



Marymount Hospital

a Cleveland Clinic hospital

MEDICAL STAFF & ALLIED HEALTH PROFESSIONAL STAFF BYLAWS

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MARYMOUNT HOSPITAL
GARFIELD HEIGHTS, OHIO 44125

Board of Trustees Approved 08.18.15

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MEDICAL STAFF BYLAWS
OF
MARYMOUNT HOSPITAL

PREAMBLE

WHEREAS, Marymount Hospital, hereinafter referred to as “Hospital” is a private corporation organized under the laws of the state of Ohio and is lawfully doing business in Ohio, and is not an agency or instrumentality of any state, country or federal government; and

WHEREAS, no practitioner is entitled to Medical Staff Membership and / or privileges at this Hospital solely by reason of education or licensure, or Membership of the Medical Staff of another hospital; and

WHEREAS, the purpose of this Hospital is to serve as a general short-term, acute care hospital, providing patient care and education; and

WHEREAS, the Hospital must ensure that such services are delivered efficiently and with concern for keeping medical costs within reasonable bounds and meeting the evolving regulatory requirements applicable to functions within the Hospital; and

WHEREAS, the Medical Staff must cooperate with and is subject to the ultimate authority and direction of the Governing Body; and

WHEREAS, the cooperative efforts of the Medical Staff, Administration and the Governing Body are necessary to fulfill these goals; and

WHEREAS, with the authority conferred upon them by the Governing Body, and subject to such limitations as the Governing Body may formally impose, the Medical Staff Members practicing in the Hospital organize themselves in conformity with the Bylaws, the Rules and Regulations hereinafter stated. These Medical Staff Bylaws, Rules and Regulations are not, and in no event shall be construed to be, a contract between the Medical Staff and the Governing Body; and

NOW, THEREFORE, the practitioners practicing in Marymount Hospital hereby organize themselves into a Medical Staff conforming to these Bylaws.

DEFINITIONS

1. "Active Staff" Members shall be those physicians (MD's and DO's) licensed in the state of Ohio that have the privilege of admitting patients, holding office and voting.
2. "Allied Health Professional" or "AHP" means an individual, other than a practitioner, who is qualified to render direct or indirect medical or surgical care under the supervision of a practitioner who has been afforded privileges to provide such care in the Hospital. Such AHP's shall include, with limitation, Nurse Practitioners, Physicians Assistants, Surgical Assistants, Clinical Nurse Specialists, and other such professionals. The authority of an AHP to provide specific patient care services is established by the Medical Staff based on the professional's qualifications.
3. "Board Certification" shall mean certification in one of the Member Boards of the American Board of Medical Specialties (AMBS) or the Bureau of Osteopathic Specialists certifying boards of the American Osteopathic Association (AOA). For podiatrists, board certification shall mean certification of the American Board of Podiatric Surgery (ABPS) or American Board of Foot & Ankle Surgery (ABFAS). For dentists, board certification shall mean certification by the American Board of Oral/Maxillofacial Surgeons (ABOMS).
4. "Clinical Privileges" means the Governing Body's recognition of the practitioners' competence and qualifications to render specific diagnostic, therapeutic, medical, dental, podiatric, or surgical services.
5. "Data Bank" means the National Practitioner Data Bank, established pursuant to the Health Care Quality Improvement Act of 1986, for the purposes of reporting of adverse actions and Medical Staff malpractice information.
6. "Dentist" means an individual with a DDS or DMD degree who is properly licensed to practice dentistry in Ohio.
8. "Ex-Officio" means service as a Member of a body by virtue of an office or position held, and unless otherwise expressly provided, means without voting rights.
9. "Fair Hearing Plan" means the procedure adopted by the Medical Staff with approval by the Governing Body to provide for an evidentiary hearing and appeals procedure when a physician's or dentists clinical privileges are adversely affected by a determination based on the physician's or dentist's professional conduct or competence.
10. "Governing Body" means the organized body responsible for the overall operations of the Hospital and for the conduct of the Hospital in keeping with the philosophy, goals and objectives of the Hospital, referred to as the Board.
11. "Hospital" means Marymount Hospital, Garfield Heights, Ohio.
12. "Licensed Independent Practitioner" means any individual permitted by law and by the Medical Staff and Governing Body to provide care and services without direction or

supervision, within the scope of the individual's license and consistent with individually granted clinical privileges.

13. "Medical Executive Committee" or "MEC" means the Executive Committee of the Medical Staff.
14. "Medical Staff": The doctors of medicine or osteopathy, dentists, oral surgeons, podiatrists, and psychologists, providing health care services in the Hospital, subject to the provisions of these Bylaws. Such references as "medical organization" and Medical Staff Member" refer to organizational functions of the Hospital performed by the practitioners.
15. "Medical Staff Bylaws" means the Bylaws of the Medical Staff and the accompanying Rules and Regulations, policies and such other rules and regulations as may be adopted by the Medical Staff subject to the approval of the Governing Body.
16. "Member" means a practitioner who has been granted Medical Staff Membership pursuant to these Bylaws.
17. "Organized Medical Staff": A self-governing entity accountable to the Governing Body that operates under a set of Bylaws, Rules and Regulations, and policies developed and adopted by the voting Members of the Organized Medical Staff and approved by the Governing Body. The Organized Medical Staff is comprised of doctors of medicine and osteopathy, and in accordance with the Medical Staff Bylaws, may include other practitioners.
18. "Parties" means the practitioner who requested the hearing or Appellate Review and the body or bodies upon whose adverse action a hearing or Appellate Review request is predicated.
19. "Peer Review Policy" means the policy and procedure adopted by the Medical Staff with approval of the Governing Body to provide evidence of objective monitoring of quality concerns for clinical management and evaluation of outcomes, provide oversight of the professional performance of all practitioners with delineated clinical privileges, evaluate the competence of practitioner performance, establish guidelines and triggers for referring cases identified or suspected as variations from quality indicators, and facilitate delivery of quality service that meets professionally recognized standards.
20. "Physician" means an individual with a DO or MD degree who is properly licensed to practice medicine in Ohio.
21. "Practitioner" means a physician, dentist, oral surgeon, psychologist or podiatrist who has been granted clinical privileges at the Hospital.
22. "Prerogative" means a participatory right granted by the Medical Staff and exercised subject to the conditions imposed in these Bylaws and in other Hospital and Medical Staff policies.
23. "President of the Hospital" means the individual appointed, qualified and delegated to act on behalf of the Governing Body for the overall administrative management of the Hospital.

24. "Special Notice" means a written notice sent by mail with a return receipt requested, delivered by hand with a written acknowledgement of receipt, or by email with receipt acknowledged.
25. "Telemedicine" means the use of electronic communication or other communication technologies to provide or support clinical care at a location remote from the Hospital.

ARTICLE I: NAME

The name of this organization shall be the Medical Staff of Marymount Hospital.

ARTICLE II: PURPOSES AND RESPONSIBILITIES

2.1 PURPOSE

The purposes of the Medical Staff are:

- 2.1(a) To exercise self-governance over the Medical Staff members and all individuals with clinical privileges.
- 2.1(b) To be the organization through which the benefits of Membership on the Medical Staff (mutual education, consultation and professional support) may be obtained and the obligations of Staff Membership may be fulfilled;
- 2.1(c) To foster cooperation with Administration and the Governing Body while allowing Staff Members to function with relative freedom in the care and treatment of their patients;
- 2.1(d) To provide a mechanism to ensure that all patients admitted to or treated in any of the facilities or services of the Hospital shall receive a uniform level of appropriate quality care, treatment and services commensurate with community resources during the length of stay with the organization, by accounting or and reporting regularly to the Governing Body on patient care evaluation, including monitoring and other quality (Quality Assessment Performance Improvement) activities in accordance with the Hospital's quality program;
- 2.1(e) To serve as a primary means for accountability to the Governing Body to ensure high quality professional performance of all practitioners and AHPs authorized to practice in the Hospital through delineation of clinical privileges, on-going review and evaluation of each practitioner's performance in the Hospital, and supervision, review, evaluation and delineation of duties and prerogative of AHP's;
- 2.1(f) To promulgate, maintain and enforce Bylaws, Rules and Regulations, and other policies and procedures related to medical care for the proper functioning of the Medical Staff;

- 2.1(g) To participate in educational activities as may be justified by the facilities, personnel, funds or other equipment that are or can be made available;
- 2.1(h) To assist the Governing Body in identifying changing community health needs and preferences and implement programs to meet those needs and preferences;
- 2.1(i) To provide a means by which issues concerning the Medical Staff and the Hospital may be discussed with the Governing Body or the President of the Hospital;
- 2.1(j) To accomplish its goals through appropriate Committees and Departments; and,
- 2.1(k) To establish and maintain standards of medical care consistent with current practices recommended by various specialty societies and accrediting agencies.

2.2 RESPONSIBILITIES

The responsibilities of the Medical Staff include:

- 2.2(a) Accounting for the quality, appropriateness and cost effectiveness of patient care rendered by all practitioners and AHP's authorized to practice in the Hospital, by taking action to:
 - (1) Assist the Governing Body and President of the Hospital and their designees in data compilation, medical record administration, review and evaluation of cost effectiveness and other such functions necessary to meet accreditation and licensure standards, as well as federal and state law requirements;
 - (2) Define and implement credentialing procedures, including a mechanism for appointment and reappointment and the delineation of privileges and assurance that all individuals with clinical privileges provide services within the scope of individual clinical privileges granted;
 - (3) Participate in continuing medical education programs addressing issues of quality and including the types of care offered by the Hospital;
 - (4) Implement a utilization management program, based on the requirements of the Hospital's Utilization Management Plan;
 - (5) Develop an organizational structure that provides continuous monitoring of patient care practices and appropriate supervision of AHP's;
 - (6) Initiate and pursue corrective action with respect to practitioners, when warranted;
 - (7) Develop, administer and enforce these Bylaws, the Rules and Regulations of the Medical Staff and other Hospital policies related to medical care;

- (8) Review and evaluate the quality of patient care through a valid and reliable patient care monitoring procedure, including identification and resolution of important problems in patient care and treatment;
- (9) Implement a process to identify and manage matters of individual practitioner health that is separate from the Medical Staff disciplinary function in accordance with the Impaired Practitioner Policy;
- (10) Shall adhere to the Ethical and Religious Directives for Catholic Health facilities and to the principles of ethics of the American Medical Association, or the American Osteopathic Association, or the American Dental Association, or American Podiatric Medical Association, whichever is applicable; and
- (11) Agree to practice in conformity with the requirements of the Emergency Medical Treatment and Active Labor Act ("EMTALA") and to abide by such related Medical Staff and Departmental Rules and Regulations, and Hospital and Department policies, including but not limited to On-Call obligations under EMTALA.

2.2(b) Maintain confidentiality with respect to the records and affairs of the Hospital, except as disclosure is authorized by the Governing Body or required by law.

2.3 PARTICIPATION IN ORGANIZED HEALTH CARE ARRANGEMENT

Patient information shall be collected, stored and maintained so that privacy and confidentiality are preserved. The Hospital and each Member of the Medical Staff shall be part of an Organized Health Care Arrangement ("OHCA"), which is defined as a clinically-integrated care setting in which individuals typically receive healthcare from more than one healthcare provider. The OHCA allows the Hospital and the Medical Staff Members to share information for purposes of treatment, payment and health care operations. Under the OHCA, at the time of admission, a patient shall receive the Hospital's Notice of Privacy Practices.

2.4 NOTIFICATION REQUIREMENT

Each privileged practitioner or AHP shall promptly notify the President of the Hospital, or his/her designee, and/or the President of the Medical Staff of:

- The revocation, lapse or suspension of professional license;
- The imposition of terms of probation or limitation of practice by a state licensing agency;
- Restriction, suspension, termination, lapse or revocation of privileges at any Hospital or other health care institution;
- Cancellation or restriction of professional liability coverage;
- Final judgment or settlement of a professional liability action;

- Restriction, suspension, termination, lapse, revocation or voluntary relinquishment of their DEA Registration;
- Any suspicion that a practitioner or AHP may be impaired due to physical or mental issues or the excessive use of drugs and/or alcohol;
- Suspension, termination, exclusion or voluntary relinquishment from any federal or state health insurance program, including the Medicare or Medicaid Programs;
- A plea, indictment, or conviction of any criminal offense, excluding minor traffic violations;
- Results of a formal investigation by the Department of Health and Human Services, or any enforcement agency of the United States or the State of Ohio;
- The practitioner's management of patients which may have given rise to investigation by the State Medical Board; and
- The practitioner has received a "Notice of Hearing" from the State Medical Board.

2.5 MEDICO-ADMINISTRATIVE RESPONSIBILITIES

Physicians, dentists, podiatrists, oral surgeon and psychologists with medico-administrative responsibilities must qualify for Membership and clinical privileges in the same manner provided in these Bylaws for other Medical Staff Members. Medical Staff Membership and clinical privileges shall not be contingent on their continued occupation of that position, unless otherwise provided in an employment agreement or contract. The physician, dentist, podiatrist, oral surgeon or psychologist in a purely administrative capacity is subject to regular Hospital personnel policies as modified by contractual agreements with the Hospital.

ARTICLE III: MEDICAL STAFF MEMBERSHIP

3.1 NATURE OF MEDICAL STAFF MEMBERSHIP

Medical Staff Membership is a privilege extended by the Hospital, and is not a right of any person. Membership on the Medical Staff or the exercise of emergency privileges shall be extended only to professionally competent practitioners who continuously meet the qualifications, standards and requirement set forth in these Bylaws. Membership on the Medical Staff shall confer on the practitioner only such clinical privileges and prerogatives as have been granted by the Governing Body in accordance with these Bylaws. No person shall admit patients to, or provide services to patients in this Hospital, unless he/she is a practitioner or AHP with appropriate privileges, or has been granted emergency privileges as provided herein.

3.2 BASIC QUALIFICATIONS / CONDITIONS OF STAFF MEMBERSHIP

3.2(a) Basic Qualifications

The only people who shall qualify for Membership on the Medical Staff are those practitioners legally licensed in Ohio, who;

- (1) Document their professional experience, background, education, training, demonstrated ability, character, current competence, professional clinical judgment and physical and mental health status with sufficient adequacy to demonstrate to the Medical Staff and the Governing Body that any patient treated by them shall receive quality care and that they are qualified to provide needed services within the Hospital;
- (2) Are determined, on the basis of documented references, to adhere strictly to the ethics of their respective professionals, to work cooperatively with others and to be willing to participate in the discharge of Staff responsibilities;
- (3) Comply and have complied with federal, state and local requirements, if any, for their medical practice, are not and have not been subject to any liability claims, challenges to licensure, or loss of Medical Staff Membership or privileges which shall adversely affect their services to the Hospital;
- (4) Have professional liability insurance that meets the requirements of these Bylaws;
- (5) Are graduates of an approved educational institution holding appropriate degrees;
- (6) Show evidence of the following education achievements: CME or relevant documentation for additional training specific to their Board Certification specialty or the specialty they have been granted privileges to practice in the Hospital. The education should be related to the physician's specialty and to the provision of quality patient care in the Hospital;
- (7) Meet one of the following requirements, in addition to those listed above:
 - (i) Board Certification, in the specialty or subspecialty for which privileges are requested, as demonstrated by proof of maintenance.
 - (ii) Have successfully completed an approved residency or fellowship program in the specialty or subspecialty for which privileges are requested, and agree to obtain board certification within the following periods:
 - Within the time period permitted by the applicable certifying Board for the applicant to complete the certifying examination; or

- If there is no time limit specified by the Board, the applicant must successfully complete the certifying exam within three (3) years of appointment to the Medical Staff.
- (iii) Demonstration to the satisfaction of the MEC and the Governing Body, competency and training equal or equivalent to that required for Board Certification.
 - (iv) Based on the collective decision of the President of the Medical Staff, the Vice President of Medical Operations, and the President of the Hospital, the Board Certification requirement may be waived if the applicant is a Member in Good Standing of a the Medical Staff of a Hospital with which Marymount Hospital has a current delegated credentialing agreement.

The above Board Certification requirement shall not apply to any practitioner already a Member of the Medical Staff as of January 1, 2001.

3.2(b) Effects of Other Affiliations

No person shall be automatically entitled to Membership on the Medical Staff or to exercise the particular clinical privileges merely because he/she is licensed to practice in this or any other state, or because he/she is a Member of any professional organization, or because he/she is certified by any clinical board, or because he/she had, or presently has, Staff Membership at this Hospital or at another health care facility or in another practice setting.

3.2(c) Non-Discrimination

No aspect of Medical Staff Membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, national origin, gender identity, sexual orientation, pregnancy, marital status, military status, disability (except as such may impair the practitioner's ability to provide quality patient care or fulfill his/her duties under these Bylaws), or on the basis of any other criteria unrelated to the delivery of quality patient care in the Hospital, to professional ability and judgment, or to community need.

3.2(d) Ethics

The burden shall be on the application to establish that he/she is professionally competent and worthy in character, professional ethics and conduct. Acceptance of Membership on the Medical Staff shall constitute the Member's certification that he/she has in the past, and agrees that he/she shall in the future, abide by the lawful principles of Medical Ethics of the American Osteopathic Association, of the American Medical Association, or other applicable codes of ethics and the Ethical and Religious Directive for Catholic Health facilities.

