspension, or automatic suspension or termination of the Medical Staff appointment and/or all, or any portion of, the Appointee's Privileges in accordance with the procedures set forth in §§8.3, 8.4 and 8.5.

**SECTION 8.3. AUTOMATIC SUSPENSION OR LIMITATION**

8.3.1. **Imposition of Automatic Suspension or Limitation and Subsequent Process.** The following events shall result in an automatic suspension or limitation of appointment and/or Privileges without recourse to the procedural rights set forth in Article 9:

a. **Licensure.** Action by any federal or state authority suspending or limiting an Appointee’s professional license shall result in an automatic comparable suspension/limitation on the Appointee’s Privileges. Whenever an Appointee’s licensure is made subject to probation, the Appointee’s right to practice shall automatically become subject to the same terms of the probation. The imposition by the Ohio State Medical Board of any restriction or condition shall give rise to a formal investigation pursuant to §8.2 of these Bylaws.

b. **Controlled Substance Authorization.** Whenever an Appointee’s federal or state controlled substance certificate is suspended, limited, or revoked, or not renewed, the Appointee shall automatically and correspondingly be limited of the right to prescribe medications covered by the certificate as of the time such action becomes effective and through its term. Whenever an Appointee’s state or federal controlled substance certificate is made subject to probation, the Appointee’s right to prescribe such medications shall automatically become subject to the same terms of the probation.

c. **Professional Liability Insurance Coverage.** If an Appointee’s Professional Liability Insurance coverage lapses, falls below the required minimum, is terminated, or otherwise ceases to be in effect, in whole or in part, the Appointee’s granted Clinical Privileges shall be automatically suspended until valid coverage is obtained and becomes effective and the Hospital is provided with proof of required coverage and a written statement from the Appointee (i) explaining the circumstances of the previous insurance being canceled or not renewed, and any limitations on the new policy; and (ii) providing a summary of relevant activities during the period of no coverage to establish current competency. An automatic suspension of Privileges shall not apply if the Appointee has timely requested a waiver or reduction of such coverage in
connection with changed circumstances in compliance with law and these Bylaws, and is awaiting final action on such request.

d. **Federal Health Program.** Whenever an Appointee is suspended, for cause, from participating in a Federal Health Program, the Appointee’s Privileges shall be immediately and automatically suspended. Voluntary non-participation or exclusion for contractual non-participation is not grounds for suspension/termination.

e. **Failure to Provide Requested Information.** Failure to provide required information pursuant to a written request by the Medical Executive Committee or the President/CEO as set forth herein shall result in automatic suspension of all Privileges until the required information is provided. For purposes of this section, "required information" may include but not be limited to: (i) physical or mental examination reports if authorized by these Bylaws, or (ii) information regarding a conflict of interest.

f. **Failure to Satisfy Continuing Education Requirements.** Failure to complete mandated state licensure continuing education requirements shall result in automatic suspension of the Appointee’s Privileges and Prerogatives until such time as the requirements are met.

g. **Failure to Pay Dues/Assessments.** Failure to pay Medical Staff dues or fines as required within ninety (90) days after notice that such dues or fines are due shall result in an automatic suspension of the Appointee’s privileges until such time as the dues or fines are paid. An Appointee will not be granted a reappointment or regrant of Privileges to the Medical Staff unless and until all prior dues/assessments have been paid.

h. **Failure to Obtain NPI.** Failure to obtain a National Provider Identifier ("NPI"), (which is required as part of the administrative simplification section of the Health Insurance Portability and Accountability Act) shall result in the automatic suspension of the Practitioner’s Privileges until such time as the NPI is obtained.

i. **Failure to Complete Medical Records.** Whenever a Practitioner fails to complete medical records in accordance with applicable policy, rules and regulations, the Practitioner shall be automatically suspended consistent with such policy.

j. **Contractual.** When the Hospital elects to enter into an exclusive contract for the provision of certain services, an affected Practitioner who is not a party to the exclusive arrangement will not be able to exercise Privileges granted in the certain service.

8.3.2. **Impact of Automatic Suspension/Limitation.** During such period of time when an Appointee’s Privileges are suspended or limited pursuant to Section 8.3.1 above, he/she may not exercise any Prerogatives of appointment or exercise any Privileges at the Hospital, participate in Emergency Department call, schedule surgery, or otherwise provide professional services within the Hospital for patients. Provided, however, that if
a Practitioner’s Privileges are suspended pursuant to Section 8.3.1(i) (delinquent medical records), he/she may render professional care in the following circumstances:

a. Emergency Department call.

b. To conclude the management of any patient under his/her care in the Hospital at the time of the effective date of the suspension of Privileges.

c. To attend an obstetrical patient who has been under his/her active care and management and who comes to term and is admitted to the Hospital in labor.

d. To attend to the management of any patient under his/her care whose admission or outpatient procedure was scheduled prior to the effective date of the suspension.

e. To attend to the management of any patient requiring emergency care and intervention.

8.3.3. Action Following Imposition of Automatic Suspension. As soon as practical after the imposition of an automatic suspension, the MEC shall convene to determine if further corrective action is necessary in accordance with this Article 8. The lifting of the action or inaction that gave rise to an automatic suspension or limitation of the Practitioner’s Privileges shall result in the automatic reinstatement of such Privileges; provided, however, that to the extent the suspension or limitation remained in effect for a period of more than thirty (30) days, the Practitioner shall be obligated to provide such information as Medical Staff Services Department shall reasonably request to assure that all information in the Practitioner’s credentials file is current.

SECTION 8.4. AUTOMATIC TERMINATION

The following events shall result in an automatic termination of a Practitioner’s Privileges without recourse to the procedural rights set forth in Article 9.

8.4.1. Licensure. Action by any federal agency or the Ohio State Medical Board terminating an Appointee’s professional license or a Practitioner’s failure to renew his/her license.

8.4.2. Professional Liability Insurance. If a Practitioner’s Professional Liability Insurance coverage lapses, falls below the required minimum, is terminated, or otherwise ceases to be in effect for a period greater than sixty (60) days, the Practitioner’s privileges shall automatically terminate as of the sixty-first (61st) day. Termination shall not apply if the Practitioner has timely requested a waiver or reduction of such coverage in connection with changed circumstances in compliance with law and these Bylaws and is awaiting final action on such request.