3.3 BASIC RESPONSIBILITIES OF STAFF MEMBERSHIP

Each Member of the Medical Staff shall:

- 3.3(a) Provide his/her patients with continuous care at the generally recognized professional level of quality;
- 3.3(b) Consistent with generally recognized quality standards, deliver patient care in an efficient and financially prudent manner, and adhere to local medical review policies with regard to utilization;
- 3.3(c) Abide by the Medical Staff Bylaws and other lawful standards, policies and Rules and Regulations of the Medical Staff;
- 3.3(d) Discharge the Staff, Department, Committee and Hospital functions for which he/she is responsible by Staff category assignment, appointment, election or otherwise;
- 3.3(e) Cooperate with other Members of the Medical Staff, Administration, the Governing Body and employees of the Hospital;
- 3.3(f) Adequately prepare and complete in a timely fashion the medical and other required records for all patients he/she admits or, in any way provides care to, in the Hospital;
- 3.3(g) Attest that he/she suffers from no health problems which could affect ability to perform the functions of the Medical Staff Membership and exercise the privileges requested prior to initial exercise of privileges;
- 3.3(h) Abide by the ethical principles of his/her profession and specialty;
- 3.3(i) Refuse to engage in improper inducements for patient referrals;
- 3.3(j) Notify the President of the Hospital and President of the Medical Staff immediately of any events as outlined in Section 2.4 of these Bylaws;
- 3.3(k) Comply with all state and federal requirements for maintaining confidentiality of patient identifying medical information, including the Health Insurance Portability and Accountability Act of 1996, as amended, and its associated regulations; and
- 3.3(l) Acknowledge and comply with the following standards concerning conflicts of interest:

The best interests of the community, Medical Staff and the Hospital are served by Medical Staff Members who are objective in the pursuit of their duties, and who exhibit that objectivity at all times. The decision-making process of the Medical Staff may be altered by interests or relationships which might in any instance, either intentionally or coincidentally, bear on that Member's opinions or decision. Therefore, it is considered to be in the best interest of the Hospital and the Medical Staff for relationships of any Medical Staff Member which may influence the decisions related to the Hospital to be disclosed on a regular and contemporaneous basis.

No Medical Staff Member shall use his/her position to obtain or accrue any improper benefit. All Medical Staff Members shall at all times avoid even the appearance of influencing the actions of any other Staff Member or employee of the Hospital or Corporation, except through his/her vote, and the acknowledgement of that vote, for or against opinions or actions to be stated or taken by or for the Medical Staff as a whole or as a Member of any Committee of the Medical Staff.

3.4 HISTORY AND PHYSICAL EXAMINATION

A medical history and physical examination 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, regardless of whether the care is being provided on an inpatient or outpatient basis. An H&P is performed and documented by a physician (MD/DO), oral maxillofacial surgeon, or other licensed qualified individual working within the scope of his/her license who is granted privileges to do so and in accordance with Hospital policy.

An H&P may be submitted prior to the Patient's hospital admission or registration by a currently licensed physician who may not be a member of the hospital's medical Staff or who does not have admitting privileges at that hospital, or by a qualified currently licensed individual who does not practice at that hospital but is acting within his/her scope of practice under State law or regulations. Generally, this occurs where the H&P is completed in advance by the patient's primary care practitioner.

When the H&P is conducted within thirty (30) days before admission or registration, the physician must complete and document an updated examination of the patient with 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician (MD/DO), an oromaxillofacial surgeon, or other qualified licensed individual working within the scope of his/her license who is granted privileges to do so and in accordance with Hospital policy. If, upon examination, the licensed practitioner finds no change in the patient's condition since the history and physical examination was completed, he/she may indicate in the patient's medical record that the history and physical examination was reviewed, the patient was examined, and that "no change" has occurred in the patient's condition since the history and physical examination was completed.

3.5 DURATION OF APPOINTMENT

3.5(a) Duration of Initial Appointment

All initial appointments to the Medical Staff shall be for a period not to exceed two (2) years. In no case shall the Governing Body take action on an application, refuse to renew an appointment, or cancel an appointment, except as provided for herein. Appointment to the Medical Staff shall confer to the appointee only such privileges as may hereinafter be provided.

3.5(b) Reappointment

Reappointment to the Medical Staff shall be for a period not to exceed two (2) years.

3.6 LEAVE OF ABSENCE

3.6(a) Leave Status

Leaves of absence may be granted by the Governing Body upon written request accompanied by the recommendation of the MEC, provided that the Leave does not exceed the remainder of the current Medical Staff appointment. Such a leave of absence may be because of illness, military service, advanced study, inability to secure professional liability insurance or indemnification or other just cause. If the Staff Member's period of appointment ends while the Member is on leave, he/she must reapply for Medical Staff Membership and clinical privileges. Any such application must be submitted and shall be processed in the manner specified in these Bylaws for application for initial appointment.

3.6(b) Termination of Leave

- (1) At least forty-five (45) days prior to the termination of leave, or at any earlier time, the Staff Member may request reinstatement of his/her privileges by submitting a written notice to that effect to the President of the Hospital or his/her designee for transmittal to the MEC. The Staff Member shall submit a written summary of his/her relevant activities during leave. The MEC shall make a recommendation to the Governing Body concerning the reinstatement of the Member's privileges. If the Governing Body rejects a favorable recommendation of the Medical Executive Committee, then the Member shall be afforded a right to a hearing pursuant to these bylaws. After the hearing, the decision of the panel shall be sent to the Governing Body. The Governing Body shall review the panel's decision and render a decision. The decision of the Governing Body is final. Notice of the final decision of the Governing Body will be provided to the Member, the Medical Executive Committee and the President of the Hospital.

Failure to request reinstatement in a timely manner shall result in automatic termination of Staff Membership, privileges and prerogatives without right of hearing or appellate review. Termination of Medical Staff Membership, privileges and prerogatives pursuant to this section shall not be considered an adverse action, and shall not be reported to the Data Bank. A request for Staff Membership subsequently received from a Staff Member so terminated shall be submitted and processed in the manner specified for application for initial appointment.

- (2) If a Member requests leave of absence for any reason for any length of time, including but not limited to obtaining further medical training or an armed services commitment, the MEC may require proof of competency

by further education, such as a refresher course, or appropriate monitoring for a period of time, or both.

Any new privileges requested shall be acted upon and monitored in similar fashion as if the Member were a new applicant.

ARTICLE IV: CATEGORIES OF THE MEDICAL STAFF

4.1 CATEGORIES

The Staff shall include Active, Associate, Affiliate, Telemedicine and Emeritus categories.

4.2 ACTIVE STAFF

4.2(a) Qualifications

The Active Staff shall consist of practitioners who:

- (1) Meet the basic qualifications set forth in these Bylaws;
- (2) Regularly admit to, or are otherwise involved in the care of at least twenty-five (25) patients in the Hospital in a calendar year. For purposes of determining whether a practitioner is “regularly involved” in the care of the requisite number of patient encounter or contact shall be deemed to include any of the following: admission; consultation with active participation in the patient’s care; provision of direct patient care or intervention in the Hospital setting; performance of any outpatient or inpatient surgical or diagnostic procedure; or interpretation of any inpatient or outpatient diagnostic procedure or test. When a patient has more than one procedure or diagnostic test performed or interpreted by the same practitioner during a single hospital stay, the multiple tests for that patient shall count as one patient contact.

4.2(b) Prerogatives

The prerogatives of an Active Staff Member shall be:

- (1) To admit patients without limitation, unless otherwise provided in the Medical Staff Bylaws and Rules and Regulations;
- (2) To exercise such clinical privileges as are granted to him/her pursuant to these Bylaws;
- (3) To vote on all matters presented at general and special meetings of the Medical Staff;
- (4) To vote and hold office in the Staff organization, Departments and on Committees to which he/she is appointed; and

- (5) To vote in all Medical Staff elections.

4.2(c) Responsibilities

Each Member of the Active Staff shall:

- (1) Meet the basic responsibilities set forth in Section 3.3;
- (2) Within his/her area of professional competence, retain responsibility for the continuous care and supervision of each patient in the Hospital for whom he/she is providing services, or arrange a suitable alternative for such care and supervision;
- (3) Actively participate:
 - (i) in the Quality program and other patient care evaluation and monitoring activities required of the Staff and possess the requisite skill and training for the oversight of care, treatment and services in the Hospital;
 - (ii) in supervision of other appointees where appropriate;
 - (iii) in the Emergency Department on-call rotation, including personal appearance to assess patients in the Emergency Department when deemed appropriate by the Emergency Department physician. Any Member of the Medical Staff who has reached the age of sixty-five (65) may request to be removed from the Emergency Department on-call rotation. Patient referred from the Emergency Department must have at least one follow-up visit;
 - (iv) in promoting effective utilization of resources consistent with delivery of quality patient care; and
 - (v) in discharging such other Staff functions as may be required from time-to-time.
- (4) Be required to pay full Medical Staff Membership annual dues;
- (5) Satisfy the requirements set forth in these Bylaws for attendance at meetings of the Medical Staff and of the Departments and Committees of which he/she is a Member.

4.2(d) Failure

Failure to carry out the responsibilities or meet the qualifications as enumerated shall be grounds for corrective action, including, but not limited to, termination of Staff Membership.

4.3 ASSOCIATE STAFF

4.3(a) Qualifications

The Associate Staff shall consist of practitioners who:

- (1) Meet the basic qualifications set forth in these Bylaws;
- (2) (a) Admit to, or are otherwise involved in the care of at least twenty-five (25) patients in the Hospital in a calendar year. Associate Members who admit or are involved in the care of more than twenty-five (25) patients in a calendar year must transfer to Active Staff. The requirement to transfer to Active Staff may be waived by the Governing Body for practitioners who have their primary practice outside the community and provide services not otherwise available in the community; and
- (b) A Member whose primary practice is at another hospital and
 - 1) Requires privileges for the purpose of providing call and/or specialty coverage for an Active Member of the Medical Staff and
 - 2) Does not exceed more than twenty-five (25) days of call and/or specialty coverage within a calendar year.

4.3(b) Prerogatives

The prerogatives of an Associate Staff Member shall be to:

- (1) Admit patients within the limitations provided in Section 4.3(a);
- (2) Exercise such clinical privileges as are granted to him/her pursuant to these Bylaws;
- (3) May attend meetings of the Staff and any Staff or hospital education programs;
- (4) May serve and vote on Medical Staff Committees, if assigned;
- (5) May hold office, serve as Department Director or Chair a Medical Staff Committee, if no other Active Staff Member is able to serve in such role; and
- (6) May vote on Medical Staff matters if they hold office, service as a Department Director, or Committee Chair or are a Member of a Medical Staff Committee.

4.3(c) Responsibilities

Each Member of the Associate Staff shall:

- (1) Meet the basic responsibilities set forth in Section 3.3;
- (2) Within his/her area of professional competence, retain responsibility for the continuous care and supervision of each patient in the Hospital for whom he/she is providing services, or arrange a suitable alternative for such care and supervision;

- (3) Actively participate:
 - (i) in the Quality program and other patient care evaluation and monitoring activities required of the Staff and possess the requisite skill and training for the oversight of care, treatment and services in the Hospital;
 - (ii) in supervision of other appointees where appropriate;
 - (iii) in the Emergency Department on-call rotation, depending upon the needs of the Department /Division, after discussion with the Department Director and the President of the Hospital or his/her designee. This includes making a personal appearance to assess patients in the Emergency Department when deemed appropriate by the emergency Department physician. Any Member of the Medical Staff who has reached the age of sixty-five (65) may request to be removed from the Emergency Department on-call rotation. Patient referred from the Emergency Department must have at least one follow-up visit;
 - (iv) in promoting effective utilization of resources consistent with delivery of quality patient care; and
 - (v) in discharging such other Staff functions as may be required from time-to-time.
- (4) Be required to pay full Medical Staff Membership annual dues;
- (5) Satisfy the requirements set forth in these Bylaws for attendance at meetings of the Medical Staff and of the Departments and Committees of which he/she is a Member.

4.3(d) Failure

Failure to carry out the responsibilities or meet the qualifications as enumerated shall be grounds for corrective action, including, but not limited to, termination of Staff Membership.

4.4 AFFILIATE STAFF

4.4(a) Qualifications

The Affiliate Staff shall consist of practitioners who desire to be associated with the Hospital, but who do not intend to care for or treat patients in this Hospital.

4.4(b) Prerogatives

Affiliate Staff Members:

- (1) May refer patients for outpatient diagnostic testing and special services provided by the Hospital;

- (2) May refer patients to other appointees of the Medical Staff for admission, evaluation, and/or care and treatment;
- (3) Visit their hospitalized patients, review their hospital medical records and provide advice and guidance to the attending physicians, but shall not be permitted to admit patients, to attend patients, to exercise any clinical privileges, to write orders or progress notes, to make any notations in the medical record or to actively participate in the provision of care or management of patients in the Hospital;
- (4) Are not required to have on-call responsibilities;
- (5) Are required to pay annual medical Staff dues;
- (6) May hold office, serve as Department Director or Chair a Medical Staff Committee, if no other Active Staff Member is able to serve in such role;
- (7) May serve and vote on Medical Staff Committees, if assigned; and
- (8) May vote on Medical Staff matters if they hold office, service as a Department Director, or Committee Chair or are a Member of a Medical Staff Committee.

4.4(c) Failure

Failure to carry out the responsibilities or meet the qualifications as enumerated shall be grounds for corrective action, including, but not limited to, termination of Staff Membership.

4.5 TELEMEDICINE CATEGORY

4.5(a) Qualifications

The Telemedicine Staff shall consist of physicians providing care, treatment and services of patient only via an electronic communication link. These physicians are subject to the credentialing and privileging process that is outlined in these Bylaws.

4.5(b) Prerogatives

Telemedicine Members:

- (1) Are required to pay annual Medical Staff dues based on a prorated formula that is mutually agreed upon by the Institute providing services and the Medical Executive Committee;
- (2) May serve on Medical Staff Committees;
- (3) May vote on matters presented at Committees to which he/she has been appointed;

- (4) May not vote on Medical Staff matters presented at general or special meetings of the Medical Staff or of the Department of which he/she is a Member; and
- (5) May not hold office.

4.5(c) Failure

Failure to carry out the responsibilities or meet the qualifications as enumerated shall be grounds for corrective action, including, but not limited to, termination of Staff Membership.

4.6 EMERITUS STAFF CATEGORY

4.6(a) Qualifications

The Emeritus Staff shall consist of physicians who have retired from active hospital services, but continue to demonstrate a genuine concern for the Hospital. Emeritus Staff Members shall not be required to meet the qualifications set forth in Section 3.2(a) of these Bylaws.

4.6(b) Prerogatives

- (1) Emeritus Staff Member shall attend, by invitation, any such meetings or social events that he/she may wish to attend as a non-voting visitor.
- (2) Emeritus Staff Members shall not in any circumstances admit patients to the Hospital or be the physician of primary care or responsibility for any patient within the Hospital. Emeritus Staff Members shall not hold office nor be eligible to vote in the Medical Staff organization.

4.7 HOUSE PRACTITIONER

House Practitioners may work in the Hospital under a contractual agreement, and only in accordance with their Job Descriptions, Clinical Privileges and the provisions so listed below:

- (1) House Practitioners are not Members of the Medical and the procedural provisions of these Bylaws regarding notices, hearing and appellate review are not applicable; however, House Practitioners are subject to all other Bylaw provisions including quality standards and peer review;
- (2) House Practitioners are contracted by the Hospital via a staffing agreement and are ultimately responsible to the President of the Hospital, and are subject to the policies of the Hospital;
- (3) House Practitioners application and reappointment application for clinical privileges will be processed in the manner as outlined in these Bylaws for Licensed Independent Practitioners; and

- (4) Upon termination of the contractual agreement between the Hospital and the House Practitioner Provider Agency, the privileges of the House Practitioner(s) will automatically terminate.

4.8 CHANGE OR TRANSFER OF MEMBERSHIP CATEGORY

The Medical Executive Committee, on its own volition, upon recommendation by the Credentialing Committee, or pursuant to a request by a Member, may recommend a change or transfer in the Medical Staff category of a Member consistent with the requirements of these Bylaws, subject to the approval of the Governing Body. A change or transfer of a Member's Medical Staff Category will not entitle the affected Member to a Hearing or Appeal under these Bylaws. A Member who has been transferred may reapply to become a Member of his or her desired Staff category after six (6) months, provided that Member demonstrates an ongoing commitment to meet the requirements for that category.

ARTICLE V: ALLIED HEALTH PROFESSIONALS

5.1 CATEGORIES

Allied Health Professionals ("AHP's") shall be identified as any person(s) other than physicians who are granted privileges to practice in the Hospital and are directly involved in patient care. Such persons may be employed by physicians on the Staff; but whether or not so employed, must be under the direct supervision and direction of a Staff physician who maintains clinical privileges to perform procedures in the same specialty area as the AHP and not exceed the limitations of practice set forth by their respective licensure.

5.2 QUALIFICATIONS

Only AHP's holding a license, certificate or other official credential as provided under state law, shall be eligible to provide specified services in the Hospital as delineated by the MEC and approved by the Governing Body.

5.2(a) AHP's must:

- (1) Document their professional experience, background, education, training, demonstrated ability, current competence and physical and mental health status with sufficient adequacy to demonstrate to the Medical Staff and the Governing Body that any patient treated by them shall receive quality care and that they are qualified to provide needed services within the Hospital;
- (2) Establish, on the basis of documented references, that they adhere strictly to the ethics of their respective provisions, work cooperatively with others and are willing to participate in the discharge of AHP Staff responsibilities;

- (3) Have professional liability insurance in the amount required by these Bylaws;
- (4) Provide a needed service within the Hospital; and
- (5) Unless permitted by law and by the Hospital to practice independently, provide written documentation that a Medical Staff appointee has assumed responsibility for the acts and omissions of the AHP and responsibility for directing and supervising the AHP.

5.3 PREROGATIVES

Upon establishing experience, training and current competence, AHP's, as identified in Section 5.1, shall have the following prerogatives:

- 5.3(a) To exercise judgment within the AHP's area of competence, providing that a physician Member of the Medical Staff has the ultimate responsibility for patient care;
- 5.3(b) To participate directly, including admitting patients, if applicable, and writing orders to the extent permitted by law, in the management of patients under the supervision or direction of a Member of the Medical Staff; and
- 5.3(c) To participate, as appropriate, in patient care evaluation and other quality assessment and monitoring activities required of the Staff, and to discharge such other Staff functions as may be required from time-to-time.

5.4 CONDITIONS OF APPOINTMENT

- 5.4(a) AHP's shall be credentialed in the same manner as outlined in these Medical Staff Bylaws for credentialing of practitioners. Each AHP shall be assigned to one (1) of the clinical Departments and shall be granted clinical privileges relevant to the care provided in that Department. The Governing Body in consultation with the MEC shall determine the scope of the activities which each AHP may undertake. Such determination shall be furnished in writing to the AHP and shall be final and non-appealable, except as specifically and expressly provided in these Bylaws.
- 5.4(b) Privileges of AHP's must be approved by the Governing Body and may be terminated by the Governing Body or the President of the Hospital. Adverse actions or recommendations affecting AHP privileges shall not be covered by the provisions of the Fair Hearing Plan. However, the affected AHP shall have the right to request to be heard before the Credentialing Committee with an opportunity to rebut the basis for termination. Upon receipt of a written request, the Credentialing Committee shall afford the AHP an opportunity to be heard by the Committee concerning the AHP's grievance. Before the appearance, the AHP shall be informed of the general nature and circumstances giving rise to the action, and the AHP may present information relevant thereto. A record of appearance shall be made. The Credentialing Committee shall, after conclusion

of the investigation, submit a written decision simultaneously to the MEC and to the AHP.