8.4.3. Federal Health Program. Whenever a Practitioner is excluded, for cause, from participating in a Federal Health Program, the Practitioner’s Privileges shall be automatically terminated. Voluntary non-participation or exclusion for contractual non-participation is not grounds for suspension/termination
8.4.4. **Illegal Conduct.** If a Practitioner pleads guilty or no contest to, or is found guilty of, a felony of any degree or other serious misdemeanor offense that involves (i) violence or abuse upon a person, conversion, embezzlement, or misappropriation of property; (ii) fraud, bribery, evidence tampering, or perjury; or, (iii) a drug offense, (iv) an offense involving moral turpitude, the Practitioner’s Privileges shall be immediately and automatically terminated; provided, however, if the behavior that triggered the conviction is based upon Practitioner impairment, then the matter shall be referred to the Medical Staff Wellness Committee for consideration and recommendation to the MEC as to what action should be taken.

8.4.5. **Contracts.** If an Appointee has a contractual arrangement with the Hospital, the terms and conditions of the contract will govern the obligations of the Hospital and Medical Staff relative to corrective action under Article 8 of these Bylaws and will supersede the due process rights of the Appointee, if any, as set forth in Article 9 of these Bylaws to the extent that such due process rights are in conflict with the terms and conditions of the contractual arrangement.

**SECTION 8.5. SUMMARY SUSPENSION**

8.5.1. **Initiation.** A summary suspension may be initiated by the MEC, the Board, or any two (2) of the following (who shall be deemed to be acting as a peer review committee): a Medical Staff officer, the chair of the Board, the President/CEO, or a Department Chief (with respect to Appointees in the Department). Each has the authority to summarily suspend the Medical Staff appointment and/or suspend or restrict all, or any portion of, the Privileges of an Appointee whenever failure to take such action may result in an imminent danger to the health and/or safety of any individual. Such summary suspension/restriction shall be deemed an interim step for the purpose of investigation and not a final finding of responsibility for the situation that caused the suspension.

8.5.2. **Effective Date.** Such summary/suspension/restriction shall become effective immediately upon imposition, shall immediately be reported in writing to the President/CEO (unless imposed by the President/CEO) who will inform the Board and the Chief of Staff. The President/CEO must give prompt written notice, by Special Notice, of the suspension to the Appointee. Such suspension/restriction shall remain in effect unless or until modified by the Chief of Staff, the Board, or as provided in §8.5.3.

8.5.3. **Medical Executive Committee Action.** As soon as convenient, but in no event later than seventy-two (72) hours after a summary suspension is imposed, the MEC (if it did not impose the summary suspension) shall convene to review and consider the need, if any, for continuing the summary suspension. Such a meeting of the MEC shall not be considered a hearing as contemplated in Article 9 (even if the Appointee involved attends the meeting) and no procedural rights shall apply. The MEC may modify, continue, or terminate a summary suspension provided that the summary suspension was not imposed by the Board or the Chief Executive Officer. In the case of such summary suspension imposed by the Board or Chief Executive Officer, the MEC shall give its recommendation to the Board as to whether such summary suspension should be modified, continued, or terminated. The Board may accept, modify, or reject the MEC's
recommendation. Not later than fourteen (14) days following the original imposition of the summary suspension, the Appointee shall be advised, by Special Notice, of the MEC's determination or, in the case of a summary suspension imposed by the Board or CEO, of the MEC's recommendation as to whether such suspension should be terminated, modified, or sustained, and of the Appointee’s rights, if any, pursuant to Article 9.

8.5.4. **Procedural Rights.** Unless the summary suspension is lifted within fourteen (14) days of its imposition on the grounds that it was not necessary, the summary suspension shall be deemed adverse.

8.5.5. **Other Action.** A Medical Executive Committee recommendation to terminate or modify a summary suspension to a lesser sanction not triggering procedural rights must be transmitted, together with all supporting documentation, to the Board. In this instance, the Medical Executive Committee's recommendation will have the effect (except in the situation where the suspension was imposed by the CEO or the Board) of immediately revoking the summary suspension completely or reinstating the Appointee with whatever corrective action was assessed by the Medical Executive Committee pending the final decision of the Board of Directors.

**SECTION 8.6. CONTINUITY OF PATIENT CARE**

Upon the imposition of a summary suspension, automatic suspension, or automatic termination, and in the event that another member of the Practitioner's group is unable to assume care, a suspended/terminated Practitioner's patients then in the Hospital must be assigned to another Practitioner by an officer of the Medical Staff or the appropriate Department Chief. The wishes of the patient should be considered in choosing a substitute Practitioner when feasible.
ARTICLE 9.
CORRECTIVE ACTION

SECTION 9.1. INITIATION OF HEARING

Unless waived, an applicant or an Appointee shall be entitled to a hearing whenever an adverse recommendation or action has been made or taken by the Medical Executive Committee or the Board. The hearing shall be conducted pursuant to this Article. No applicant or Appointee shall be entitled as a matter of right to more than one (1) hearing with respect to the subject matter of any proposed adverse recommendation or action giving rise to a hearing right.

For purposes of this Article, the term “Appointee” shall include “applicant,” as appropriate. For purposes of this Article, in the event an adverse recommendation/action and subsequent hearing is triggered by the Board, then reference to the Chief of Staff shall mean the Board chair and reference to the Medical Executive Committee shall mean the Board, as applicable.

SECTION 9.2. THE HEARING

9.2.1. Notice of Adverse Recommendation/Action.

9.2.1.1. When an adverse recommendation is made or action taken which, according to these Bylaws, entitles an Appointee to a hearing prior to a final decision by the Board, the affected Appointee shall promptly be give notice, by Special Notice, by the Chief of Staff. This notice shall contain:

a. A statement of the adverse recommendation made/action taken and the reasons for it, including the Appointee's alleged acts or omissions, a list of the specific or representative medical records in question, if applicable, and any other information forming the basis for the adverse recommendation or action.

b. Notice that the Appointee has the right to request, in writing and by Special Notice to the Chief of Staff a hearing on the adverse recommendation/action within thirty (30) days of his/her receipt of the notice.

c. A summary of the Appointee's rights at the hearing as provided for in these Bylaws.

d. A statement that if the Appointee fails to request a hearing, in the manner and within the time period prescribed, such failure shall constitute a waiver of his/her right to a hearing and to an appellate review on the issue that is the subject of the notice.