- 5.4(c) AHP privileges shall automatically terminate upon revocation of the privileges of the AHP's supervising physician Member, unless another qualified physician indicates his/her willingness to supervise the AHP and complies with all requirements in accordance with the law and hereunder for undertaking such supervision. In the event the AHP's supervising physician Member's privileges are significantly reduced or restricted, the AHP's privileges shall be reviewed and modified by the Governing Body upon recommendation of the MEC. Such actions shall not be covered by the provisions of the Fair Hearing rights as outlined in these Bylaws. In the case of CRNA's who are supervised by the Anesthesiology, the CRNA's privileges shall be unaffected by the termination of a given Anesthesiologist's privileges so long as other Anesthesiologists remain willing to supervise the CRNA for purposes of their cases.
- 5.4(d) If the supervising practitioner employs or directly contracts with the AHP for services, the practitioner shall indemnify the Hospital and hold the Hospital harmless from and against all actions, causes of actions, claims, damages, costs and expenses, including reasonable attorney fees, resulting from, caused by or arising from improper or inadequate supervision of the AHP, negligence of such AHP, the failure of such AHP to satisfy the standards of proper care of patients, or any action by such AHP beyond the scope of his/her license or clinical privileges. If the supervising practitioner does not employ or directly contract with the AHP, the practitioner shall indemnify the Hospital and hold the Hospital harmless from and against all actions, causes of actions, claims, damages, costs and expenses, including reasonable attorney fees, resulting from, caused by or arising from improper or inadequate supervision of the AHP by the practitioner in question.

5.5 RESPONSIBILITIES

Each AHP shall:

- 5.5(a) Provide his/her patients with continuous care at the generally recognized professional level of quality;
- 5.5(b) Abide by the Medical Staff Bylaws and other lawful standards, policies and Rules and Regulations of the Medical Staff, and personnel policies of the Hospital, if applicable;
- 5.5(c) Discharge any Committee functions for which he/she is responsible;
- 5.5(d) Cooperate with Members of the Medical Staff, Administration, the Governing Body and employees of the Hospital:
- 5.5(e) Adequately prepare and complete in a timely fashion the medical and other required records for which he/she is responsible;
- 5.5(f) Abide by the ethical principles of his/her profession and specialty; and

5.5(g) Notify the President of the Hospital and the President of the Medical Staff immediately if:

- (1) His/Her professional license in any state is suspended or revoked;
- (2) His/Her professional liability insurance is modified or terminated;
- (3) He/She is named as a defendant, or is subject to a final judgment or settlement, in any court proceeding alleging that he/she committed professional negligence or fraud; or
- (4) He/She ceases to meet any of the standards or requirements set forth herein for continued enjoyment of AHP clinical privileges.

5.5(h) Comply with all state and federal requirements for maintaining confidentiality of patient identifying medical information, including the Health Insurance Portability and Accountability Act of 1996, as amended, and its associated regulations, and execute a health information confidentiality agreement with the Hospital.

ARTICLE VI: PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

6.1 GENERAL PROCEDURES

The Medical Staff through its designated Committees and Departments shall investigate and consider each application for appointment or reappointment to the Staff, each request for clinical privileges and each request for modification of Staff Membership status and shall adopt and transmit recommendation thereon to the Governing Body which shall be the final authority on granting, extending, terminating or reducing Medical Staff privileges. The Governing Body shall be responsible for the final decision as to Medical Staff appointments. A separate, confidential record shall be maintained for each individual requesting Medical Staff Membership or clinical privileges.

6.2 CONTENT OF APPLICATION FOR INITIAL APPOINTMENT

Each application for appointment and/or clinical privileges shall be in writing, submitted on the prescribed form approved by the Governing Body, and signed by the applicant. Documentation of all active state licenses, current DEA registration/controlled substance certificates, a signed Medicare penalty statement, copy of ECFMG and a certificate of insurance must be submitted with the application. Applicants shall supply the Hospital with all information requested on the application.

The application form shall include, at a minimum, the following:

- (a) **Acknowledgement & Agreement:** A statement that the applicant has received and read the Bylaws, Rules and Regulations and Policies of the Medical Staff and that he/she agrees:
 - (i) to be bound by the terms thereof if he/she is granted Membership and/or clinical privileges; and

- (ii) to be bound by the terms thereof in all matters relating to consideration of his/her application, without regard to whether or not he/she is granted Membership and/or clinical privileges.
- (b) Administrative remedies: A statement indicating that the practitioner agrees that he/she shall exhaust the administrative remedies afforded by the Bylaws before resorting to formal legal action, should an adverse ruling be made with respect to his/her Staff Membership, and/or clinical privileges;
- (c) Fraud: Any allegations of civil or criminal fraud pending against any applicant and any past allegations including their resolution and any investigations by any private, federal or state agency concerning participation in any health insurance program, including Medicare and Medicaid;
- (d) Health Status: Evidence of current physical and mental health status only to the extent necessary to demonstrate that the applicant is capable of performing the functions of Staff Membership and/or clinical privileges. In instances where there is doubt about an applicants' ability to perform privileges requested, an evaluation by an external or internal source may be requested by the MEC or Governing Body;
- (e) Information on Malpractice Experience: All information concerning malpractice cases against the applicant either filed, pending, settled, or pursued to final judgment. It shall be the continuing duty of the practitioner to notify the MEC of the initiation of any professional liability action against him/her. The practitioner shall have a continuing duty to notify the MEC through the President of the Hospital or his/her designee, and/or the President of the Medical Staff, within seven (7) days of receiving notification of the initiation of a professional liability action against him/her. The President of the Hospital or his/her designee, and/or the President of the Medical Staff, shall be responsible for notifying the MEC of all such actions;
- (f) Education: Detailed information concerning the applicant's education and training;
- (g) Insurance: Information as to whether the application has currently in force professional liability coverage meeting the requirements set forth in the Rules and Regulations. Each practitioner must, at all times, keep the President of the Hospital, and /or the President of the Medical Staff, informed of changes in his/her professional liability coverage;
- (h) Notification of Release and Immunity Provisions: Statements notifying the applicant of the scope and extent of authorization, confidentiality, immunity and release provisions;
- (i) Professional Sanctions: Information as to previously successful or currently pending challenges to, or the voluntary relinquishment, of any of the following:
 - The revocation, lapse or suspension of professional license;

- The imposition of terms of probation or limitation of practice by a state licensing agency;
- Restriction, suspension, termination, lapse or revocation of privileges at any Hospital or other health care institution;
- Cancellation, limitation or restriction of professional liability coverage;
- Final judgment or settlement of a professional liability action;
- Revocation, lapse, suspension, reduction or voluntary relinquishment of their DEA Registration;
- Any suspicion that a practitioner or AHP may be impaired due to physical or mental issues or the excessive use of drugs and/or alcohol;
- Suspension, termination, exclusion or voluntary relinquishment from any federal or state health insurance program, including the Medicare or Medicaid Programs;
- A plea, indictment or conviction of any criminal offense, excluding minor traffic violations;
- Results of a formal investigation by the Department of Health and Human Services, or any enforcement agency of the United States or the State of Ohio; and,
- The practitioner's management of patients which may have given rise to investigation by the state medical board.

If any such actions were taken, the particulars thereof shall be obtained before the application is considered completed. The practitioner shall have a continuing duty to notify the MEC, in writing through the President of the Hospital, or his/her designee, and/or the President of the Medical Staff, within seven (7) days of receiving notice of the initiation of any of the above actions against him/her. The President of the Hospital, or his/her designee, and/or the President of the Medical Staff shall be responsible for notifying the MEC of all such actions.

- (j) Qualifications: Detailed information concerning the applicant's experience and qualifications for the requested Staff category, including information in satisfaction of the basic qualifications specified in these Bylaws, and the applicant's current professional license and federal drug registration numbers;
- (k) References: The names of at least two (2) practitioners (excluding employees or relatives), who have worked with the applicant within the past three (3) years and personally observed his/her professional performance and who are able to provide knowledgeable peer recommendations as to the applicant's education, relevant training, experience, clinical ability and current competence, ethical character, judgment and ability to exercise the privileges requested and to work with others. When the applicant is currently employed by the Cleveland Clinic or

has privileges at a Cleveland Clinic regional hospital, instead of providing two (2) professional references, one (1) professional reference from the applicants Cleveland Clinic Chair or Regional Hospital Chair must be provided;

- (l) Practice Affiliations: The name and address of all other hospitals, health care organizations or practice settings with whom the applicant is or has previously been affiliated;
- (m) Request: Specific requests stating the Staff category and specific clinical privileges for which the applicant wishes to be considered;
- (n) Photograph: A recent, wallet sized government issued photograph of the applicant; and
- (o) Citizenship Status: Proof of United States or legal residency.

6.3 PROCESSING THE APPLICATION

6.3(a) Request for Application

A practitioner wishing to be considered for Medical Staff initial appointment and/or clinical privileges may request an application form therefore by submitting his/her written request for an application form to the Medical Staff Office.

6.3(b) Applicant's Burden

By submitting the application, the applicant:

- (1) Signifies his/her willingness to appear for interviews and acknowledges that he/she shall have the burden of producing adequate information for a proper evaluation of his/her qualifications for Membership and/or clinical privileges;
- (2) Authorizes Hospital, and/or Medical Staff, representatives to consult with others who have been associated with him/her and/or who may have information bearing on his/her current competence and qualifications;
- (3) Consents to the inspection by Hospital, and/or Medical Staff, representatives of all records and documents that may be material to an evaluation of his/her licensure, specific training, experience, current competence, health status and ability to carry out the clinical privileges he/she requests as well as of his/her professional ethical qualifications for Membership and/or clinical privileges;
- (4) Represents and warrants that all information provided by him/her is true, correct and complete in all material respects, and agrees to notify the Medical Staff Office of any change in any of the information furnished in the application; and acknowledges that provision of false or misleading information, or omission of information, shall be grounds for immediate rejection of his/her application without fair hearing rights;

- (5) Acknowledges that, if he/she is determined to have made a misstatement, misrepresentation, or omission in connection with an application and such misstatement, misrepresentation, or omission is discovered after appointment and/or the granting of clinical privileges, he/she shall be deemed to have immediately relinquished his/her appointment and clinical privileges, without fair hearing rights; and
- (6) Pledges to provide continuous care for his/her patients in the Hospital.

6.3(c) Submission of Application & Verification of Information

Upon completion of the application form and attachment(s) of all required information, the Applicant shall submit the form to the Medical Staff Office. The application shall be returned to the practitioner and shall not be processed further if one (1) or more of the following applies:

- (1) Not Licensed: The practitioner is not licensed in this state to practice in a field of health care eligible for appointment to the Medical Staff; or
- (2) Privileges Denied or Terminated: Within one (1) year immediately preceding the request, the practitioner has his/her application for Medical Staff appointment at this Hospital denied, has resigned his/her Medical Staff appointment at this Hospital during the pendency of an active investigation which could have led to revocation of his/her appointment, or has had his/her appointment revoked or terminated at this Hospital; or
- (3) Exclusive Contract: The practitioner practices a specialty which is the subject of a current written exclusive contract for coverage with the Hospital; or
- (4) Inadequate Insurance: The practitioner does not meet the liability insurance coverage requirements of these Bylaws; or
- (5) Ineligible for Medicare Provider Status: The practitioner has been excluded, suspended or debarred from any government payer program or is currently the subject of a pending investigation by any government payer program; or
- (6) No DEA Number: The practitioner's DEA number/controlled substance certificate has been revoked or voluntarily relinquished; or
- (7) Continuous Care Requirement: For applicants who shall be seeking advancement to Active or Courtesy Staff, failure to maintain an office or residence within the geographical area required by these Bylaws; or
- (8) Application Incomplete: The practitioner has failed to provide any information required by these Bylaws or requested on the application or has failed to execute an acknowledgment, agreement or release required by these Bylaws or included in the application.

The refusal to further process an application form for any of the above reasons shall not entitle the practitioner to any further procedural rights under these Bylaws.

In the event that none of the above apply to the application, the President of the Hospital or his/her designees shall promptly seek to collect or verify the references, licensure and other evidence submitted. The Medical Staff Office shall promptly notify the applicant, via special notice, of any problems in obtaining the information required and it shall then be the applicant's obligation to ensure that the required information is provided within two (2) weeks of receipt of such notification. Verification shall be obtained from primary sources whenever feasible. Licensure shall be verified with the primary source at the time of appointment and initial granting of clinical privileges, at reappointment or renewal or revision of clinical privileges, when an expansion of privileges is requested and at the time of expiration. When collection and verification are accomplished, the application and all supporting materials shall be transmitted to the Director of the appropriate Department for review. An application shall not be deemed complete nor shall final action on the application be taken until verification of all information, including query of the Data Bank, is complete.

6.3(d) Description of Initial Clinical Privileges

Medical Staff appointments or reappointments shall not confer any clinical privileges or rights to practice in the Hospital. Each practitioner who is appointed to the Medical Staff of the Hospital shall be entitled to exercise only those clinical privileges specifically granted by the Governing Body. The clinical privileges recommended to the Governing Body shall be based upon the applicant's education, training, experience, past performance, demonstrated competence and judgment, references and other relevant information. The applicant shall have the burden of establishing his/her qualifications for, and competence to exercise the clinical privileges he/she requests.

6.3(e) Recommendation of Department Chairperson

The Director of the appropriate Department shall review the application, the supporting documentation, reports and recommendations, and such other relevant information available to him/her, and shall transmit to the Credentialing Committee on the prescribed form a written report and recommendation as to appointment and, if appointment is recommended, clinical privileges to be granted and any specific conditions to be attached to the appointment. The reason for each recommendation shall be stated and supported by the references to the completed application and all other information considered. Documentation shall be transmitted with the report.

6.3(f) Credentialing Committee Action

After receiving the completed application, the Members of the Credentialing Committee shall review the application, the supporting documentation, the recommendation of the Department Chairperson and such other information

available as may be relevant to consideration of the applicant's qualifications for the Staff category and clinical privileges requested. The Credentialing Committee shall transmit to the MEC on the prescribed form a written report and recommendation as to Staff appointment and, if appointment is recommended, clinical privileges to be granted and any special conditions to be attached to the appointment. The Credentialing Committee may also recommend that the MEC defer action on the application. The reason for each recommendation shall be stated and supported by references to the completed application and all other information considered by the Committee. Documentation shall be transmitted with the report.

6.3(g) Medical Executive Committee Action

At its next regular meeting after receipt of the Credentialing Committee recommendation the MEC shall consider the recommendation and other relevant information available to it. Where there is doubt about an applicant's ability to perform the privileges requested, the MEC may request an additional evaluation. The MEC shall make specific findings as to the applicant's satisfaction of the requirements of experience, ability, and current competence. The MEC shall then forward to the Governing Body a written report on the prescribed form concerning Staff recommendation and, if appointment is recommended, clinical privileges to be granted and any special conditions to be attached to the appointment. The MEC may also defer action on the application. The reasons for each recommendation shall be stated and supported by references to the completed application and all other information considered by the Committee. Documentation shall be transmitted with the report.

6.3(h) Effect of Medical Executive Committee Action

- (1) Deferral: Action by the MEC to defer the application for further consideration must be followed up within ninety (90) days with a recommendation for appointment with specific clinical privileges or for denial of the application. An MEC decision to defer an application shall include specific reference to the reasons for deferral and shall describe any additional information needed. If additional information is required from the applicant, he/she shall be so notified, and he/she shall then bear the burden of providing same.

In no event shall the MEC defer action on a completed and verified application for more than ninety (90) days beyond receipt of same.

- (2) Favorable / Adverse Recommendation: When the recommendation of the MEC is either favorable or adverse to the application, the Hospital shall promptly forward it, together with all supporting documentation to the Governing Body. The Governing Body shall act upon the recommendation at its next scheduled meeting, or may defer action if additional information or clarification of existing information is needed. If the Governing Body concurs with the recommendation of the Medical Executive Committee, the decision of the Governing Body shall be

deemed final action. The Governing Body may refer the recommendation back to the Medical Executive Committee for further consideration stating the reasons for such referral back and setting a time limit of thirty (30) days within which a subsequent recommendation shall be made. If the Governing Body rejects the recommendation of the Medical Executive Committee then the matter shall be referred to the Joint Conference Committee for consideration within thirty (30) days and final action. The Committee shall have access to all records in connections with the application. The decision of the Joint Conference Committee shall be in writing within forty-five (45) days of receipt of the matter unless extended by that Committee for good cause. If the action of the Governing Body is adverse to the applicant, the President of the Medical Staff shall immediately inform the practitioner by special notice which shall specify the reason or reasons for denial and the practitioner then shall be entitled to the procedural rights as provided for in these Bylaws.

6.3(i) Board Action

- (1) Expedited: The Governing Body may accept, reject or modify the MEC recommendation. The Governing Body may delegate a Committee of at least two (2) individuals who are Members of the Governing Body to review the recommendations received from the MEC on behalf of the Governing Body. They shall take action on the application and may grant the individual appointment and clinical privileges. If the Committee returns a positive decision concerning the application, the full Board shall be informed of the appointments at its next regular meeting. If the Committee returns a negative decision concerning the application, the application shall be returned to the MEC for further recommendation prior to final action by the Governing Body.

The expedited process may not be used in the following circumstances:

- (i) The MEC makes a recommendation that is adverse or with limitation;
- (ii) The applicant's Medical Staff appointment, Staff status, and/or clinical privileges have been involuntarily resigned, denied, revoked, suspended, restricted, reduced, surrendered, or not renewed at any other healthcare facility;
- (iii) The applicant has withdrawn application for appointment, reappointment, or clinical privileges or resigned from the medical Staff before a decision was made by another healthcare facility's governing board or to avoid denial or termination of such;
- (iv) Licenses, DEA, or board certification have ever been suspended, modified, terminated, or voluntarily or involuntarily surrendered;

- (v) The applicant has been named as a defendant in a criminal action or been convicted of a crime;
- (vi) There are significant adverse findings, reported by the National Practitioner Data Bank, Healthcare Practitioner Data Bank, Federation of State Medical Boards, the American Medical Association / American Osteopathic Association, or any other practitioner's data base;
- (vii) There are past or pending malpractice actions, including claims, lawsuits, arbitrations, settlements, award, or judgments, that show an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant; and/or,
- (viii) There are proposed or actual exclusions and/or any pending investigations of the applicant from any healthcare program.

Any of the above circumstances shall require review and consideration by the full Governing Body.

Under no circumstances shall any applicant be entitled to more than one evidentiary hearing, as outlined in these Bylaws, based upon an adverse action.

6.3(j) Interview

An interview may be scheduled with the applicant during any of the steps set out in these Bylaws. Failure to appear for a requested interview without good cause may be grounds for denial of the application.

6.3(k) Reapplication After Adverse Appointment Decision

An application who has received a final adverse decision regarding appointment shall not be considered for appointment to the Medical Staff for a period of one (1) year after notice of such decision is sent, or until the defect constituting the grounds for the adverse decision is corrected, whichever is later. An applicant who has received a final adverse decision as a result of fraudulent conduct, misrepresentation in the application process, or other basis involving dishonesty shall not be permitted to reapply for a period of five (5) years after notice of the final adverse decision is sent. Any reapplication shall be processed as an initial application and the applicant shall submit such additional information as may be require. For purposes of this section, "final adverse decision" shall include denial after exercise or waiver of fair hearing rights and/or rejection or refusal to further process an application (or relinquishment of privileges) due to the applicant's provision of false or misleading information on, or the omission of information from, the application materials.

6.3(l) Time Periods for Processing

Applications for Staff appointment shall be considered in a timely and good faith manner by all individuals and groups required by these Bylaws to act thereon and, except for good cause, shall be processed within the time periods specific in this section. The Medical Staff Office shall transmit a completed application to the Department Chairperson upon completing his/her verification tasks, but in any event within 120 days after receiving the completed application, unless the practitioner has failed to provide required information needed to complete the verification process.

6.3(m) Denial for Hospital's Inability to Accommodate Applicant

A decision by the Governing Body to deny Staff Membership, Staff category assignment or particular clinical privileges based on any of the following criteria shall not be deemed to be adverse and shall not entitle the applicant to the procedural rights provided in these Bylaws:

- (1) On the basis of the Hospital's present inability to provide adequate facilities or supportive services for the applicant and his/her patients as supported by documented evidence; or
- (2) On the basis of professional contracts the Hospital has entered into for the rendition of services within various specialties.

6.3(n) Appointment Considerations

Each recommendation concerning the appointment of a Member and/or for clinical privileges to be granted shall be based upon an evidence-based assessment of the applicant's experience, ability, and current competence by the Credentialing Committee, Medical Executive Committee and the Governing Body, including assessment of the applicant's proficiency in areas such as the following:

- (1) **Patient Care** with the expectation that practitioners provide patient care that is compassionate, appropriate and effective;
- (2) **Medical/Clinical Knowledge** of established and evolving biomedical clinical and social sciences, and the applicant of the same to patient care and educating others;
- (3) **Practice-Based Learning and Improvement** through demonstrated use and reliance on scientific evidence, adherence to practice guidelines, and evolving use of science, evidence and experience to improve patient care practices;
- (4) **Interpersonal and Communication Skills** that enable establishment and maintenance of professional working relationships with patients, patients' families, Members of the Medical Staff, Hospital Administration and employees, and others;

- (5) **Professional** behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude to patients, the medical profession and society; and
- (6) **Systems-Based Practice** reflecting an understanding of the context and systems in which health care is provided.

6.4 **REAPPOINTMENT PROCESS**

6.4(a) **Information Form for Reappointment**

At least ninety (90) days prior to the expiration date of a practitioner's present Staff appointment, the Medical Staff Office shall provide the practitioner a reapplication form for use in considering reappointment. The Member who desires reappointment shall, at least sixty (60) days prior to such expiration date, complete the reapplication form by providing updated information with regard to his/her practice during the previous appointment period, and shall forward his/her reapplication form to the Medical Staff Office. Failure to return a completed application form shall result in automatic termination of Membership at the expiration of the Member's current term.

6.4(b) **Content of Reapplication Form**

The Reappointment Form shall include, at a minimum, updated information regarding the following:

- (1) **Education**: Continuing training, education, and experience during the preceding appointment period that qualifies the Member for the privileges sought on reappointment;
- (2) **License**: Current licensure;
- (3) **Health Status**: Current physical and mental health status only to the extent necessary to determine the practitioner's ability to perform the functions of Membership or to exercise the privileges requested;
- (4) **Previous Affiliations**: The name and address of any other health care organizations or practice setting where the Member provided clinical services during the preceding appointment period:
- (5) **Professional Sanctions**: Information as to previously successful or currently pending challenges to, or the voluntary relinquishment of, any of the following during the preceding appointment period:
 - The revocation, lapse or suspension of professional license;
 - The imposition of terms of probation or limitation of practice by a state licensing agency;
 - Restriction, suspension, termination, lapse or revocation of privileges at any Hospital or other health care institution;

- Cancellation, reduction, or restriction of professional liability coverage;
- Final judgment or settlement of a professional liability action;
- Revocation, lapse, reduction, suspension or voluntary relinquishment of their DEA Registration;
- Any suspicion that a practitioner or AHP may be impaired due to physical or mental issues or the excessive use of drugs and/or alcohol;
- Suspension, termination, exclusion or voluntary relinquishment from any federal or state health insurance program, including the Medicare or Medicaid Programs;
- A plea, indictment or conviction of any criminal offense, excluding minor traffic violations;
- Results of a formal investigation by the Department of Health and Human Services, or any enforcement agency of the United States or the State of Ohio;
- The practitioner's management of patients which may have given rise to investigation by the State Medical Board; and
- The practitioner has received a "Notice of Hearing" from the State Medical Board.

- (6) Information on Malpractice Experience: Details about filed, pending, settled, or litigated malpractice claims and suits during the preceding appointment period;
- (7) Insurance: Information as to whether the applicant has currently in force professional liability coverage meeting the requirements of these Bylaws, together with a letter from the insurer stating that the Hospital shall be notified should the applicant's coverage change at any time. Each practitioner must, at all times, keep the President of the Hospital informed of changes in his/her professional liability coverage;
- (8) Current Competency: Objective evidence of the individual's clinical performance, competence, and judgment based on the findings of Departmental evaluations of care, including, but not limited to an evaluation by the Department Chairperson and by one (1) practitioner and results from the quality process of the Medical Staff. Such evidence shall include as the results of the applicant's ongoing practice review, including data comparison to peers, core measures, outcomes, and focused review outcomes during the prior period of appointment. Practitioners who have not actively practiced in this Hospital during the prior appointment period shall have the burden of providing evidence of the practitioner's

professional practice review, volumes and outcomes from organizations that currently privilege the applicant and where the applicant has actively practiced during the prior period of appointment;

- (9) Fraud: Any allegations of civil or criminal fraud pending against any applicant and any allegations resolved during the preceding appointment period, as well as any investigations during the preceding appointment period by any private, federal or state agency concerning participation in any health insurance program, including Medicare or Medicaid during the preceding appointment period;
- (10) Notification of Release & Immunity Provisions: The acknowledgments and statement of release;
- (11) References: At the request of the Credentialing Committee, the Medical Executive Committee or the Governing Body, when based on the opinion of the same, there is insufficient data concerning the applicant's exercise of privileges in this Hospital during the preceding term of appointment to base a reasonable evaluation, the names of at least three (3) practitioners (excluding partners, associates in practice, employers, employees or relatives), who have worked with the applicant within the past two (2) years and personally observed his/her professional performance and who are able to provide knowledgeable peer recommendations as to the applicant's education, relevant training and experience, clinical ability and current competence, ethical character and ability to exercise the privileges requested and the ability to work with others.

6.4(c) Verification of Information

The Medical Staff Office shall, in a timely fashion, verify the additional information made available on each Reapplication Form and collect any other materials or information deemed pertinent, including information regarding the Member's professional activities and performance and conduct in the Hospital. Peer recommendations shall be collected and considered in the reappointment process. When collection and verification are accomplished, the Medical Staff Office shall transmit the Reappointment Form and supporting material to the Director of the appropriate Department. An application shall not be deemed complete nor shall final action on the application be taken until verification of all information is complete.

6.4(d) Action on Application

The application for reappointment shall thereafter be processed as set forth as described in Section 6.3(f) through 6.3(m) for initial appointment; except that an individual whose application for reappointment is denied shall not be permitted to reapply for a period of two (2) years or until the defect constituting the basis for the adverse action is corrected, whichever is later. Any reapplication shall be processed as an initial application and the applicant shall submit such additional information as the Staff or the Governing Body may require.

6.4(e) Basis for Recommendation

Each recommendation concerning the reappointment of a Member and the clinical privileges to be granted upon reappointment shall be based upon an evaluation of the considerations described in Section 6.3(l) as they impact upon determinations regarding the Member's professional performance, ability and clinical judgment in the treatment of patients, his/her discharge of Staff obligations, including participation in continuing medical education, his/her compliance with the Medical Staff Bylaws, Rules and Regulations, his/her cooperation with other practitioners and with patients, results of Hospital monitoring and evaluation process, including practitioner-specific information compared to aggregate information from quality activities which consider criteria directly related to quality of care, and other matters bearing on his/her ability and willingness to contribute to quality patient care in the Hospital.

6.4(f) Internal Information To Be Considered

The President of the Medical Staff or his/her designee(s) shall be responsible for reviewing information from the Medical Staff Office, Health Information Department and Quality Department with respect to, but not limited to the following:

- 1) Medical Staff, Department/Division, and Committee meeting attendance;
- 2) Participation as Staff official, committee members, Emergency Department coverage, etc.;
- 3) Timely completion of medical records;
- 4) Observance of Medical Staff Rules and Regulations, policies, etc.;
- 5) Utilization of Hospital to assure sufficient quality assessment and improvement monitoring;
- 6) Current physical and mental health status;
- 7) Clinical competence;
- 8) Utilization of practice patterns related to quality care;
- 9) Cooperation with peer and hospital personnel in situations which may adversely affect the quality of patient care; and,
- 10) Continued compliance with the basic qualifications for Medical Staff Membership contained in these Bylaws and continued fulfillment of the basic responsibilities of Medical Staff Membership contained in these Bylaws.

6.5 REQUEST FOR MODIFICATION OF APPOINTMENT

A Member may, either in connection with reappointment or at any other time, request modification of his/her Staff category or clinical privileges, by submitting the request in

writing to the President of the Medical Staff, or his/her designee. Such request shall be processed in substantially the same manner as provided in these Bylaws for reappointment. No Member may seek modification of privileges or Staff category previously denied on initial appointment or reappointment unless supported by documentation of additional training and experience.

6.6 PRACTITIONERS PROVIDING CONTRACTUAL PROFESSIONAL SERVICES

6.6(a) Qualifications and Processing

A practitioner who is providing services to the Hospital must meet the same qualifications for Membership; must be processed for appointment, reappointment, and clinical privilege delineation in the same manner; must abide by the Medical Staff Bylaws and Rules and Regulations and must fulfill all of the obligations for his/her Membership category as any other applicant or Member.

6.6(b) Requirements for Service

In approving any such practitioners for Medical Staff Membership, the Medical Staff must require that the services provided meet Joint Commission and CMS Conditions of Participation, are subject to the appropriate quality controls, and are evaluated as part of the overall Hospital quality assessment and improvement programs.

6.6(c) Termination

Unless otherwise provided in the contract for services, expiration or termination of any exclusive contract for services pursuant to this Section 6.6, shall automatically result in concurrent termination of Medical Staff Membership and clinical privileges. Upon approval of the Hospital, practitioners may retain their privileges if they enter into a new contract with the Hospital for the provision of services. Fair Hearing rights do not apply in this case.

ARTICLE VII: DETERMINATION OF CLINICAL PRIVILEGES

7.1 EXERCISE OF PRIVILEGES

Every practitioner providing direct clinical services at this Hospital shall, in connection with such practice and except as provided for in these Bylaws, be entitled to exercise only those clinical privileges or services specifically granted to him/her by the Governing Body. Said privileges must be within the scope of the license authorizing the practitioner to practice in this state and consistent with any restrictions thereon. The Governing Body shall approve the list of specific privileges and limitations for each category of practitioner and each practitioner shall bear the burden of establishing his/her qualifications to exercise each individual privilege granted.

7.2 DELINEATION OF PRIVILEGES

7.2(a) Requests

Each application for appointment and reappointment to the Medical Staff must contain a request for the specific clinical privileges desired by the applicant. The request for specific privileges must be supported by documentation demonstrating the practitioner's qualifications to exercise the privileges requested. In addition to meeting the general requirements of these Bylaws for Membership, each practitioner must provide documentation establishing that he/she meets the requirements for training, education and current competence set forth in any specific credentialing criteria applicable to the privileges requested. A request by a Member for a modification of privileges must be supported by documentation supportive of the request.

7.2(b) Basis for Privileges Determination

Granting of clinical privileges shall be based upon community and Hospital need, available facilities, equipment and number of qualified support personnel and resources as well as on the practitioner's education, training, current competence, including documented experience treatment areas or procedures; the results of treatment; and the conclusions drawn from quality activities, when available. For practitioners who have not actively practiced in the Hospital within the prior appointment period, information regarding current competence shall be obtained in the manner outlined in these Bylaws. In addition, those practitioners seeking new, additional or renewed clinical privileges (except those seeking emergency privileges) must meet all criteria for Medical Staff Membership as described in these Bylaws, including a query the National Practitioner Data Bank, when applicable. When privilege delineation is based primarily on experience, the individual's credentials record should reflect the specific experience and successful results that form the basis for granting of privileges, including information pertinent to judgment, professional performance and clinical or technical skills. Clinical privileges granted or modified on pertinent information concerning clinical performance obtained from other health care institutions or practice settings shall be added to and maintained in the Medical Staff file established for a Member.

7.2(c) Procedure

All requests for clinical privileges shall be evaluated and granted, modified or denied pursuant to the procedures outlined in these Bylaws and shall be granted for a period not to exceed two (2) years.

7.2(d) Limitations on Privileges

The delineation of an individual's clinical privileges shall include the limitations, if any, on an individual's prerogatives to admit and treat patients or direct the course of treatment for the conditions for which the patients were admitted.

7.2(e) Initial and Additional Grants of Privileges: Professional Practice Evaluation

All initial appointments and grants of new or additional privileges to existing Members of the Medical Staff shall be subject to a period of focused professional practice evaluation for a period of not less than six (6) months. The evaluation period may be renewed for additional periods up to the conclusion of the Member's period of initial appointment or initial grant of new or additional privileges. Results of the focused professional practice evaluation conducted during the period of appointment shall be incorporated into the practitioner's evaluation for reappointment.

7.3 SPECIAL CONDITIONS FOR DENTAL AND PODIATRIC PRIVILEGES

Requests for clinical privileges from dentists, oral surgeons and podiatrists shall be processed, evaluated and granted in the manner specified in these Bylaws. Surgical procedures performed by dentists, oral surgeons and podiatrists shall be under the overall supervision of the Chief of Surgery; however, other dentists and/or oral surgeons or podiatrists, as applicable, shall participate in the review of the practitioner through the performance improvement process. All dental and podiatric patients shall receive the same basic medical appraisal as patients admitted for other surgical services. A physician Member of the Medical Staff shall be responsible for admission evaluation, history and physical, and for the care of any medical problem that may be present at the time of admission or that may be discovered during hospitalization, and shall determine the risk and effect of the proposed surgical procedure on the total health status of the patient.

7.4 EMERGENCY PRIVILEGES and EMERGENCY PROVISION OF CLINICAL CARE

7.4(a) Emergency Privileges

Upon the recommendation of the President of the Hospital, President of the Medical Staff or Chairperson of the applicable Department, and upon proof of current licensure, appropriate malpractice insurance, and completion of the required Data Bank query; a Member of the Governing Body may grant emergency privileges for no more than 120 days in the following circumstances:

- (1) Pendency of Application: A Member of the Governing Body, upon recommendation of the President of the Hospital, President of the Medical Staff or applicable Department chairperson, may grant such privileges upon completion of the appropriate application, consent and release; proof of current licensure, DEA certificate, and appropriate malpractice insurance, completion of the required Data Bank query, verification that there are no current or prior successful challenges to licensure or registration, that the physician has not been subject to involuntary termination of the Medical Staff Membership at another facility; and likewise has not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges at another facility.
- (2) One-Case Privileges: Upon receipt of a written request, an appropriately licensed person who is not an applicant for Membership may be granted

emergency privileges for the care of one (1) patient. Such privileges are intended for isolated instances in which extension of such privileges are shown to be in an individual's best interest, and no practitioner shall be granted one-case privileges on more than five (5) occasions in any given year. The letter approving such privileges shall include the name of the patient to be treated and the specific privileges granted. Practitioners granted one-case privileges shall attend to the patient for whom privileges were granted within thirty (30) days of the request for one-case privileges. If a given practitioner exceeds the five (5) case requirement, such person shall be required to apply for Membership on the Medical Staff before being allowed to attend to additional patients.

A Member of the Governing Body, upon recommendation of the President of the Hospital, President of the Medical Staff or applicable Department chairperson, may grant such privileges upon completion of the appropriate application, consent and release; proof of currently licensure, DEA certificate, and appropriate malpractice insurance, completion of the required Data Bank query, verification that there are no current or prior successful challenges to licensure or registration, that the physician has not been subject to involuntary termination of the Medical Staff Membership at another facility; and likewise has not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges at another facility.

7.4(b) Conditions

Emergency privileges shall be granted only when the information available reasonably supports a favorable determination regarding the requesting practitioner's qualifications, ability and judgment to exercise the privileges granted. Special requirements of consultation and reporting may be imposed by the President of the Medical Staff, including a requirement that the patients of such practitioner be admitted upon dual admission with a Member of the Active Staff. Before emergency privileges are granted, the practitioner must acknowledge in writing that he/she has received and read the Medical Staff Bylaws, Rules and Regulations, and that he/she agrees to be bound by the terms thereof in all matters relating to his/her privileges.