9.2.1.2. The Appointee shall have thirty (30) days following the date of the receipt of such notice within which to request a hearing. The request must be made in writing, sent by Special Notice, to the Hospital President/CEO with a copy to
the MEC Chair. In the event the affected Appointee does not request a hearing within the time and in the manner hereinabove set forth, he/she shall be deemed to have waived his/her right to such hearing and to any appellate review to which he/she might otherwise have been entitled. The reports of the investigation of the ad hoc committee and the MEC, together with the adverse recommendation/action and all supporting material shall thereupon be referred to the Board for final action. The Appointee shall be informed of the Board's final decision by Special Notice.

9.2.2. **Grounds for Hearing.** Except as otherwise specified in these Bylaws, any one (1) or more of the following actions (when the basis for such action is related to clinical competence or professional conduct) shall be deemed adverse and entitle an Appointee to request a hearing, provided that the action(s) has been recommended by the MEC or taken by the Board under circumstances where no prior right to request a hearing existed:

a. Denial or termination of Medical Staff appointment or reappointment.

b. Suspension of Medical Staff appointment for longer than fourteen (14) days.

c. Denial or termination of requested Privileges.

d. Involuntary reduction of existing Privileges.

e. Suspension of Privileges for longer than fourteen (14) days.

f. Imposition of individual mandatory prior or concurrent consultation requirement or direct supervision or other form of probationary status that limits the ability to exercise Privileges.

g. Imposition of modifications of Privileges or conditions for reinstatement, if a report to the National Practitioner Data Bank is required.

9.2.3. **Actions That Do Not Give Right to a Hearing.** Notwithstanding the above provision, no Appointee shall be entitled to a hearing as a result of, but not limited to, the following actions described in this subsection:

(a) An oral or written admonition, reprimand or warning, or corrective counseling.

(b) The denial, termination, modification, or suspension of temporary, disaster, emergency, locum tenens, or telemedicine Privileges.

(c) Imposition of a probationary period with retrospective or concurrent review of cases provided that such probationary period does not otherwise limit the Appointee's ability to exercise his or her Privileges.

(d) Denial of requested Privileges because the Appointee failed to satisfy the basic qualifications or criteria of training, education, or experience established for the granting of Privileges for a specific procedure or procedures. Any action taken by
the MEC or the Board against an Appointee where the action was taken solely for administrative or technical failings of the Appointee (e.g. failure of an Appointee to satisfy the basic qualifications for Medical Staff appointment and/or Privileges, or to provide requested information, etc.)

(e) Ineligibility for Medical Staff appointment or reappointment or the Privileges requested, in whole or in part, because a Department/Section or subspecialty has been closed or there exists an exclusive contract limiting the granting of Privileges requested by the Appointee.

(f) Termination of or the inability to exercise Privileges either in whole or in part because the Hospital has determined to close a Department/Section or grant an exclusive contract limiting the ability of current Appointee’s to exercise such Privileges.

(g) Termination of the Appointee's employment or other contract for services with the Hospital or through a group contract unless the contract provides otherwise.

(h) Ineligibility for Medical Staff appointment or requested Privileges because of lack of facilities, equipment, or support services, or because the Hospital has elected not to perform, or does not provide, the service which the Appointee intends to provide or the procedure for which Privileges are sought.

(i) An automatic suspension or automatic termination of appointment and/or Privileges as defined in the Bylaws.

(j) Voluntary suspension or relinquishment of Privileges or Medical Staff appointment when professional competence or conduct is not at issue.

(k) Voluntary suspension or relinquishment of Privileges or Medical Staff appointment that is not tendered during a formal investigation or that is not in return for the Medical Staff or Board refraining from conducting a formal investigation based upon professional competence or conduct.

(l) An automatic transfer to the Associate Medical Staff category, as defined at Section 3.3.1, on the basis that the Appointee failed to exercise any of the Privileges granted to the Appointee during the prior two (2) year period.

(m) Any other action that does not relate to the competence or professional conduct of an Appointee.

(n) A change in Medical Staff category resulting from a failure to meet minimum objective criteria for a particular Medical Staff category.

(o) Temporary restriction or suspension of Privileges for a period of not longer than fourteen (14) days while an investigation is pending or otherwise in accordance with corrective action that does not give rise to due process rights under the Bylaws.
(p) The appointment of an ad hoc investigation committee or the conduct of an investigation into any matter, or a resulting report of, or recommendation made by such committee.

(q) The imposition of observation, focused review, monitoring, proctoring, educational or training requirements, consultation or review requirements, any of which do not restrict Privileges and is not reportable to the National Practitioners Data Bank.

(r) Removal from an elected office under Article 4 or removal from an elected position under Article 5 of these Bylaws.

9.2.4. Notice of Hearing and Statement of Reasons. The Chief of Staff is responsible for scheduling the hearing and giving notice, in writing, by Special Notice, to the affected Appointee of the time, place, and date of the hearing. The hearing shall begin as soon as practicable, considering the schedules and availability of all concerned, but in no event earlier than thirty (30) days from the date of the hearing notice (unless the affected Appointee and the MEC agree to an earlier time). The notice shall contain the original statement of the reasons for the recommendation/action as well as the list of patient record numbers (if applicable) and information supporting the recommendation/action; a list of witnesses, if any, expected to testify on behalf of the MEC; and a summary of the Appointee’s rights in connection with the hearing.

9.2.5. List of Witnesses. A written list of the names and addresses of the individuals so far as is then reasonably known, who will give testimony or evidence in support of the Medical Executive Committee shall be given with the notice of hearing. The Appointee requesting the hearing shall provide a written list of the names and addresses of the individuals expected to offer testimony or evidence on his/her behalf within ten (10) days after receiving notice of the hearing. The witness list of either party may, at the discretion of the presiding officer, be supplemented or amended at any time during the course of the hearing, provided that notice of the change is given to the other party.

9.2.6. Exhibits. The parties shall cooperate in the exchange of exhibits reasonably in advance of the hearing date. Prior to any exchange of exhibits, the parties must agree that all such documents will be maintained as confidential peer review documents and not be disclosed or used for any purpose other than the hearing and appeals related thereto.

9.2.7. Objections. All objections to witnesses or exhibits to the extent then reasonably known, shall be submitted to the presiding officer in writing in advance of the hearing.