Practitioners are not eligible for emergency privileges if any of the following are applicable:

- (1) Current or previously successful challenge to licensure and registration;
- (2) Involuntary termination of Medical Staff Membership at another organization;
- (3) Involuntary limitation, reduction, denial or loss of clinical privileges at another organization;
- (4) Excessive number or unusual pattern of professional liability actions (as determined by the Hospital); or

- (5) Any other event that would disqualify a practitioner from Medical Staff Membership under the Medical Staff Bylaws, Rules and Regulations and/or policies.

7.4(c) Termination

On the discovery of any information or the occurrence of any event of a professionally questionable nature concerning a practitioner's qualifications or ability to exercise any or all of the privileges granted, the President of the Hospital may, after consultation with the President of the Medical Staff, terminate any or all of such practitioner's emergency or one-case privileges. Where the life or well-being of a patient is endangered by continued treatment by the practitioner, the termination may be effected by any person entitled to impose summary suspensions as outlined under these Bylaws. In the event of any such termination, the practitioner's patients then in the Hospital shall be assigned to another practitioner by the President of the Medical Staff. The wishes of the patient shall be considered, if feasible, in choosing a substitute practitioner.

7.4(d) Rights of the Practitioner

A practitioner shall not be entitled to the procedural rights afforded by these Bylaws because of his/her ability to obtain emergency or one-case privileges or because of any termination or suspension of such privileges.

7.4(e) Term

No term of emergency privileges shall exceed a total of 120 days.

7.4(f) Emergency Provision for Clinical Care

For this section, an "emergency" is defined as a condition in which serious or permanent harm would result to a patient, or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

During an emergency, any Member of the Medical Staff, who has clinical privileges, is permitted to provide any type of patient care necessary as a life-saving measure or to prevent serious harm (regardless of his/her clinical privileges), provided that the care provided is within the scope of the individual's license unless otherwise directed by a known advance directive; or in the case of a conscious, competent adult patient, a known informed directive to withhold such life sustaining treatment.

7.5 DISASTER PRIVILEGES

For purposes of this section, a "disaster" is defined as a community-wide disaster or mass injury situation in which the number of existing, available Medical Staff Members is not adequate to provide all clinical services required by the citizens served by this Hospital. In the case of a disaster, any practitioner, or licensed independent practitioner, to the degree permitted by his/her license and regardless of Staff status or clinical privileges, shall, as approved by the President of the Hospital or his/her designee or the

President of the Medical Staff, be permitted to do, and be assisted by Hospital personnel in doing everything reasonable and necessary to save the life of a patient or to treat patients as needed.

Disaster privileges may be granted by the President of the Hospital or President of the Medical Staff when, and for long as, the Hospital's emergency management plan has been activated and the Hospital is unable to handle the immediate patient needs. Practitioners granted disaster privileges are not Members of the Medical Staff and have no admitting privileges. Prior to granting any disaster privileges the volunteer practitioner, or licensed independent practitioner, shall be required to present a valid photo ID issued by a state, federal or regulatory agency, and at least one of the following:

- (1) A current hospital picture ID which clearly identifies professional designation;
- (2) A current license, certification or registration;
- (3) Primary source verification of licensure, certification or registration (if required by law to practice a profession);
- (4) ID indicating the individual is a Member of a disaster Medical Assistance Team (DMAT), or the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP);
- (5) ID indicating the individual has been granted authority to render patient care, treatment and services in a disaster; or,
- (6) ID of a current Medical Staff Member who possess personal knowledge regarding the volunteer practitioner's qualifications. The President of the Hospital and/or President of the Medical Staff are not required to grant such privileges to any individual and shall make such decision only on a case-by-case basis.

As soon as possible after disaster privileges are granted, but not less than seventy-two (72) hours thereafter, the practitioner shall undergo the same verification process outlined in Section 7.4(a) for Emergency Privileges when required to address an emergency patient care need. In extraordinary circumstances in which primary source verification of licensure, certification or registration cannot be completed within seventy-two (72) hours, it shall be done as soon as possible, and the Hospital shall document in the emergency/disaster volunteer's credentialing file why primary source verification cannot be performed in the required time frame, the efforts of the practitioner to continue to provide adequate care, treatment and services, and all attempts to rectify the situation and obtain primary source verification as soon as possible. In all cases, whether or not primary source verification could be obtained within seventy-two (72) hours following the grant of disaster privileges, the President of the Hospital or the President of the Medical Staff shall review the decision to grant the practitioner disaster privileges, and shall, based on the information obtained regarding the professional practice of the practitioner, make a decision concerning the continuation of the practitioner's disaster privileges.

In addition, each practitioner granted disaster privileges shall be issued a Hospital ID (or if not practicable by time or other circumstances to issue official Hospital ID, then another form of identification) that clearly indicates the identity of the practitioner, and the scope of the practitioner's disaster responsibility and/or privileges. A Member of the Medical Staff shall be assigned to each disaster volunteer practitioner for purposes of overseeing the professional performance of the volunteer practitioner through such mechanisms as direct observation of care, concurrent or retrospective clinical record review, mentoring, or as otherwise provided in the grant of privileges.

7.6 TELEMEDICINE

All practitioners that participate in the practice of telemedicine are fully credentialed Members of the Medical Staff utilizing the credentialing provisions as outlined in these Bylaws.

7.7 PRIVILEGES FOR PEER REVIEW ACTIVITIES

When necessary for the conducting of peer review activities, the Medical Executive Committee may admit a physician, dentist, podiatrist, or psychologist or any other individual to the Medical Staff for a limited period of time. Such membership shall be solely for the purpose of conducting peer review in a particular case or situation, and the provisional membership shall terminate upon the member's completion of duties in connection with the peer review matter.

ARTICLE VIII: CORRECTIVE ACTION

8.1 ROUTINE CORRECTIVE ACTION

8.1(a) Criteria for Initiation

Whenever activities, omissions, or any professional conduct of a practitioner with clinical privileges are detrimental to patient safety, to the delivery of quality patient care, are disruptive to Hospital operations, or violate the provisions of these Bylaws, the Medical Staff Rules and Regulations, or duly adopted policies and procedures; corrective action against such practitioner may be initiated by any officer of the Medical Staff, the Vice President of Medical Operations, the Chairperson of any Department, the Peer Review Committee, the President of the Hospital or the Governing Body.

8.1(b) Request and Notices

All requests for corrective action in accordance with these Bylaws shall be submitted in writing to the MEC, and supported by reference to the specific activities or conduct which constitutes the grounds for the request. The President of the Medical Staff shall promptly notify the President of the Hospital or his/her designee in writing of all requests for corrective action received by the Medical Executive Committee and shall continue to keep the President of the Hospital or his/her designee fully informed of all action taken in conjunction therewith. If the

matter has not been previously reviewed by the Peer Review Committee, the Medical Executive Committee shall refer the request to the Peer Review Committee for investigation, findings and recommendation.

8.1(c) Investigation by the Peer Review Committee

The Peer Review Committee shall begin to investigate the matter within forty-five (45) days or at its next regular meeting, whichever is sooner. When the investigation involves an issue of physician impairment, the MEC shall assign the matter to the Practitioner Health Committee in accordance with these Bylaws. Within thirty (30) days after the investigation begins, a written report of the investigation, findings and recommendation shall be forwarded to the Medical Executive Committee.

8.1(d) Medical Executive Committee Action

Within sixty (60) days following receipt of the report, the MEC shall take action upon the report of the Peer Review Committee the Medical Executive Committee can:

- (1) Adopt the findings and recommendation(s) of the Peer Review Committee;
- (2) Modify the findings and recommendations(s) of the Peer Review Committee;
- (3) Request that the Peer Review Committee conduct further investigation; or,
- (4) Conduct its own investigation.

Once the Medical Executive Committee has determined that the investigation has been completed, the Medical Executive Committee shall take action on the request for corrective action. Its action shall be reported in writing and may include, but is not limited to:

- (1) Rejecting the findings and recommendation(s);
- (2) Issuing a warning or a reprimand to which the practitioner may write a rebuttal, if he/she so desires;
- (3) Recommend proctoring or limitation of Staff prerogatives;
- (4) Recommending terms of probation or required consultation;
- (5) Recommending reduction, suspension or revocation of clinical privileges;
- (6) Recommending reduction of Staff category; or
- (7) Recommending suspension or revocation of Membership.

8.1(e) Procedural Rights

Any action by the MEC pursuant to Section 8.1(d)(4), (5), (6) or (7) or any combination of such action's, shall entitle the Member to the procedural rights as specified in these Bylaws. The Governing Body may be informed of the recommendation, but shall take no action until the Member has either waived his/her right to a hearing or completed the hearing.

8.1(f) Other Action

If the MEC's recommended action is as provided in Section 8.1(d)(1), (2), or (3) (where such action does not materially restrict a practitioner's exercise of privileges), such recommendation, together with all supporting documentation, shall be transmitted to the Governing Body. Fair Hearing rights shall not apply to such actions.

8.2 SUMMARY SUSPENSION

8.2(a) Criteria and Initiation

Notwithstanding the provisions of Section 8.1 above, whenever a practitioner willfully disregards these Bylaws or other Hospital policies, or his/her conduct may require that immediate action be taken to protect the life, well-being, health or safety of any patient, employee or other person, then the President of the Medical Staff, the President of the Hospital, or the Vice President of Medical Operations shall have the authority to Summarily Suspend the Medical Staff Membership status or all or any portion of the clinical privileges immediately upon imposition. Upon imposition of a Summary Suspension, the President of the Medical Staff and the President of the Hospital shall be immediately notified. Subsequently, the President of the Medical Staff or his/her designee shall, on behalf of the imposer of such suspension, promptly give special notice of the suspension to the practitioner.

Immediately upon the imposition of Summary Suspension, the President of the Medical Staff shall designate a physician with appropriate clinical privileges to provide continued medical care for the suspended practitioner's patient(s) still in the Hospital. The wishes of the patient(s) shall be considered, if feasible, in the selection of the assigned physician.

It shall be the duty of all Medical Staff Members to cooperate with the President of the Medical Staff, the Vice President of Medical Operations and the President of the Hospital in enforcing all suspensions and in caring for the suspended practitioner's patients.

8.2(b) Medical Executive Committee Action

Within fourteen (14) days after such Summary Suspension, a meeting of the Medical Executive Committee shall be convened to review and consider the action taken. The Member shall be afforded the opportunity to attend and discuss the matter at such meeting. However, this discussion shall not be deemed a

Hearing. The Medical Executive Committee may recommend modification, ratification, continuation with further investigation or termination of the Summary Suspension. The decision of the Medical Executive Committee shall be final.

8.2(c) Procedural Rights

If the Summary Suspension is terminated or modified such that the practitioner's privileges are not materially restricted, the matter shall be closed and no further action shall be required.

If the Summary Suspension is continued for the purposes of further investigation, the Medical Executive Committee shall reconvene within thirty (30) days of the original imposition of the Summary Suspension and shall modify, ratify or terminate the Summary Suspension.

Upon ratification of the Summary Suspension or modification which materially restricts the Member's clinical privileges, the Member shall be entitled to the procedural rights provided for in these Bylaws. The terms of the Summary Suspension, as sustained or as modified by the Medical Executive Committee, shall remain in effect pending a final decision by the Governing Body.

8.3 SUSPENSION DURING INVESTIGATION

8.3(a) Criteria

The President of the Medical Staff, the President of the Hospital, or the Vice President of Medical Operations shall have the authority to suspend the clinical privileges of a Member for a period of not more than fourteen (14) days while an investigation is being conducted to determine if any permanent professional review action should be taken. The President of the Medical Staff or the Vice President of Medical Operations, upon the concurrence of the President of the Hospital shall have suspension authority during the investigation when dealing with quality of medical care issues and the President of the Hospital, upon the concurrence of the President of the Medical Staff and the appropriate Department Director(s), shall have suspension authority during the investigation in all non-medical care situations. Such a suspension shall be imposed in any circumstances in which the President of the Medical Staff, the President of the Hospital or the Vice President of Medical Operations reasonably believes the suspension is necessary to protect the health of any patient or employee of the Hospital.

8.3(b) Procedure

Suspension during investigation shall be imposed in the same manner as provided for Summary Suspension but shall not be subject to the provisions of these Bylaws. At the end of the suspension during investigation, the Medical Executive Committee shall either:

- A. Restore all clinical privileges of the practitioner;

- B. Proceed with Summary Suspension under the provisions of these Bylaws; or
- C. Terminate the suspension and initiate a request for formal corrective action.

Suspension during investigation does not trigger the Fair Hearing Rights of a practitioner.

8.4 AUTOMATIC SUSPENSION

8.4(a) License

A Staff Member or AHP whose license, certification, or other legal credential authorizing him/her to practice in Ohio is revoked, relinquished, suspended, lapsed, expired or restricted shall immediately and automatically be suspended until such time as the license is reinstated.

8.4(b) Drug Enforcement Administration (DEA) Registration Number

Any practitioner (except a pathologist or radiologist) whose DEA registration number/controlled substance certificate or equivalent state credential is revoked, relinquished, suspended, lapsed, expired or restricted shall immediately and automatically be suspended such time as the registration is reinstated.

8.4(c) Medical Records

Automatic suspension of a practitioner's privileges shall be imposed for failure to complete medical records as required by the Rules and Regulations. The suspension shall continue until such records are completed unless the practitioner satisfies the President of the Medical Staff that he/she has a justifiable excuse for such omissions.

8.4(d) Malpractice Insurance Coverage

Any practitioner or AHP unable to provide proof of current medical malpractice coverage in the amounts prescribed in these Bylaws shall be automatically suspended until proof of such coverage is provided to the President of the Hospital or his/her designee.

8.4(e) Exclusions/Suspension from Medicare / Medicaid

Any practitioner or AHP whose participate in the Medicare or Medicaid Program is suspended, terminated, excluded or voluntarily relinquished shall be automatically suspended.

8.4(f) Health System Privileging Action

Any practitioner or AHP whose clinical privileges have been restricted, suspended, terminated or revoked, except for medical records suspension, from a health system hospital shall automatically be suspended until such time as the matter can be reviewed by the Hospital's Peer Review Committee and may result

in a similar restriction, suspension, termination or revocation of a practitioner's or AHP's clinical privileges. This section shall not limit the due rights set forth in these Bylaws.

8.4(g) Automatic Suspension - Fair Hearing Plan Not Applicable

No Member of the Medical Staff, whose privileges are automatically suspended under this Section, shall have the right of hearing or appeal as provided for in these Bylaws.

8.4(h) Special Appearance; Cooperation with Medical Executive Committee

Any Committee or Department of the Medical Staff may request the appearance of a Medical Staff Members at a Committee meeting when the Committee or Department is questioning the practitioner's clinical course of treatment or conduct. Such special appearance requirement shall not be considered an adverse action and shall not constitute a hearing under these Bylaws. Whenever apparent suspected deviation from standard clinical practice is involved, seven (7) days advance notice of the time and place of the meeting shall be given to the practitioner. When such special notice is given, it shall include a statement of the issue involved and that the practitioner's appearance is mandatory. Failure of the practitioner to appear at any meeting with respect to which he/she was given such special notice shall and/or failure to comply with any reasonable directive of the MEC, unless excused by the MEC upon a showing of good cause, shall result in an automatic suspension of all or such portion of the practitioner's clinical privileges as the MEC may direct. Such suspensions shall remain in effect until the matter is resolved by the MEC or the Governing Body, or through corrective action, if necessary.

8.5 CONFIDENTIALITY

To maintain confidentiality, participants in the corrective action process shall limit their discussion of the matters involved to the formal avenues provided in these Bylaws for peer review and corrective action.

8.6 PROTECTION FROM LIABILITY

All Members of the Governing Body, the Medical Staff and Hospital personnel assisting in Medical Staff peer review shall have immunity from any civil liability to the fullest extent permitted by state and federal law when participating in any activity described in these Bylaws.

8.7 SUMMARY SUPERVISION

Whenever criteria exist for initiating correction action pursuant to this Article, the practitioner may be summarily placed under supervision concurrently with the initiation of professional review activities until such time as final determination is made regarding the practitioner's privileges. Any of the following shall have the right to impose supervision: President of the Medical Staff, Vice President of Medical Operations, applicable Department Chairperson, the Governing Body and/or the President of the Hospital.

8.8 FALSE INFORMATION APPLICATION

Any practitioner who, after being granted appointment and/or clinical privileges, is determined to have made a material misstatement, misrepresentation, or omission in connection with an application shall be deemed to have immediately relinquished his/her appointment and clinical privileges. No practitioner who is deemed to have relinquished his/her appointment and clinical privileges pursuant to this Section 8.8 shall be entitled to the procedural rights under these Bylaws and the Fair Hearing Plan, except that the MEC may, upon written request from the practitioner, permit the practitioner to appear before it and present information solely as to the issue of whether the practitioner made a material misstatement, misrepresentation, or omission in connection with his/her application. If such appearance is permitted by the MEC, the MEC shall review the material presented by the practitioner and render a decision as to whether the finding that he/she made a misstatement, misrepresentation, or omission was reasonable, which MEC decision shall be subject to the approval of the Governing Body.

ARTICLE IX: INTERVIEWS AND HEARINGS

9.1 INTERVIEWS

When the MEC or Governing Body is considering initiating an adverse action concerning a practitioner, it may in its discretion, give the practitioner an interview. The interview shall not constitute a hearing, shall be preliminary in nature and shall not be conducted according to the procedural rules provided with respect to hearings. The practitioner shall be informed of the general nature of the proposed action and may present information relevant thereto. A summary record of such interview shall be made. No legal or other outside representative shall be permitted to participate for any party.

9.2 HEARINGS

9.2(a) Procedure

Whenever a practitioner requests a hearing based upon or concerning a specific adverse action as defined in these Bylaws, the hearing shall be conducted in accordance with the procedures set forth in these Bylaws.

9.3 ADVERSE ACTION AFFECTING AHP'S

Any adverse actions affecting AHP's shall be accomplished in accordance with Section 5.4 of these Bylaws.

ARTICLE X: FAIR HEARING AND APPELLATE REVIEW

10.1 PREAMBLE AND APPELLATE REVIEW

10.1(a) Exhaustion of Remedies

If an adverse ruling is made with respect to a Medical Staff Member's membership, Staff status, or clinical privileges at any time, regardless of whether he/she is an applicant or a Medical Staff Member, he/she must exhaust the remedies afforded by these Bylaws before resorting to formal legal action challenging the decision, the procedures used to arrive at it, or asserting any claim against Marymount Hospital, or participants in the decision process; and the exclusive procedure for obtaining review will be by Petition for Writ of Mandate.

10.1(b) Definitions

Except as otherwise provided in these Bylaws, the following definitions apply under this Article:

- a. "Appellate Review Body" means the group designated pursuant to this Plan to hear a request for an Appellate Review that has been properly filed and pursued by the practitioner.
- b. "Date of Receipt" of any notice or other communication will be deemed to be the date such notice or communication was delivered personally, electronically, or by U.S. Mail to the required addressee.
- c. "Hearing Committee" means the Committee appointed pursuant to this Plan to hear a request for an evidentiary Hearing that has been properly filed and pursued by a practitioner.
- d. "Notice" refers to a written communication delivered personally, electronically or by U.S. Mail addressed to the required addressee at his/her address as it appears in the records of Medical Staff Services; and
- e. "Petitioner" refers to the Medical Staff Member or applicant who has requested a Hearing or appearance pursuant to this Article.

10.2 GROUND FOR A HEARING

Any one or more of the following actions or recommended actions constitute grounds for a Hearing unless otherwise specified in these Bylaws:

- a. Denial of Medical Staff Membership;
- b. Denial of requested advancement in Medical Staff Membership status;
- c. Denial of Medical Staff appointment;
- d. Demotion to lower Medical Staff category or Membership status;
- e. Summary restriction or suspension of Medical Staff Membership and / or privileges;
- f. Expulsion from Medical Staff Membership;
- g. Denial of requested privileges (excluding Emergency Privileges);

- h. Suspension of Membership or clinical privileges;
- i. Reduction in privileges; and/or
- j. Termination of privileges;

10.3 REQUESTS FOR HEARINGS

10.3(a) Notice of Action or Proposed Action

In all cases in which a recommendation has been made or an action proposed to be taken as set forth in these Bylaws, the President of the Medical Staff or his/her designee or the Chairman of the Governing Body or his/her designee, depending upon which entities recommendation gave rise to the Hearing, shall give the Member prompt written notice. Said notice shall contain the following information:

- A. A description of the recommendation made or an action propose to be taken;
- B. The basis for the recommendation or action proposed to be taken, including the acts or omissions with which the Member is charged and a list of charts in question, where applicable;
- C. The right of the Member to request a Hearing within thirty (30) days following receipt of notice of such recommendation to request a Hearing; and,
- D. A summary of the rights in the Hearing as set forth in these Bylaws.

10.3(b) Request of Hearing: Waiver of Hearing

The Member shall have thirty (30) days following receipt of notice of such action or recommendation to request a Hearing. The request shall be in writing addressed to the Medical Executive Committee or to the Governing Body, depending upon which entities recommendation gave rise to the Hearing, with a copy to the Governing Body and the President of the Medical Staff. In the event the Member does not request a Hearing within the time and in the manner described, the Member shall be deemed to have waived any right to a Hearing and to have accepted the recommendation involved.

10.3(c) Notice of Hearing

Upon receipt of a request for Hearing, the Medical Executive Committee or the Governing Body, depending upon which entities recommendation gave rise to the Hearing, shall schedule a Hearing and, within fifteen (15) days give notice to the Member of the time, place and date of the Hearing. The notice of the Hearing shall include a list of the Committee and appointed Hearing Officer and a list of witnesses (if any) expected to testify at the Hearing on behalf of the Medical Executive Committee or the Governing Body, depending upon which entities recommendation gave rise to the Hearing.

10.3(d)Time for Hearing

Unless extended by the Hearing Officer or waived by both parties, the date of the commencement of the Hearing shall not be less than thirty (30) days, nor more than ninety (90) days from the date of receipt of the request for Hearing by the Medical Executive Committee or the Governing Body; provided, that when the request is received from a Member who is under Summary Suspension the Hearing shall be held as soon as the arrangements may reasonably be made, but not to exceed forty-five (45) days from the date of receipt of the request.

10.3(e)Hearing Committee or Medical Executive Committee

The Hearing will be held before the Hearing Committee appointed by the Medical Executive Committee unless both the Member and the Medical Executive Committee or Governing Body, depending upon which entities recommendation gave rise to the Hearing, agree in writing that the matter will be heard by the Medical Executive Committee or Governing Body.

10.3(f)Failure to Appear or Proceed

Failure of the petitioner to appear without good cause and proceed at a Hearing will be deemed to constitute voluntary acceptance of the actions involved and waiver to any hearing rights, and it will thereupon become the final recommendation of the Medical Executive Committee or the Governing Body, depending on which entities recommendation gave rise to Hearing.

10.3(g)Postponements and Extensions

Postponements and extensions of time beyond the times expressly permitted in these Bylaws may be requested by an affected person and will be permitted by the Hearing Officer, or President of the Medical Staff before appointment of a Hearing Officer, on a showing of good cause.

10.4 HEARING PROCEDURE

10.4(a)The Hearing Committee and Hearing Officer

The Medical Executive Committee or the Governing Body, depending upon which entities recommendation gave rise to the Hearing, acting on behalf of the Hospital, shall appoint a three (3) Member Hearing Committee and designate a Member as the Hearing Officer; or the parties can mutually agree to the appointment of a single Hearing Officer or another form of Hearing Committee. No Member of the Hearing Committee nor the Hearing Officer shall be in direct economic competition with the Member. No Member of the Hearing Committee nor the Hearing Officer may act as a prosecuting officer or as an advocate. The Members of the Hearing Committee and the Hearing Officer shall be considered employees of the Medical Staff for the purposes of Ohio Revised Code Sections 2305.24, 2305.25, and 2305.251. The Hearing Officer shall endeavor to assure that all participate in the Hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious

manner, and that proper decorum is maintained. The Hearing Officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the Hearing. The Hearing Committee shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure or the admissibility of evidence. If the Hearing Officer determines that either side in a Hearing is not proceeding in an efficient and expeditious manner, the Hearing Officer may take such discretionary action as seems warranted by the circumstances. The Hospital shall provide legal defense for the Hearing Officer and Hearing Committee for any legal actions taken by the Member against the Hearing Officer or the Hearing Committee for actions arising from the Hearing procedure.

10.4(b) Pre-Hearing Procedure

- A. If the Medical Executive Committee or the Governing Body (whichever is appropriate), or the Hearing Officer requests a list of witnesses, within fifteen (15) days of such request, the Member shall furnish a written list of the names and addresses of the individuals, so far as is then reasonably known or anticipated, who may give testimony or evidence in support of the Member at the Hearing. While neither side in a Hearing shall have any right to the discovery of documents or other evidence in advance of Hearing, the Hearing Officer may confer with both sides to encourage an advance mutual exchange of documents which are relevant to the issues to be presented at the Hearing.
- B. It shall be the duty of the Member and the Medical Executive Committee or the Governing Body to exercise reasonable diligence in notifying the Hearing Officer of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the Haring. Objections to any pre-hearing decisions may be succinctly made at the Hearing.

10.4(c) Rights of the Parties

Both the Member and the Medical Executive Committee or the Governing Body, depending upon which entities recommendation gave rise to the Hearing, have the right:

- A. To be represented at any phase of the Hearing or preliminary procedures by an attorney at law or by any other person of that party's choice;
- B. To have a record made of the proceedings, copies of which may be obtained by the Member upon payment of any reasonable charges associated with the preparation thereof;
- C. To call, examine, cross-examine, and impeach witnesses, and the Medical Executive Committee or the Governing Body may call the Member as if under cross-examinations;

- D. To present evidence determined to be relevant by the Hearing Committee, regardless of its admissibility in a court of law; and,
- E. To submit a written statement at the close of the Hearing.

10.4(d)Oath

The Hearing Committee may, but shall not be required to, order that oral evidence shall be taken only upon oath administered by any person lawfully authorized to administer such oath.

10.4(e)Miscellaneous Rules

- A. Judicial rules of evidence and procedure related to the conduct of the Hearing, examination of witnesses, and presentation of evidence shall not apply to a Hearing conducted under this Article.
- B. Any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely upon in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.
- C. The Hearing Committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate.
- D. The President of the Medical Staff and the President of the Hospital, or his/her designee, may attend the Hearing, but may not participate, unless called as a witness.

10.4(f)Burdens of Presenting Evidence and Proof

At the Hearing, unless otherwise determined for good cause, the Medical Executive Committee or Governing Body, depending upon which entities recommendation gave rise to the Hearing, shall have the initial duty to present evidence for each case or issue in support of its action or recommendation. The Member shall be obligated to present evidence in response. Throughout the Hearing, the Member shall bear the burden of persuading the Hearing Committee, by the preponderance of the evidence, that the adverse action or recommendation lacks any substantial factual bases or the conclusions drawn therefrom are arbitrary, unreasonable or capricious.

10.4(g)Adjournment and Conclusion

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

10.4(h)Recommendation and Report for the Hearing Committee

- A. Within ten (10) days after final adjournment of the Hearing, the Hearing Committee shall render a recommendation which shall be accompanied by a report in writing stating the reasons for the recommendation and shall be delivered to the Medical Executive Committee, the Governing Body, the President of the Medical Staff and the Member. If the Member is currently under suspension, however, the time for the recommendation and report shall be five (5) days. A copy of said recommendation and report shall also be forwarded to the President of the Medical Staff and the President of the Hospital and the Governing Body. The report shall contain a concise statement of the reasons in support of the recommendation.
- B. Within thirty (30) days after receipt of the report of the Hearing Committee, the Medical Executive Committee or the Governing Body, depending upon which entities recommendation gave rise to the Hearing, shall reconsider its adverse action or recommendation in light of the Hearing Committee's report and recommendation.
- C. In the case of reconsideration by the Medical Executive Committee, the Medical Executive Committee shall forward its adverse or favorable recommendation to the Governing Body. In the event of a split vote or separate vote, the matter shall be sent to the Joint Conference Committee as provided for in these Bylaws.
- D. If the Governing Body concurs with the recommendation of the Medical Executive Committee, the decision of the Governing Body shall be deemed final action. If the Governing Body does not concur with the recommendation of the Medical Executive Committee, then the matter shall be referred to the Joint Conference Committee for consideration within thirty (30) days and such Committee shall have access to all records in connection with the investigation, recommendation and decision any may interview the applicant or Member. The decision of the Joint Conference Committee shall be in writing within fifteen (15) days of receipt of the matter unless extended by that Committee for good cause.
- E. The decision of the Joint Conference Committee shall be sent to the Governing Body for final action. The Governing Body may adopt the recommendation of the Joint Conference Committee, in whole or in part or refer the matter back to the Medical Executive Committee for further consideration. The Governing Body shall then review the reconsidered decision of the Medical Executive Committee and take final action at the next regular meeting.
- F. The Chair of the Governing Body shall notify the practitioner and the President of the Medical Staff of the decision of the Governing Body within five (5) days of the final decision. A modification or termination of clinical privileges shall not take effect until any Hearings or appeals

provide for in these Bylaws and requested by the Member concerning the modification or termination have been completed.

10.4(i) Basis for Recommendation

The recommendation of the Hearing Committee shall be based on evidence introduced at the Hearing, including all logical and reasonable inferences from the evidence and the testimony.

10.4(j) Right to One Hearing

No applicant or Member shall be entitled to more than one evidentiary Hearing on any matter which shall have been the subject of adverse recommendation.

10.4(k) Parties

The parties to the Hearing shall be the affected Member and the Medical Executive Committee or Governing Body, whichever made the initial adverse decision, on behalf of the Hospital. If a Hearing is requested on a timely basis, the President of the Medical Staff shall appoint an advocate who may be an attorney at law to present the case in support of any adverse recommendation against the Member before the Hearing Committee. The advocate appointed by the President of the Medical Staff shall not be in direct economic competition with the Member.

10.4(l) Costs

The application or Member shall be responsible for his own attorney fees, if any. The Hospital shall be responsible for the costs of the Hearing.

10.5 APPEAL: PROCEDURAL DETAILS

10.5(a) Request for Appellate Review

A Medical Staff Member or the Hospital shall have thirty (30) days following receipt of notice pursuant to these Bylaws to file a written request for an appellate review. Such request shall be delivered to the Medical Staff Office. A party who fails to request appellate review within the time and manner specified herein will be deemed to have waived all further appeals.

10.5(b) Arrangement for Appellate Review

If a party makes a timely appeal, the Chair of the Governing Body, within ten (10) calendar days of receiving such request, will schedule and arrange for appellate review. Notice of the time, date, and place of the appellate review will be given to the appealing party. The date of appellate review must be not less than thirty (30) calendar days after the request is received. If the Member appealing is under suspension, then the appellate review is held as soon as arrangements can reasonably be made, but not more than fourteen (14) calendar days from receiving the appeal request. The stated times within which appellate review must be accomplished may be extended by the Board Chair for good cause.

10.5(c) Appellate Review Panel and Procedures

- A. The Chair of the Governing Body appoints an Appellate Review Panel of not less than three (3) persons, which may include Members of the Governing Body and the Active Medical Staff. The Appellate Review Panel considers the record upon which the recommendation or action being appealed was made.
- B. The Appellate Review Panel may accept additional oral or written evidence in its discretion. Each of the two parties in the matter have the right to present a written statement in support of their position on the appeal and, in its sole discretion, the Appellate Review Panel may allow a representative of each party to appear personally and make oral arguments.
- C. The Appellate Review Panel will issue written recommendations of final action to the Governing Body. The Board may accept, modify, or reverse the recommendation of the Appellate Review Panel, or, in some instances, request further review by the Appellate Review Panel for good cause. When further review is necessary, a report back to the Governing Body shall be accomplished within thirty (30) calendar days after the conclusion of appellate review, and it will issue such decision in writing to the affected party and to the Medical Executive Committee, including a statement of the basis for the decision.
- D. The decision of the Governing Body following the appeal is effective immediately, and not subject to further review.

10.5(d) Only One Appeal

There is no exception to the rule that the applicant or Medical Staff Member is entitled to only one appellate review of any single matter.

10.5(e) Reapplication Following Adverse Decision on Appellate Review

If the final decision of the Governing Body, following appellate review, is adverse, the applicant or Medical Staff Member may reapply for appointment or for the denied clinical privileges, whatever is applicable, no sooner than one (1) year from the Board's final decision, unless the Board provides otherwise in its final written decision.

It is the intent of this Hearing and Appeals Procedure, which is part of the Medical Staff Bylaws, approved by the Governing Body, to be in compliance with the Health Care Quality Improvement Act of 1986.

ARTICLE XI: OFFICERS

11.1 OFFICERS OF THE STAFF

11.1(a) Identification

The officers of the Medical Staff shall be:

- (1) President of the Medical Staff;
- (2) President-Elect of Staff;
- (3) Secretary; and
- (4) Treasurer.

11.1(b) Qualifications

Officers must be Members of the Active Staff at the time of nomination and election and must remain Members in good standing during their term of office. Failure of an officer to maintain such status shall immediately create a vacancy in the office.

11.1(c) Nominating Committee and Nominations

- (1) The Nominating Committee shall consist of the President of the Medical Staff, the President-Elect of the Medical Staff, the Vice President of Medical Operations and the President of the Hospital. This Committee shall offer one (1) or more nominees for the position of President of the Medical Staff and President-Elect to the Medical Staff thirty (30) days prior to the annual meeting. The positions of Secretary and Treasurer shall be selected by the President of the Medical Staff and President-Elect from those Members-at-Large representing the clinical Medical Staff Departments.
- (2) Nominations may also be made:
 - a. From the floor at the time of the annual meeting; or
 - b. By petition filed prior to the annual meeting signed by at least ten percent (10%) of the Active Staff, with a signed statement of willingness to serve by the nominee.

11.1(d) Election

Officers shall be elected at the annual meeting of the Staff and when otherwise necessary to fill vacancies.

By a date no later than two weeks prior to the December Quarterly Staff meeting, the Medical Staff Office will mail a ballot to all Members of the Active Medical Staff. The ballot, when properly marked and sealed may be returned to the Medical Staff Office and deposited in a sealed ballot box. The same ballot box will be present at the December Quarterly Staff meeting room thirty (30) minutes prior to the meeting start time. Ballots may be deposited in the ballot box until the meeting is called to order at which time balloting by pre-printed ballot ceases.

The President of the Medical Staff, or their designee, will tabulate the ballots prior to the close of the meeting and announce the elected Officers. A majority of votes shall constitute election to the office, subject to approval by the Governing Body, which approval may be withheld only for good cause. In the event that an equal number of votes are received by two or more nominees for the same office or position, a vote by secret ballot will be conducted of the Active Staff members present at the December meeting until one nominee secures a majority of votes.

11.1(e) Removal

Whenever the activities, professional conduct or leadership abilities of a Medical Staff officer are believed to be below the standards established by the Medical Staff or to be disruptive to the operations of the Hospital, the Governing Body or the Medical Executive Committee may initiate an action to remove an Officer by a two-thirds (2/3) majority vote of the Active Medical Staff. Reasons for removal may include, but shall not be limited to violation of these Bylaws, breaches of confidentiality or unethical behavior. Such removal shall not affect the officer's Medical Staff Membership or clinical privileges and shall not be considered an adverse action.

11.1(f) Term of Elected Officers

Each officer shall serve a two (2) year term, commencing on the first day of the Medical Staff year following his/her election. Each officer shall serve until the end of his/her term and until a successor is elected, unless he/she shall sooner resign or be removed from the office.

11.1(g) Vacancies in Elected Offices

Vacancies in office, other than President of the Medical Staff, shall be filled by the MEC until such time as an election can be held. If there is a vacancy in the office of President of the Medical Staff, the President-Elect shall serve out the remaining term.