9.2.8. Continuing Obligation. Each party remains under a continuing obligation to provide to the other party any exhibits or witnesses identified after the initial exchange which a party intends to introduce at the hearing. The introduction of any exhibits not provided prior to the hearing, or the admissibility of testimony to be presented by a witness not so listed, shall be at the discretion of the presiding officer.
SECTION 9.3. HEARING PANEL AND PRESIDING OFFICER

9.3.1. **Determination.** The hearing shall be conducted by a hearing panel as that term is defined herein.

9.3.1.1. **Presiding Officer.** The President/CEO and the Chief of Staff shall appoint a presiding officer who is experienced in conducting administrative hearings and, in particular, peer review hearings and is knowledgeable regarding HCQIA and Ohio law. The presiding officer may be an Appointee or an individual from outside the Hospital qualified to conduct the hearing. The affected Appointee shall be notified of the name of the prospective presiding officer and, if the affected Appointee has an objection to such appointment he/she shall, within five (5) calendar days after notification, state the objection and reason therefor in writing to the Chief of Staff. The President/CEO and Chief of Staff, after considering such objection, shall decide, in their sole discretion, whether to uphold the objection and replace the presiding officer.

9.3.1.2. **Hearing Panel.** When a hearing is requested, the President/CEO and Chief of Staff shall appoint a hearing panel which shall consist of either:

   a. A single impartial individual who may be an Appointee, Practitioner, or layperson (such as an attorney or retired judge) not connected with the Hospital.

   b. Not less than three (3) impartial individuals with one (1) alternative, none of whom actively participated in the consideration of the matter involved at any previous level. The individuals may be Appointees, Practitioners, or lay persons not connected with the Hospital, or any combination of such persons, except that if the matter involves an issue of clinical quality, then the panel should be composed, where feasible, with at least one (1) member who is an individual practicing the same specialty as the affected Appointee. The Chief of Staff shall designate one (1) of the panel members to act as panel chair (with the right to vote); and shall appoint a presiding officer (e.g. an attorney), in addition to the hearing panel members, to assist the hearing panel but who shall not have the right to vote on the hearing panel's recommendation. Subject to (c) below, knowledge of the matter involved shall not preclude any individual from serving as a member of the hearing panel.

9.3.1.3. **Service on Hearing Panel.** Any person shall be disqualified from serving on the hearing panel or as a presiding officer if the person directly participated in initiating the adverse recommendation or action or in investigating the underlying matter at issue; if the person has taken an active part in the matter contested; or, if the person is a direct economic competitor or otherwise has a conflict of interest with the Appointee involved in the hearing. In the event that an attorney serves as the hearing officer or as a presiding officer, he/she must not represent clients
in direct economic competition with the Appointee who is the subject of the hearing.

9.3.2. **Failure to Appear.** The personal presence of the Appointee who requested the hearing shall be required at the hearing. An Appointee who fails, without good cause, to appear and proceed at such a hearing shall be deemed to have waived his/her right to such hearing and to any appellate review to which he/she might otherwise have been entitled. The matter shall then be referred to the Board for final decision.

9.3.3. **Time Frame, Postponements, and Extensions.** A hearing must occur no later than three (3) months after receipt of the request therefore, unless postponements or extensions are granted. Postponements and extensions of time beyond any time limit set forth in these Bylaws may be requested but shall be permitted only by the President/CEO if a hearing date has not yet been set, or only by the presiding officer after such has been appointed. The affected Appointee must make every reasonable effort to be available for the hearing dates established by the President/CEO and/or presiding officer.

**SECTION 9.4. HEARING PROCEDURE**

9.4.1. **Representation.** The affected Appointee, at his/her sole expense, shall be entitled to be represented at the hearing by an attorney or other person of the Appointee's choice to examine/cross-examine witnesses and present his/her case. He/She shall inform the President/CEO, in writing, of the name of that person not less than ten (10) days prior to the date of the hearing. The President/CEO may also appoint a person, who may be an attorney, to represent the position of the MEC and who may examine and cross-examine witnesses at the hearing. Presentation by counsel shall in no way interfere with the ability of the hearing officer/panel to hear directly from the affected Appointee.

9.4.2. **Presiding Officer.** The presiding officer must not act as a prosecuting officer or as an advocate for either side at the hearing. The presiding officer shall act to insure that all participants in the hearing have a reasonable opportunity to be heard and to present all oral and documentary evidence, that decorum is maintained throughout the hearing, and that no intimidation is permitted. He/She shall have the authority and discretion, in accordance with these Bylaws, to make rulings on all questions that pertain to matters of procedure, the admissibility of evidence, access to information, and regarding requests for postponements or extensions of time, and shall generally be responsible to regulating the proceedings. The presiding officer shall have the authority to impose time limits for examination and cross-examination of witnesses, and to limit the number of witnesses to be called. It is understood that the presiding officer is acting at all times to see that all relevant information is made available to the hearing panel for its deliberations, report, and recommendation(s) to the Board.

9.4.3. **Record of Hearing.** A record of the hearing shall be maintained by a court reporter. The cost of such court reporter shall be borne by the Hospital. Upon request, the affected Appointee shall be entitled to obtain a copy of the record at his/her own expense. The record of any hearing is absolutely protected from disclosure to the greatest extent permitted by law.
9.4.4. **Rights of Both Sides.** At the hearing both sides shall have the following rights: to be represented by an attorney or other person of the party's choice; to be provided with a list of witnesses and copies of documents to be relied upon by the other party at the hearing; to have a record make of the proceedings, copies of which may be obtained by the affected Appointee upon payment of any reasonable charges associated with the preparation thereof; to call and examine witnesses to the extent available and relevant; to introduce exhibits; to cross-examine any witness on any matter relevant to the issues; to present and/or rebut any evidence determined relevant by the presiding officer regardless of the admissibility of the evidence in a court of law; to submit a written statement at the close of the hearing; to receive, upon completion of the hearing, a copy of the written recommendation of the hearing panel (including a statement of the basis for the hearing panel's recommendation); and, to receive a copy of the written decision of the Board (including a statement of the basis for the Board's decision).