11.1(h) Duties of Elected Officers

- (1) President of the Medical Staff: The President of the Medical Staff shall serve as the principal officer of the Staff. As such he/she shall:
 - (i) appoint multi-disciplinary Medical Staff Committees;
 - (ii) be responsible to the Governing Body, in conjunction with the MEC, for the quality and efficiency of clinical services and

professional performance within the Hospital and for the effectiveness of patient care evaluations and maintenance functions delegated to the Staff; work with the Governing Body in implementation of the Governing Body's quality, performance, efficiency and other standards;

- (iii) in concert with the MEC and clinical Departments, develop and implement methods for credentials review and for delineation of privileges; along with the continuing medical education programs, utilization review, monitoring functions and patient care evaluation studies;
- (iv) participate in the selection (or appointment) of Medical Staff representatives to Medical Staff and Hospital management Committees;
- (v) report to the Governing Body and the President of the Hospital concerning the opinions, policies, needs and grievances of the Medical Staff;
- (vi) be responsible for enforcement and clarification of Medical Staff Bylaws and Rules and Regulations, for the implementation of sanctions where indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner;
- (vii) call, preside and be responsible for the agenda of all general meetings of the Medical Staff;
- (viii) serve as the chair of the MEC and an ex-officio Member of all other Staff Committees or functions;
- (ix) assist in coordinating the educational activities of the Medical Staff;
- (x) confer with the President of the Hospital on at least a quarterly basis as to whether there exists sufficient space, equipment, Staffing, and financial resources or that the same shall be available within a reasonable time to support each privilege requested by applicants to the Medical Staff; and report on the same to the MEC and to the Governing Body; and
- (xi) assist the Department Directors as to the types and amounts of data to be collected and compared in determining and informing the Medical Staff of the professional practice of its Members.

- (2) President-Elect of Staff: The President-Elect of Staff shall be a Member of the MEC and shall be the Chair of the Credentialing Committee. In the absence of the President of the Medical Staff, he/she shall assume all the duties and have the authority of the President of the Medical Staff.

He/She shall perform such additional duties as may be assigned to him/her by the President of the Medical Staff, the MEC or the Governing Body.

(3) Secretary: The duties of the Secretary shall be to:

- (i) Give proper notice of all Staff meetings on order of the appropriate authority;
- (ii) Prepare accurate and complete minutes for MEC and Medical Staff meetings;
- (iii) Assure that an answer is rendered to all official Medical Staff correspondence;
- (iv) Perform such other duties as ordinarily pertain to the office of the Secretary.

(4) Treasurer: The duties of the Treasurer shall be to:

- (i) Supervise the collection and accounting for any funds that may be collected in the form of Medical Staff dues and assessments;
- (ii) Authorize the disbursement of funds from the Doctor's Fund;
- (iii) Perform such other duties as ordinarily pertain to office of the Treasurer.

11.1(i) Conflict of Interest of Medical Staff Leaders

The best interest of the community, Medical Staff and the Hospital are served by the Medical Staff leaders (as defined as any Member of the Medical Executive Committee, Officers of the Medical Staff, Department Directors, and/or Members of the Medical Staff who are also Members of the Hospital's Governing Body) who are objective in the pursuit of their duties, and who exhibit that objectivity at all times. The decision making process of the Medical Staff may be altered by interests or relationships which might in any instance, either intentionally or coincidentally, bear on that Member's opinions or decision. Therefore, it is considered to be in the best interest of the Hospital and the Medical Staff for relationship of any Medical Staff leader which may influence the decisions related to the Hospital to be disclosed on a regular and contemporaneous basis.

No Medical Staff leader shall use his/her position to obtain or accrue any benefit. All Medical Staff leaders shall at all times avoid even the appearance of influencing the actions of any other Staff Member or employee of the Hospital, except through his/her vote, and the acknowledgment of that vote, for or against opinions or actions to be stated or taken by or for the Medical Staff as a whole or as a Member of any Committee of the Medical Staff.

Annually, each Medical Staff leader shall file with the MEC a written statement describing each actual or proposed relationship of that Member, whether

economic or otherwise, other than the Member's status as a Medical Staff leader, and/or a Member of the community, which in any way and to any degree may impact on the finances or operations of the Hospital or its Staff, or the Hospital's relationship to the community, including but not limited to each of the following:

- (1) Any leadership position on another Medical Staff or educational institution that creates a fiduciary obligation on behalf of the practitioner, including, but not limited to Member of the Governing Body, executive Committee, or Department chairmanship with an entity or facility that competes directly or indirectly with the Hospital;
- (2) Direct or indirect financial interest, actual or proposed, in an entity or facility that competes directly or indirectly with the Hospital;
- (3) Business practices that may adversely affect the Hospital or community.

A new Medical Staff leader shall file the written statement immediately upon being elected or appointed to his/her leadership position. This disclosure requirement is to be construed broadly, an a Medical Staff leader should finally determine the need for all possible disclosures of which he/she is uncertain on the side of disclosures, including ownership and control of any health care delivery organization that is related to or competes with the Hospital. This disclosure procedure shall not require any action which would be deemed a breach of any state or federal confidentiality law, but in such circumstances minimum allowable disclosures should be made.

Medical Staff leaders with a direct or indirect financial interest, actual or proposed, in an entity or facility that competes directly with the Hospital shall not be eligible for service on the Medical Executive Committee, Credentialing Committee, Bylaws Committee, Quality Council or the Governing Body, unless both the MEC and the Governing Body review and approve the appointment.

Medical Staff leaders shall abstain from voting on any issue in which the Medical Staff leader has an interest other than as a fiduciary of the Medical Staff. A breach of these provisions is deemed sufficient grounds for removal of a breaching Member by the remaining Members of the MEC or the Governing Body on majority vote.

ARTICLE XII: CLINICAL DEPARTMENTS AND DIVISIONS

12.1 ORGANIZATION OF CLINICAL DEPARTMENTS AND DIVISIONS

The Medical Staff shall divide itself into clinical Departments. Each Department shall be organized as a separate component of the Medical Staff and shall have a Director selected and entrusted with the authority, duties and responsibilities specified herein. A Department may be further divided, as appropriate, into Divisions which shall be directly

responsible to the Department within which they function, and each of which shall have a Division Head selected and entrusted with the authority, duties and responsibilities herein. The Medical Executive Committee is responsible for recommending to the Medical Staff the creation, elimination, modification, or combination of Departments or Divisions with approval by the Governing Body.

12.2 DEPARTMENTS AND DIVISIONS

12.2(a) Department of Medicine

The Department of Medicine shall include the Divisions of:

- (i) Cardiology;
- (ii) Gastroenterology;
- (iii) Internal Medicine;
- (iv) Infectious Disease;
- (v) Hematology / Oncology;
- (vi) Endocrinology;
- (vii) Nephrology;
- (viii) Neurology;
- (ix) Occupational Health;
- (x) Pulmonary Disease;
- (xi) Rheumatology;
- (xii) All other medical subspecialties not specifically noted in these Bylaws.

12.2(b) Department of Surgery

The Department of Surgery shall include the Divisions of:

- (i) General Surgery;
- (ii) Neurosurgery;
- (iii) Ophthalmology;
- (iv) Oral Surgery;
- (v) Otolaryngology;
- (vi) Orthopedic Surgery;
- (vii) Plastic Surgery;
- (viii) Podiatry;

- (ix) Thoracic Surgery;
- (x) Urology;
- (xi) Vascular Surgery; and
- (xii) All other surgical subspecialties not specifically noted in these Bylaws.

12.2(c) Other Clinical Departments

- (i) Department of Anesthesiology
- (ii) Department of Emergency Medicine
- (iii) Department of Family Practice
- (iv) Department of Laboratory
- (v) Department of OBGYN
- (vi) Department of Psychiatry
- (vii) Department of Radiology

12.3 ASSIGNMENT TO DEPARTMENTS AND DIVISIONS

Each Member of the Medical Staff shall be assigned Membership in one Department, and to a Division, if any, within such Department, but may also be granted privileges in other Departments or Divisions consistent with clinical privileges granted.

12.4 DEPARTMENT FUNCTIONS

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

- 12.4(a) Require that patient care evaluations be performed and that appointees exercising privileges within the Department be reviewed on an ongoing basis and upon application for reappointment;
- 12.4(b) Establish guidelines for the granting of clinical privileges within the Department and submit the recommendations as required under these Bylaws regarding the specific clinical privileges for applicants and reapplicants for clinical privileges;
- 12.4(c) Conduct, participate in, and make recommendations regarding the need for continuing education programs pertinent to changes in current professional practices and standards;
- 12.4(d) Monitor on an ongoing basis the compliance of its Department Members with these Bylaws, and the Rules and Regulations, policies, procedures and other standards of the Hospital;

- 12.4(e) Monitor on an ongoing basis the compliance of its Department Members with applicable professional standards;
- 12.4(f) Coordinate the patient care provided by the Department's Members with Nursing, Administration, and other non-Medical services;
- 12.4(g) Foster an atmosphere of professional decorum within the Department;
- 12.4(h) Submit written reports or minutes of Department meetings to the MEC on a regular basis concerning:
- (1) Findings of the Department's review and evaluation activities, actions taken thereon, and the results thereof;
 - (2) Recommendations for maintaining and improving the quality of care provided in the Department and in the Hospital; and
 - (3) Such other matters as may be requested from time to time by the MEC.
- 12.4(i) Make recommendations to the MEC subject to the Governing Body approval of the kinds, types, and amounts of data to be collected and evaluated to allow the Medical Staff to conduct an evidence-based analysis of the quality of professional practice of its Members; and receive regular reports from Department subcommittees regarding all pertinent recommendations and actions by the subcommittees.

12.5 ORGANIZATION OF DEPARTMENT

- 12.5(a) All organized Departments shall have written rules and regulations, and/or policies, which govern the activity of the Department. These Department rules and regulations shall be approved by the Governing Body. Policies may require Governing Body approval based on certain criteria. The exercise of clinical privileges within any Department is subject to the Department Rules and Regulations and to the authority of the Department Director.
- 12.5(b) Each Department shall meet at least quarterly to present educational programs and conduct clinical review of practice within their Department. Written minutes must be maintained and furnished to the MEC.

12.6 DEPARTMENT DIRECTOR

12.6(a) Qualifications

Each Department Director shall be a Member of the Active or Affiliate Medical Staff and of the Department which he/she is to direct shall:

- (1) Be qualified by professional experience and demonstrated administrative ability for the position;
- (2) Be Board Certified, or have been deemed by the MEC and the Governing Body to possess the necessary quality, education and training required for their specialty;

- (3) Have been appointed in good standing to the Medical Staff for at least two (2) years;
- (4) Not presently be serving as a Medical Staff or Corporate Officer, Department Director or Credential Committee Chair at another hospital, and shall not so serve during the term of office;
- (5) Maintain an active clinical practice;
- (6) Be willing to discharge faithfully the duties and responsibilities of the position to which the individual is elected; and
- (7) Be knowledgeable concerning the duties of the office.

12.6(b)Appointment

Department Director shall be recommended for appointment by the Nominating Committee and appointed by the Medical Executive Committee at the beginning of each Medical Staff year, subject to the approval of the Governing Body, which approval may be withheld only for good cause.

12.6(c)Term of Office

Each Department Director shall serve a one (1) year term. Department Directors are eligible to succeed themselves if reappointed. If a Director resigns, is removed from office, or he/she loses Medical Staff Membership or clinical privileges in that Department, an interim Director shall be appointed by the President of the Medical Staff in consultation with the Medical Executive Committee subject to the approval of the Governing Body, which approval may be withheld only for good cause.

12.6(d)Removal of Director

After appointment to the Director position, the Governing Body or the MEC may initiate an action to remove a Department Director from office. Removal may occur for cause by a majority vote of the Members of the Medical Executive Committee or a majority vote of the Members of that specific Department who are eligible to vote on Departmental matters with a majority vote approval by the Medical Executive Committee. Such removal is subject to approval by the Governing Body, which approval may be withheld only for good cause.

12.6(e)Grounds for Removal

Permissible grounds for removal include, but shall not be limited to:

- (1) Failure to perform the duties of the position held in a timely and appropriate manner;
- (2) Failure to satisfy continuously the qualifications for the position;
- (3) Violations of these Bylaws;

- (4) Breaches of confidentiality; and / or
- (5) Unethical behavior.

12.6(f) Responsibilities

The responsibilities of the Department Director include:

- (1) Accountability to the MEC for all professional and Medical Staff administrative and clinical activities within the Department;
- (2) Continuing review of the professional performance qualifications and competence of the Medical Staff Members and AHP's who exercise privileges in the Department;
- (3) Assuring that a formal process for monitoring and evaluating the quality and appropriateness of the care and treatment of patients served by the Departments is carried out;
- (4) Assuring the participation of Department Members in Department orientation, continuing education programs and required meetings;
- (5) Assuring participation in risk management activities related to the clinical aspects of patient care and safety;
- (6) Assuring that required QAPI and quality control functions that may include surgical case review, blood usage review, drug usage evaluation, medical record review, pharmacy and therapeutics, risk management, safety, infection prevention and utilization review, are performed within the Department, and that findings from such activities are properly integrated with the primary functions of the Department level;
- (7) Recommending criteria for clinical privileges and specific clinical privileges for each Member;
- (8) Implementing within the Department any actions or programs designated by the MEC;
- (9) Assisting in the preparation of reports as may be required by the MEC, the President of the Hospital or the Governing Body;
- (10) Developing, implementing and enforcing the Medical Staff Bylaws, Rules and Regulations, and policies and procedures that guide and support the provision of services;
- (11) Participating in every phase of administration with other Departments, in cooperation with Nursing, Hospital Administration and the Governing Body;
- (12) Assessing and recommending to the President of the Hospital any off-site

sources for needed patient care services not provided by the Department or organization;

- (13) Making recommendations for a sufficient number of qualified and competent persons to provide care or service within the Department;
- (14) Integration of the Department into the primary functions of the organization and coordination and integration of inter-and intradepartmental services;
- (15) Determination of the qualifications and competence of Department personnel who are not LIP's and who provide patient care, treatment and services;
- (16) Recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the Department; and
- (17) Recommending space and other resources needed by the Department.

12.7 DIVISION HEAD

12.7(a) Qualifications

Each Division shall have a Head who shall be a Member of the Active, Associate or Affiliate Staff, unless such Division does not have any Active, Associate or Affiliate Medical Staff Members, and a Member of the Division which he/she is to head, and shall be qualified by training, experience, and demonstrate current ability in the clinical area covered by the Division.

12.7(b) Appointment

Each Division Head shall be nominated for appointment by the Department Director subject to approval by the MEC and the Governing Body. Vacancies due to any reason shall be filled for the unexpired term by the Department Director.

12.7(c) Term of Office

Each Division Head shall serve a one (1) year term. Division Heads are eligible to succeed themselves if reappointed.

12.7(d) Removal from Office

After appointment to the Division Head position, the Governing Body or the MEC may initiate an action to remove a Division Head from office. Removal may occur for cause by a majority vote of the Members of the Medical Executive Committee or a majority vote of the Members of that specific Department who are eligible to vote on Departmental matters with a majority vote approval by the Medical Executive Committee. Such removal is subject to approval by the Governing Body, which approval may be withheld only for good cause.

12.7(e)Duties

The Division Head shall have the following duties with respect to his/her Division:

- (1) Account to the appropriate Department Director and to the MEC for all professional activities within the Division;
- (2) Develop and implement Division programs in cooperation with the Department Director;
- (3) Maintain continuing review of the professional performance of all Medical Staff and AHP Staff appointments having clinical privileges in the Division and report regularly thereon to the Department Director;
- (4) Implement within his/her Division any actions or programs designated by the MEC;
- (5) Participate in every phase of administration of his/her Division in cooperation with the Department Director, Nursing, other departments, Administration and the Governing Body;
- (6) Assist in the preparation of such annual reports regarding the Division as may be required by the MEC, the President of the Hospital or the Governing Body;
- (7) As applicable, establish a system for adequate professional coverage within the Division, including an on-call system, which systems shall be fair and non-discriminatory; and
- (8) Perform such other duties as may reasonably be requested by the President of the Medical Staff, the MEC, the Department Director or the Governing Body.

12.8 MEDICAL EXECUTIVE COMMITTEE MEMBERS-AT-LARGE

12.8(a)Qualifications

The Departments of Medicine and Surgery will be represented by at least one (1) Member-At-Large. The Member-At-Large shall be a Member of the Active or Affiliate Medical Staff and a Member of the Department to which they will represent.

12.8(b)Appointment

Each Member-At-Large shall be nominated for appointment by the Department Director subject to approval by the MEC and the Governing Body. Vacancies due to any reason shall be filled by appointment of the Medical Executive Committee, subject to the approval of the Governing Body, which approval may be withheld only for good cause.

12.8(c)Term of Office

Each Division Head shall serve a one (1) year term. Members-At-Large are eligible to succeed themselves if reappointed.

12.8(d)Removal from Office

After appointment to the Division Head position, the Governing Body or the MEC may initiate an action to remove a Division Head from office. Removal may occur for cause by a majority vote of the Members of the Medical Executive Committee or a majority vote of the Members of that specific Department who are eligible to vote on Departmental matters with a majority vote approval by the Medical Executive Committee. Such removal is subject to approval by the Governing Body, which approval may be withheld only for good cause.

ARTICLE XIII: FUNCTIONS AND COMMITTEES

13.1 GENERAL PROVISIONS

- 13.1(a) The Standing Committees and the functions of the Medical Staff are set forth below and in the Rules and Regulations. The MEC shall appoint Special or Ad Hoc Committees to perform functions that are not within the stated functions of one (1) of the Standing Committees.
- 13.1(b) Each Committee shall keep a permanent record of its proceedings and actions. All Committee actions shall be reported to the MEC.
- 13.1(c) All information pertaining to activities performed by the Medical Staff and its Committees and Departments shall be privileged and confidential to the full extent provided by law.
- 13.1(d) The President of the Hospital or his/her designee and the President of the Medical Staff shall serve as an ex-officio Member, without vote, of each Standing and Special Medical Staff Committee, unless designated a Member of the Committee.
- 13.1(e) Standing Committees shall meet as scheduled by the Chair of each Committee. Ad Hoc Committees shall meet as needed, to meet Medical Staff interests not addressed by Standing Committees, or for other special and justified causes.
- 13.1(f) The purpose for the appointment of each Ad Hoc Committee shall be stated by the Medical Executive Committee and addressed by the Committee; the Committee shall disband when its charge is accomplished.
- 13.1(g) All Medical Staff Committees may meet in Executive Session. In those sessions, all Members of the Committee who are not Members of the Medical Staff shall be excused as determined by the Chairperson. The Executive Session of the Committee may thereupon receive reports and information and otherwise

conduct business. The Committee may not take any final action on any matter before it while in Executive Session.