9.4.5. **Admissibility of Evidence.** The hearing shall not be conducted according to rules of Ohio law, or any other state or sovereign law, relating to the examination of witnesses or presentation of evidence; provided, however, that oral evidence shall only be taken on oath or affirmation administered by any person designated by the presiding officer and entitled to notarize documents in the State of Ohio. Any relevant evidence may be admitted by the presiding officer if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The hearing panel may question the witnesses, call additional witnesses, or request documentary evidence or a memorandum of points and authorities if deemed appropriate. It shall not be a defense to any action proposed by the MEC or the Board that different actions have been taken in the past with regard to any other Practitioner. No affected Appointee shall be permitted to introduce any evidence at the hearing or have access to any peer review records, medical records, minutes, or other documents relating to any other Practitioner, or any action taken or not taken with regard to any other Practitioner. The affected Appointee shall be entitled to any documents relied on by the MEC or Board in making any recommendation or decision (unless otherwise stated herein), and to any documents to be introduced at the hearing, and to any medical records relied on or to be introduced at the hearing, so long as the affected Appointee and his/her attorney/representative agree in writing to keep all such documents confidential and not use them for any purpose other than in the hearing and appellate review proceedings. The production of such documents shall not constitute a waiver of any peer review protection for those documents or any other documents.

9.4.6. **Official Notice.** The presiding officer shall have the discretion to take official notice of any matters, either technical or scientific, relating to the issues under consideration that may be judicially noticed by the courts of the State of Ohio. Participants in the hearing shall be informed of the matters to be officially noticed and such matters shall be noted in the record of the hearing. Either party shall have the opportunity to request that a matter be officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority. Reasonable additional time shall be granted, if requested, to present written rebuttal of any evidence admitted on official notice.
9.4.7. **Observers.** The hearing shall be restricted to those individuals involved in the proceeding. Appropriate administrative personnel may be present as determined by the Chief of Staff and the President/CEO.

9.4.8. **Basis of Report and Recommendation.** The decision of the hearing panel shall be based on the evidence produced at the hearing. This evidence may consist of the following:

a. Oral testimony of witnesses.

b. Memorandum of points and authorities presented in connection with the hearing.

c. Any information regarding the affected Appointee so long as that information has been admitted into evidence at the hearing and the affected Appointee had the opportunity to comment on and, by other evidence, refute it.

d. All officially noticed matters.

e. Any other evidence that has been admitted.

9.4.9. **Order of Presentation.** At the hearing, the MEC and the affected Appointee may make opening statements. Following the opening statements, the evidence will be presented in the following order:

a. The MEC shall first come forward with evidence in support of its recommendation/action.

b. The affected Appointee shall then come forward with evidence in his/her support.

c. The MEC may then submit evidence in rebuttal to that presented by the affected Appointee.

d. The MEC may then make a closing statement.

e. The affected Appointee may then make a closing statement. The affected Appointee’s right to make a closing statement is not foreclosed if the MEC elects not to make a closing statement.

f. The triggering party and the affected Appointee may submit written statements within fourteen (14) days of the adjournment of the hearing (See subsection 9.4.12).

9.4.10. **Burden of Proof.** In order to prevail, the affected Appointee must establish by clear and convincing evidence (substantially more likely than not) that the recommendation/action that prompted the hearing was unreasonable, not sustained by the evidence, or otherwise unfounded.

9.4.11. **Attendance By Hearing Panel Members.** Recognizing that it may not be possible for all members of the hearing panel to be present continually at all sessions of the panel, the
hearing may continue provided at least two (2) members of the hearing panel are present at all times. The fact that certain panel members were not physically present at all times during the hearings will not disqualify them or invalidate the hearing. The vote shall be by majority of those appointed to the hearing panel. An alternate shall be disqualified if not present at all times.

9.4.12. Recesses and Adjournment. The presiding officer may recess the hearing and reconvene the same for the convenience of the participants, to obtain new or additional evidence, or if consultation is required for resolution of the matter. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The hearing shall be adjourned at such time as the transcript of the proceedings is received, or upon the submission of written closing statements by the parties (if applicable), whichever is later.

9.4.13. Deliberations and Recommendations of the Hearing Officer. Within twenty (20) days after adjournment of the hearing, the hearing panel shall deliberate outside the presence of any other person except the presiding officer and shall render a written report and recommendation that shall contain a concise statement of the reasons justifying the recommendation made. The hearing recommendation shall be based exclusively upon the evidence presented at the hearing as set forth in Subsection 11.4.8.

9.4.14. Disposition of Hearing Officer Report & Recommendation. Upon its receipt, the President/CEO shall forward the hearing panel's report and recommendations, along with all supporting documentation, to the MEC. Within fifteen (15) days of receiving the hearing panel's report and recommendation, the MEC shall make its final recommendation and deliver it to the President/CEO, who shall deliver such to the Board (if the Board is not the initiating body) for final determination.

a. Favorable Recommendation or Action. When the MEC's recommendation is favorable to the affected Appointee, the Board may adopt or reject all, or any portion, of the MEC's recommendation, or refer the matter back to the MEC for additional consideration. Any such referral shall state the reason(s) for the requested reconsideration, set a time limit within which a subsequent recommendation must be made, and may include a directive that an additional hearing be conducted to clarify issues in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, the Board shall take action. A favorable determination by the Board shall be effective as its final decision and the matter shall be considered closed.

b. Adverse Recommendation or Action. If the recommendation of the MEC is or continues to be adverse to the affected Appointee after exhaustion of his/her hearing rights, the Appointee shall be entitled, upon timely and proper request, to an appellate review before a final decision is rendered on the matter by the Board.

c. Notice of Result. The President/CEO shall provide a copy of the final recommendation, together with a copy of the hearing panel's report and recommendation, to the affected Appointee, by Special Notice, and to the Board. The Board shall also be provided with a copy of the transcript of the proceedings.
and exhibits. In the event of an adverse result, the notice shall inform the affected Appointee of the right to request an appellate review by the Board before a final decision regarding the matter is rendered.

SECTION 9.5. APPEAL

9.5.1. Time for Appeal. Within ten (10) days after the affected Appointee is notified of the MEC’s final recommendation/action, and provided such recommendation/action continues to be adverse, he/she may request an appellate review. The request shall be in writing, be delivered to the President/CEO by Special Notice, and include a brief statement of the reasons for appeal. If such appellate review is not requested within ten (10) days as provided herein, the affected Appointee shall be deemed to have accepted the final recommendation/action, and it shall thereupon be referred to the Board for final action.

9.5.2. Grounds for Appeal. The grounds for appeal from an adverse recommendation/action are limited to:

a. There was substantial failure on the part of the Medical Executive Committee or hearing panel to comply with the Medical Staff Bylaws in the conduct of hearings and/or recommendations/actions based upon hearing so as to deny procedural due process.

b. The recommendation/action was made arbitrarily, capriciously or with prejudice.

c. The recommendation/action was not supported by the evidence.

9.5.3. Time, Place, and Notice. Whenever an appeal is requested and is consistent with the grounds for appeal as set forth in the preceding sections, the President/CEO (after consultation with the Board chair) shall promptly schedule and arrange for an appellate review. The President/CEO shall give the affected Appointee notice of the time, place, and date of the appellate review.

9.5.4. Nature of Appellate Review

9.5.4.1. Review Panel. The Board may hear the appeal as a whole or the chair may appoint a subcommittee composed of not less than three (3) Board members.

9.5.4.2. Additional Evidence. In the event a party seeks to submit additional evidence at the appeal, it will be considered only if the Review Panel determines, at its discretion, that (1) the party seeking to admit it has demonstrated that he/she was unfairly deprived of the opportunity to admit it at the hearing; or (2) the information was not known, and on the basis of reasonable efforts could not have been known, at the time of the hearing. The Review Panel, at its discretion, shall decide whether to (1) hear the evidence, subject to the same rights of cross-examination or confrontation provided at the hearing; or (2) remand the matter back to the presiding officer and direct that the hearing be re-opened. In the latter case, the presiding officer shall be required to submit an amended report and
recommendation to the triggering body and the provisions of subsections 10.3.5 and 10.3.6 shall thereafter apply.

9.5.4.3. Written Statements and Oral Arguments. Each party shall have the right to present a written statement in support of his/her position on appeal. At its sole discretion, the Review Panel may allow each party or its representative to appear personally and present oral arguments. The Review Panel, if consisting of less than the full Board, shall recommend final action to the Board. Its recommendation shall be in writing and supported by the reasons for such recommendation.

9.5.5. Final Decision of the Board

9.5.5.1. Board Decision. If the appellate review is conducted by the Board as a whole, the Board may render its final decision upon conclusion of the appellate review or may defer rendering its final decision until its next regularly scheduled Board meeting. If the appellate review is conducted by a subcommittee of the Board, the Board shall render its final decision at its next regularly scheduled Board meeting following receipt of the subcommittee’s written recommendation. In such event, the Board may affirm, modify, or reverse the recommendation of the subcommittee or, at its discretion, refer the matter back to the subcommittee or the hearing panel for further action. The President/CEO shall then be responsible for notifying the MEC and the affected Appointee (by Special Notice), in writing, of the Board’s final decision.

9.5.5.2. Reporting Obligations. If the final decision of the Board is adverse, the decision shall include the actual coding and a description of the underlying action that will be reported to the National Practitioner Data Bank.

9.5.5.3. Further Review. Except where the matter is referred for further action and recommendation in accordance with this Article, the final decision of the Board following the appeal shall be effective immediately and shall not be subject to further review. If the matter is referred for further action and recommendation, such recommendations shall be promptly made to the Board in accordance with the instructions given by the Board. This further review process and the report back to the Board should not, except for good cause shown as determined by the Board, exceed thirty (30) days in duration.

9.5.5.4. Right to One Appeal Only. No Appointee shall be entitled as a matter of right to more than one (1) appellate review on any single matter that may be the subject of an appeal, without regard to whether such subject is the result of action by the Medical Executive Committee the Board, or a combination of acts of such bodies. In the event that the Board ultimately determines to deny initial appointment or reappointment to the Medical Staff or Privileges to an applicant, or to revoke or terminate the Medical Staff appointment and/or Privileges of an Appointee, that Appointee may not again apply for Medical Staff appointment or
Privileges at the Hospital for a period of two (2) years from the final Board decision, unless the Board’s decision provides otherwise.

SECTION 9.6. REPRESENTATION BY COUNSEL

At such time as the Appointee, Medical Executive Committee, or Board is represented by legal counsel, then all notices required to be sent herein may be served upon the Appointee or MEC/Board’s legal counsel, and the requirement that such notices be sent by Special Notice is hereby waived; rather, such notices may be sent by regular first class U.S. mail.
ARTICLE 10.
REVIEW, REVISION, ADOPTION AND AMENDMENT

SECTION 10.1. MEDICAL STAFF RESPONSIBILITY

The Medical Staff shall have the responsibility to formulate, review, adopt, and recommend to the Board Medical Staff Bylaws, Manuals, and amendments thereto, which shall be effective when approved by the Board. Such responsibility shall be exercised in good faith and in a reasonable, responsible, and timely manner. Neither the Board nor the Medical Staff may unilaterally amend or nullify the Medical Staff Bylaws or other related Medical staff governance documents. Rather, the provisions set forth in this Article X shall be the sole means for creating or adopting such documents. The Medical Staff shall review the Bylaws and Manuals at least once every two (2) years. Policies of the Medical Staff shall be supportive of and congruent with the Medical Staff Bylaws and other related documents.

SECTION 10.2. METHODS OF ADOPTION AND AMENDMENT

Publication: Bylaw revisions and amendments shall be sent in hard copy or electronically to the Members of the Medical Staff eligible to vote for approval and vote. Voting may also be by electronic means or other method as determined by the MEC.

Urgent Amendment to Bylaws: In cases of urgent, documented need, the Bylaws may be temporarily amended by a two-thirds (2/3) affirmative vote at a regular or Special Meeting of the MEC with subsequent approval by the Governing Body. Such temporary amendments shall be submitted to the Medical Staff at the next Annual or Special Meeting at which time they shall either be affirmed or disbanded according to the voting procedure described in these Bylaws.

Medical Staff Bylaws may be adopted, amended or repealed by the following actions:

10.2.1. Medical Executive Committee Action: The Medical Executive Committee may make corrections and minor, non-substantive, technical changes when such correction or change is necessary due to a change in law, or due to clerical error such as spelling, punctuation, or grammar. Any correction or technical change shall be approved by the affirmative vote of two-thirds (2/3) of the Medical Executive Committee. No prior notice to the Medical Staff of such change is required. All corrections or changes thus made will be reported at the next scheduled general meeting of the Medical Staff.

10.2.2. Medical Staff Action. The Bylaws may be adopted, amended, or repealed by the affirmative vote of two-thirds (2/3) of the active Appointees in Good Standing present at a regular or special meeting of the Medical Staff provided that a copy of the proposed documents or amendments was provided to each active Appointee not less than twenty-one (21) days in advance of the meeting and provided that each active Appointee was notified that such matter would come to vote at the meeting. Absentee ballots are permitted.

10.2.3. Board Action. Adoption, amendment, or repeal of the Medical Staff Bylaws shall require the affirmative vote of the Board of Directors.
SECTION 10.3. RELATED MEDICAL STAFF GOVERNANCE DOCUMENTS

The MEC may develop and amend Manuals and Medical Staff policies provided that such documents are approved by a two-third (2/3) vote of the voting members of the Medical Executive Committee. The development and amendment of such Manuals and Medical Staff policies will not require the approval of the active Medical Staff. Such Manuals and Medical Staff policies must be consistent with the Bylaws. Any such Manual or Medical Staff policy, or amendments thereto, shall not become effective until approved by the Board. The Medical Staff will be notified of any such documents or amendments, and such documents will be available in the Medical Staff Services Department for review. A current copy of the Bylaws, Organization Manual, and, Credentials Policy Manual will be made available to allow the Practitioner to attest to reading and abiding by them at the time of appointment, reappointment, and/or grant of Privileges.

SECTION 10.4. BOARD ACTION

10.4.1. Conflict with MEC/Medical Staff Recommendation. If the Board has determined not to accept a recommendation submitted to it by the Medical Executive Committee or the Medical Staff, the Medical Executive Committee may request a conference between the officers of the Board and the officers of the Medical Staff. Such conference shall be for the purpose of further communicating the Board's rationale for its contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the recommendation. The President/CEO will schedule such conference within fourteen (14) days after receipt of a request for a conference from the Chief of Staff. The Board may then take final action.

10.4.2. Board-Initiated Action.

In the event the Medical Staff or MEC, as applicable, fails to exercise its responsibility in good faith and in a reasonable and timely manner, and after written notice from the Board to such effect, including a reasonable time for responses, the Board may take action pursuant to these Bylaws. Should the Medical Staff/MEC fail to respond under such circumstances or should the Board disagree with any responses or recommendations from the Medical Staff/MEC for adoption, amendment or repeal of, as applicable, the Medical Staff Bylaws, Manuals, or Medical Staff policies, the Board’s recommendation shall be referred to a Joint Conference Committee for consideration of the recommendations of the Board and the Medical Staff/MEC regarding the proposed adoption, amendment or repeal of, as applicable, the Bylaws, Manuals or Medical Staff policies prior to final action by the Board.

The Joint Conference Committee shall make a recommendation to the Board within thirty (30) days of receipt of the proposed adoption, amendment or repeal of, as applicable, the Bylaws, Manuals, or Medical Staff policies. At its next regularly scheduled meeting after receipt of a recommendation from the Joint Conference Committee, the Board shall take final action with respect to the adoption, amendment, or repeal under consideration. Such action by the Board may include ratifying or modifying, in whole or in a part, the recommendation of the Joint Conference Committee in order to remain in compliance.
with law and accreditation requirements. Should there be a tie among the Joint Conference Committee members with respect to the issues being considered, the chair of the Board shall be called upon to cast a vote on the issue under consideration.

10.4.3. **Conflict within Documents.** In the event of a conflict between the Hospital’s code of regulations or a Hospital policy and the Medical Staff Bylaws, the Hospital’s code of regulations or policy, as applicable shall control. If there is a conflict between the Medical Staff Bylaws and a Manual or Medical Staff policy, the Medical Staff Bylaws shall control. Such conflict shall then be reviewed by the MEC to determine how such conflict can be resolved.

**SECTION 10.5. APPOINTEE ACTION**

To the extent that a Manual provision or Medical Staff policy is not required by federal or state law or regulations, accrediting or certification standards, Medicare Conditions of Participation, or third party payors, any active Appointee in Good Standing may raise a reasonable challenge made in good faith to any Manual provision(s) or Medical Staff policy established by the MEC and approved by the Board. In order to raise such challenge, the active Appointee must submit to the MEC a petition signed by not less than ten percent (10%) of the active Appointees in Good Standing. Upon receipt of the petition, the MEC shall either (a) provide the petitioner(s) with information clarifying the intent of such Manual provision(s) or Medical Staff policy; and/or (b) schedule a meeting with the petitioner(s) to discuss the issue. In the event that the issue cannot be resolved to the satisfaction of the petitioner(s), the matter shall be brought before the Medical Staff for vote and forwarded to the Board for final action.

**NOTE:** The Appointee is responsible for researching relevant federal and state law and regulations, accrediting and certification standards, Medicare Conditions of Participation, and third party payors’ requirements, and must believe, in good faith, that the provision or policy being challenged is not required under any of such law, regulations, standards, or conditions.

**SECTION 10.6. MISCELLANEOUS**

If significant changes are made to any of the Medical Staff governing documents, Appointees to the Medical Staff and other Practitioners or AHPs who have Privileges that are affected by such changes shall be provided with a text of the revised materials.
ARTICLE 11.
CONFIDENTIALITY, IMMUNITY AND RELEASE

SECTION 11.1. SPECIAL DEFINITIONS

For purposes of the Article, the following definitions shall apply:

- INFORMATION means record of proceedings, minutes, interviews, records, reports, forms, memoranda, statements, investigations, examinations, hearing, meetings, recommendations, findings, evaluations, opinions, conclusions, actions, data and other disclosures or communications whether in written or oral form relating to any of the subject matter specified in §1.5.

- REPRESENTATIVE means the Board and any director or committee thereof; the President/CEO or the President/CEO’s designee; registered nurses and other employees of the Hospital; the Medical Staff organization and any Appointee, officer, Department, or committee thereof; any individual authorized by any of the foregoing to perform specific information gathering, analysis, use or disseminating functions.

- THIRD PARTIES means any individual or organization providing information to any Representative.

SECTION 11.2. AUTHORIZATIONS AND RELEASES

Each Practitioner shall, upon request of the Hospital, execute general and specific releases and authorizations in accordance with the tenor and import of this Article, subject to such requirements as may be applicable under the state of Ohio and federal law. Execution of such releases and authorizations is not a prerequisite to the effectiveness of this Article. Such releases and authorizations will operate in addition to the provisions of this Article.

By submitting an application for Medical Staff appointment or reappointment or by applying for or exercising privileges or scope of services at the Hospital, a Practitioner:

a. Authorizes Representatives to solicit, provide and act upon information bearing on his or her professional ability and other qualifications.

b. Agrees to be bound by the provisions of the Article and to waive all legal claims against any Representative who acts in accordance with the provisions of the Article.

c. Acknowledges that the provisions of this Article are express conditions to his or her application for, or acceptance of, Medical Staff appointment and the continuation of such appointment and to his/her exercise of Privileges or provisions or specified patient care services at the Hospital.
SECTION 11.3. CONFIDENTIALITY OF INFORMATION

Information with respect to any Practitioner submitted, collected or prepared by any representative of this or any other health care facility or organization or medical staff for the purpose of evaluating, monitoring or improving the quality, appropriateness and efficiency of patient care, reducing morbidity and mortality, contributing to teaching or clinical research, or determining that health care services are professionally indicated or were performed in compliance with the applicable standards of care or establishing and enforcing guidelines to help keep health care costs within reasonable bounds shall, to the fullest extent permitted by law, be confidential. Said information shall not be disseminated to anyone other than a representative or other health care facility or organization of health professionals engaged in an official, authorized activity for which the information is needed, nor be used in any way except as provided herein or except as otherwise required by law. Such confidentiality shall also extend to information of like kind that may be provided to third parties. This information shall not become part of any particular patient's record. It is expressly acknowledged by each Practitioner that violation of the confidentiality provided herein is grounds for immediate and permanent revocation of Medical Staff appointment and/or Privileges or specified services.

SECTION 11.4. IMMUNITY FROM LIABILITY

11.4.1. For Action Taken. No Representative of the Hospital or Medical Staff shall be liable to a Practitioner for damages or other relief for any decision, opinion, action, statement or recommendation made within the scope of his or her duties as a representative, unless such representative acts on the basis of false information knowing it to be false, after reasonable effort under the circumstances to ascertain the truthfulness of the facts and in the reasonable belief that the decision, opinion, action, statement, or recommendation is warranted by such facts.

11.4.2. For Providing Such Information. No Representative of the Hospital or Medical Staff and no Third Party shall be liable to a Practitioner for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative of this Hospital or Medical Staff or to any other health care facility or organization of health professionals concerning a Practitioner who is or has been an Applicant to or Appointee of the Medical Staff or who did or does exercise Clinical Privileges or provide specified services at this Hospital, provided that such representative or Third Party does not act on the basis of false information knowing it to be false, and provided further that such information is related to the performance of the duties and functions of the recipient and is reported in a factual manner.

SECTION 11.5. ACTIVITIES AND INFORMATION COVERED

11.5.1. Activities. The confidentiality and immunity provided by this Article applies to all acts, communications, proceedings, interviews, reports, records, minutes, forms, memoranda, statements, recommendations, findings, evaluations, opinions, conclusions or disclosures performed or made in connection with this or any other health care facility's or organization's activities concerning, but not limited to:
a. Applications for appointment, privileges, or specific services.

b. Periodic reappraisals for reappointment, privileges or specific services.

c. Corrective actions, recommended or taken.

d. Hearings and appellate reviews.

e. Performance improvement/quality assessment activities.

f. Utilization review activities.

g. Claims reviews.

h. Profiles and profile analysis.

i. Risk management activities.

j. Other Hospital, committee, Department, or Medical Staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

11.5.2. Information. The information referred to in this Article may relate to a Practitioner's professional licensure or certification, education, training, clinical competency, judgment, utilization practices, character, ability to fully and competently carry out the privileges requested, professional ethics, or any other matter that might directly or indirectly affect the quality, efficiency, or appropriateness of patient care provided in the Hospital.

SECTION 11.6. CUMULATIVE EFFECT

Provisions in these Medical Staff Bylaws and in application forms relating to authorization, confidentiality of information, and immunities from liability are in addition to other protections provided by state and federal law and not in limitation thereof.

SECTION 11.7. Conflict of Interest

Conflicts of interest among Medical Staff leaders are not completely avoidable since they often indicate broad experience, accomplishments and diversity. The goals of the Medical Staff are therefore to identify and manage interests that could conflict with fulfilling the Medical Staff’s responsibilities and functions and to ensure the integrity of Medical Staff decision making.

Disclosure. Elected and appointed Medical Staff leaders, entrusted with fulfilling the Medical Staff’s responsibilities and with decision-making authority on behalf of the Medical Staff, shall use good faith to disclose material financial and personal interests that may potentially lead to a conflict to the Medical Staff as described below. Candidates for elected and appointed Medical Staff leadership positions shall disclose material financial and personal interests with potential for conflicts to the MEC prior to election and appointment.
Means. When relevant to a deliberation or decision on behalf of the Medical Staff (e.g., during a committee meeting), Medical Staff leaders should disclose interests verbally to the relevant Medical Staff body. The existence of a potential conflict of interest or bias on the part of any leader may be called to the attention of the Chief of Staff, applicable committee chair, or Department Chief by any other member with knowledge of a potential conflict.

Confidentiality. Any documentation of disclosures shall be maintained by Medical Staff Services as privileged and confidential, pursuant to Medical Staff-approved policy and not be accessible or used for other purposes.

Action on the Disclosure. Whether a disclosed interest constitutes a conflict (and, if so, its nature and scope) is determined by the deliberating Medical Staff committee. If a conflict is identified, the committee shall take the least disruptive action(s) to manage the conflict and to preserve (to the extent feasible and appropriate) the leader’s ability to carry out his/her leadership responsibilities, including but not limited to: (1) Abstention from voting on the matter to which the conflict relates; (2) Recusal from the decision-making process; and/or (3) Non-receipt of written and/or verbal information related to the matter to which the conflict relates.

Failure to Disclose. The MEC may take appropriate action when a leader has failed to disclose, abstain or recuse as required by these Bylaws and as is applicable to Hospital and Medical Staff Policies governing Conflicts of Interest.
CERTIFICATION OF ADOPTION AND APPROVAL

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

Adopted by the Board of Directors on
November 14, 2013

[Signature]
Chair
Board of Directors

Adopted by the Medical Staff on
December 9, 2013

[Signature]
Chief of Staff