13.2 MEDICAL EXECUTIVE COMMITTEE

13.2(a) Composition

Members of the Committee shall include the following:

- (1) President of the Medical Staff, who shall act as the Chairperson;
- (2) President-Elect of the Medical Staff;
- (3) Vice President of Medical Operations;
- (4) The Directors of Departments;
- (5) Secretary and Treasurer of the Medical Staff;
- (6) The Members At Large of the Departments of Medicine and Surgery;
- (7) The President of the Hospital, ex-officio, or his/her designee; and
- (8) Other individuals as invited or required by the Medical Executive Committee, without vote.

13.2(b) Functions

The Committee shall be responsible for governance of the Medical Staff, shall serve as a liaison mechanism between the Medical Staff, Hospital Administration and the Governing Body and shall be empowered to act for the Medical Staff in the intervals between Medical Staff meetings, within the scope of its responsibilities as defined below. When approval of procedural details related to credentialing, corrective action, or selection and duties of Department leadership are delegated to the MEC, it shall represent to the Governing Body the organized Medical Staff's views on issues of patient safety and quality of care. All Active or Affiliate Medical Staff Members shall be eligible to serve on the MEC. The authority of the MEC is outlined in this Section and additional functions may be delegated or removed through amendment of this Section. The functions and responsibilities of the MEC shall include, at least the following:

- (1) Receiving and acting upon Department and Committee reports;
- (2) Implementing the approved policies of the Medical Staff;
- (3) Recommending to the Governing Body all matters relating to appointments and reappointments, the delineation of clinical privileges, Staff category and corrective action;
- (4) Fulfilling the Medical Staff's accountability to the Governing Body for the quality of the overall medical care rendered to the patients in the Hospital;

- (5) Initiating and pursuing corrective action when warranted, in accordance with the Medical Staff Bylaws provisions;
- (6) Assuring regular reporting of Quality and other Staff issues to the MEC and to the Governing Body and communicating findings, conclusions, recommendations and actions to improve performance to the Governing Body and appropriate Staff Members;
- (7) Assuring an annual evaluation of the effectiveness of the Hospital's Quality program is conducted;
- (8) Developing and monitoring compliance with these Bylaws, the Rules and Regulations, policies and other Hospital standards;
- (9) Recommending action to the President of the Hospital on matters of medico-administrative nature;
- (10) Taking reasonable steps to develop continuing medical education activities and program for the Medical Staff;
- (11) Developing and maintain methods for the protection and care of patients and others in the event of an internal or external disaster;
- (12) Reviewing the quality and appropriateness of services provided by contracted services;
- (13) Informing the Medical Staff of the Accreditation Program and the Accreditation Status of the Hospital;
- (14) Participating in identifying community health needs, in setting Hospital goals and in implementing programs to meet these needs and goals;
- (15) Recommending Rules and Regulations to the Governing Body for approval after communication with the Organized Medical Staff. If the Organized Medical Staff approved of the proposed rule or regulations, the MEC shall advise the Governing Body of approval. If the Organized Medical Staff objects to the proposed rule or regulation, the MEC shall forward the proposed rule or regulation, noting the disapproval of the Organized Medical Staff and the results of the Conflict Resolution process outlined in these Bylaws;
- (16) Developing and implementing programs to inform the Staff about physician health and recognition of illness and impairment in physicians, and addressing prevention of physical, emotional and psychological illness.
- (17) Requesting evaluation of practitioners in instances where there is doubt about an applicant's ability to perform the privileges requested. Initiating an investigation of any incident, course of conduct, or allegation indicating that a practitioner to the Medical Staff may not be complying with the Bylaws, may be rendering care below the standards established for

practitioner to the Medical Staff, or may otherwise not be qualified for continued enjoyment of Medical Staff appointment or clinical privileges without limitation, further training, or other safeguards;

- (18) Making recommendations to the Governing Body regarding the Medical Staff structure and the mechanisms for review of credentials and delineation of privileges, fair hearing procedures and the mechanisms by which Medical Staff Membership may be terminated; and
- (19) Designating appropriate Medical Staff Committees to perform the functions of the Medical Staff.

13.2(c) Meetings

The MEC shall meet as needed, but at least ten times annually and maintain a permanent record of its proceedings and actions.

13.2(d) Special Meeting of the Medical Executive Committee

A special meeting of the MEC may be called by the President of the Medical Staff, when a majority of the MEC can be convened.

13.2(e) Removal of MEC Members

All Members of the MEC shall be removed in accordance with the provisions governing removal from their respective Medical Staff leadership provisions.

13.3 JOINT CONFERENCE COMMITTEE

13.3(a) Composition

The Joint Conference Committee shall be composed of an equal number of Members of the Governing Body and of the Medical Executive Committee, and the MEC Members shall at least include the President of the Medical Staff and the President-Elect. The President of the Hospital and the Vice President of Medical Operations shall be non-voting ex-officio Members. The Chairperson of the Committee shall alternate yearly between the Governing Body (even years) and the Medical Staff (odd years).

13.3(b) Duties

The Joint Conference Committee shall constitute a forum for the discussion of matters of Hospital and Medical Staff policy, practice and planning, including discussions and, if necessary, informal dispute resolution, relating to disputes between the Hospital and the Medical Staff relative to Medical Staff self-governance. The Joint Conference Committee shall also serve as a forum of interaction between the Governing Body and the Medical Staff on such other matters as may be referred by the MEC or the Governing Body. The Joint Conference Committee shall exercise other responsibility set forth in these Bylaws.

13.3(c) Meetings

The Joint Conference Committee shall meet as needed and shall transmit written reports of its activities to the Medical Executive Committee, for information, and to the Governing Body for final action.

13.4 CREDENTIALING COMMITTEE

13.4(a) Composition

The Credentialing Committee shall consist of no less than four (4) Members of the Medical Staff selected on a basis that shall ensure, insofar as feasible representation of major clinical specialties and each of the Medical Staff Departments, and the President of the Medical Staff, the Vice President of Medical Operations, the President-Elect. The President of the Hospital, Legal Counsel and a Member of the Governing Body shall be ex-officio Members. This Committee shall be chaired by the President-Elect.

13.4(b) Duties

The Credentialing Committee shall:

- (1) Review and evaluate the qualifications of each practitioner applying for initial appointment, reappointment, modification of clinical privileges or Staff category, and, in connection therewith, obtain and consider the recommendation of the appropriate Departments;
- (2) Submit required reports and information on the qualifications of each practitioner applying for Membership and/or clinical privileges, and include recommendations with respect to appointment, category, Department affiliation, clinical privileges and special conditions;
- (3) Investigate, review and report on matters referred by the President of the Medical Staff, the Medical Executive Committee, President of the Hospital and/or the Vice President of Medical Operations regarding qualifications, conduct, professional character or competence of any applicant or Medical Staff Member; and
- (4) Submit reports to the Medical Executive Committee on its activities and the status of pending applications.

13.4(c) Meetings

The Credentialing Committee shall meet monthly or as often as necessary at the call of its Chairperson.

13.5 PEER REVIEW COMMITTEE

13.5(a) Composition

The Peer Review Committee shall consist of the Department Directors of Medicine, Surgery, OBGYN and Anesthesia, the President of the Medical Staff,

the President-Elect, the Vice President of Medical Operations, and ad hoc Members as appointed. The President of the Hospital, Legal Counsel and Quality shall be ex-officio Members. This Committee shall be chaired by the Vice President of Medical Operations.

In the event that a Member of the Peer Review Committee is the subject of the Committee's review, said individual shall not be allowed to participate in the relevant meetings of the Committee.

13.5(b)Duties

- (1) Review cases referred by the Medical Executive Committee and/or Quality Management concerning the utilization of Hospital services by Members of the Medical Staff. When considering cases, the Committee shall rely on information found in the medical record, documentation from review by the Medical Executive Committee and/or the Quality Management Department, and verbal / written information provided by the physician being reviewed. The Committee also retains the right to interview any additional witnesses or gather any additional information it deems necessary to complete its investigation;
- (2) Review cases concerning the level of quality of care or professional conduct on a case-by-case basis as referred by the Medical Executive Committee, another physician, a Hospital employee, the Quality Management Department and/or other Committees of the Medical Staff;
- (3) Serve as the appellate body for the attending physician concerning appropriateness of admission and/or continued patient stay as identified in the Utilization Review Plan;
- (4) Supervise the administration and quality of care of patients in all professional services of the Hospital and professional conduct;
- (5) Suggest continuing education programs for the Medical Staff regarding delivery of quality medical care professional conduct and appropriate utilization of Hospital services;
- (6) Provide the Medical Executive Committee with findings and recommendations upon request or if the Peer Review Committee seeks to assert formal corrective action, as defined in these Bylaws, against the practitioner;
- (7) Communicate to the appropriate Medical Staff Members and to the appropriate Department Director, the findings of each Committee review concerning specific practice patterns;
- (8) Receive reports related to the health, well-being, behavior or impairment of Medical Staff Members and, as it deems appropriate, may investigate such reports. With respect to matters involving individual Medical Staff Members, the Committee may, on a voluntary basis, provide such advice,

counseling, referral to an approved treatment provider, or other referrals as may seem appropriate. Such activities shall be confidential; however, in the event information received by the Committee clearly demonstrates that the health or known impairment of a Medical Staff Member poses an unreasonable risk of harm to patients, Hospital employees or other Medical Staff Members, that Member should be referred for corrective action or to an approved treatment provider (Reference ORC 4731.22(B)). The Committee shall also consider general matters related to the health, behavior and well-being of the Medical Staff. In conjunction with the Medical Executive Committee, educational programs or related activities shall be provided to the organizational leadership and Medical Staff with regard to illness and recognition of impairment.

13.5(c) Meetings

The Peer Review Committee shall meet monthly or as often as necessary at the call of its Chairperson. It shall maintain only such record of its proceedings as it deems advisable, but shall report on its activities to the Medical Executive Committee.

13.6 MEDICAL STAFF CONFERENCE COMMITTEE

13.6(a) Purpose

In the event of conflict between the Medical Executive Committee and the Medical Staff (as represented by written petition signed by at least 10% of the Active Staff) regarding a proposed or adopted Rule or policy, or other issue of significance to the Medical Staff, the President of the Medical Staff shall convene a meeting with the petitioners' representative(s).

13.6(b) Composition

The foregoing petition shall include a designation of up to three (3) members of the voting Medical Staff who shall serve as the petitioners' representative(s). The Medical Executive Committee shall be represented by an equal number of Medical Executive Committee members. The President of the Hospital and/or his/her designee shall be an ex-officio member, without a vote.

13.6(c) Duties

The Committee shall serve as a part of the conflict resolution process between the Medical Executive Committee and the Organized Medical Staff on matters referred to the Committee by the Medical Executive Committee or the Governing Body relating to the adoption, amendment or repeal of Medical Staff Rules and Regulations or policies. The Medical Executive Committee and the petitioner's representative(s) shall exchange information relevant to the conflict and shall work in good faith to resolve differences in a manner that respects the positions of the Medical Staff, the leadership responsibilities of the Medical Executive Committee, and the safety and quality of patient care at the Hospital. Resolution at this level requires a majority vote of the Medical Executive Committee's

representatives at the meeting and a majority vote of the petitioners' representatives. Unresolved differences shall be submitted to the Governing Body for its consideration in making its final decision with respect to the proposed Rule, or policy.

13.6(d)Meetings

The Medical Staff Conference Committee shall meet as directed by the Medical Executive Committee of the Governing Body.

13.7 OTHER STANDING and AD HOC COMMITTEES

All other Ad Hoc and Standing Committees of the Medical Staff shall be created by the Medical Executive Committee.

ARTICLE XIV: MEETINGS

14.1 ANNUAL STAFF MEETINGS

14.1(a)Meeting Time

The Medical Staff shall hold an annual meeting, at a date, time and place determined by the President of the Medical Staff.

14.1(b)Order of Business and Agenda

The order of business at an annual meeting shall be determined by the President of the Medical Staff. The agenda shall include:

- (1) Reading and accepting the minutes of the last regular and of all special meetings held since the last regular meeting;
- (2) Administrative reports from the President of the Hospital or his/her designee, the President of the Medical Staff and appropriate Department Chairperson(s);
- (3) The election of officers and other officials of the Medical Staff when required by these Bylaws;
- (4) Recommendations for maintenance and improvement of patient care; and
- (5) Other old or new business.

14.2 REGULAR STAFF MEETINGS

14.2(a)Meeting Frequency and Time

The Medical Staff shall meet at least twice a year at a time and place designated by the President of the Medical Staff.

14.2(b) Order of Business and Agenda

The order of business at a regular meeting shall be determined by the President of the Medical Staff.

14.2(c) Special Meetings

Special meetings of the Medical Staff or any Committee may be called at any time by the President of the Medical Staff, President of the Hospital or the Committee Chairperson and shall be held at the time and place designated in the meeting notice.

14.3 NOTICE OF MEETINGS

Notice of meetings shall be provided by the Medical Staff Office in a reasonable time frame prior to the meeting date. However, notice for special meetings will be provided as soon as practicable.

14.4 QUORUM

14.4(a) General Medical Staff

The voting Members of the Medical Staff who are present at any Staff meeting shall constitute a quorum for the transaction of all business at the meeting.

14.4(b) Committee Meetings

The Members of the a Committee who are present, but not less than two (2) Members, shall constitute a quorum at any meeting of such Committee; except that the MEC shall require fifty (50%) percent of Members to constitute a quorum.

14.5 MINUTES

Minutes of all meetings shall include a record of attendance and the vote taken on each matter. Copies of such minutes shall be signed by the presiding officer, approved by the attendees and forwarded to the MEC. A permanent file of the minutes of each meeting shall be maintained.

14.6 ATTENDANCE

14.6(a) Regular Attendance

Regular attendance of the Medical Staff is expected at all Medical Staff, Department meetings, and / or Committee meetings.

14.7 MAJORITY VOTE

Except as otherwise specified, actions are by majority vote of Medical Staff Members eligible to vote either: (1) present at the meeting, or (2) without a meeting by electronic or telephonic vote or by written ballot.

ARTICLE XV: GENERAL PROVISIONS

15.1 PROFESSIONAL LIABILITY INSURANCE

Each practitioner or Allied Health Professional granted clinical privileges in the Hospital shall maintain in force professional liability insurance in an amount not less than the current minimum state statutory requirement for such insurance or any future revisions thereto, or, should the state have no minimum statutory requirement, in an amount not less than \$1,000,000.00 per occurrence and \$3,000,000.00 in the aggregate. Such insurance shall be with a carrier reasonably acceptable to the Hospital, and shall be on an occurrence basis or, if on a claims made basis, the practitioner shall agree to obtain tail coverage covering his/her practice at the Hospital. Each practitioner shall also inform the MEC and President of the Hospital of the details of such coverage annually. He/she shall also be responsible for advising the MEC and the President of the Hospital of any change in such professional liability coverage.

15.2 MEDICAL STAFF DUES

Medical Staff dues shall be assessed annually in the amount established by the Medical Executive Committee. Members granted clinical privileges after October 1st of each year shall not be assessed annual dues.

Assessments shall be mailed to specified Members only. The Medical Executive Committee may waive, extend payment of, or refund annual dues for just cause. Payment to the Medical Staff Doctors Fund shall be made, in full, no later than April 1 of the specified year. On April 1, physicians shall receive a special notice indicating that, if Medical Staff dues are not paid within thirty (30) days, non-compliance shall be considered a voluntary resignation from the Medical Staff.

15.3 GRADUATE MEDICAL EDUCATION

From time to time, at Marymount's sole prerogative, the Hospital may choose to assist Medical Students, Residents and Fellows to gain Clinical Experience in conjunction with Members of the Medical Staff. The supervision of these individuals resides with the Medical Staff Department in which the individual is participating and is the responsibility of the Licensed Independent Practitioner who has appropriate clinical privileges. The process to credential these practitioners is outlined in the Medical Staff Policy Manual.

15.4 PROFESSIONAL PRACTICE EVALUATION

A review of a Practitioner's performance shall be conducted by the Practitioner's peers in a manner that is consistent with the Cleveland Clinic hospitals' Performance Improvement and Quality Assurance program initiatives and as outlined in the Professional Practice Evaluation Policy and the Quality Monitoring and Review of Allied Health Professionals.

15.5 CONSTRUCTION OF TERMS AND HEADINGS

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

15.6 CONFIDENTIALITY & IMMUNITY STIPULATIONS & RELEASES

15.6(a) Reports to be Confidential

Information with respect to any practitioner, including applicants, Members of the Medical Staff or AHP's, submitted, collected or prepared by an representative of the Hospital including its Governing Body or Medical Staff, for purposes related to the achievement of quality care or ethical professional conduct or practitioner impairment shall, to the fullest extent permitted by the law, be confidential and shall not be disseminated beyond those who need to know nor used in any way except as provided herein. Such confidentiality also shall apply to information of like kind provided by third parties.

15.6(b) Release from Liability

No representative of the Hospital, including its Governing Body, President of the Hospital, Administrative employees, Medical Staff or third party shall be liable to a practitioner for damages or other relief by reason of providing information, including otherwise privileged and confidential information, to a representative of the Hospital including its Governing Body, President of the Hospital or his/her designee, or Medical Staff or to any other health care facility or organization, concerning a practitioner who is or has been an applicant to or Member of the Staff, or who has exercised clinical privileges or provided specific services for the Hospital, provided such disclosure or representation is in good faith and without malice.

15.6(c) Action in Good Faith

The representatives of the Hospital, including its Governing Body, President of the Hospital, Administrative employees and Medical Staff shall not be liable to a practitioner for damages or other relief for any action taken or statement of recommendation made within the scope of such representative's duties, if such representative acts in good faith and without malice after a reasonable effort to ascertain the facts and in a reasonable belief that the action, statement or recommendation is warranted by such facts.

ARTICLE XVI: ADOPTION & AMENDMENT OF MEDICAL STAFF BYLAWS AND RULES AND REGULATIONS

16.1 MEDICAL STAFF AUTHORITY

The Organized Medical Staff shall have the responsibility and authority to formulate,

review, adopt and recommend to the Governing Body, the Medical Staff Bylaws, Rules and Regulations and policies, any and all amendments to the Medical Staff Bylaws, Rules and Regulations and amendments thereto which shall be effective when approved by the Governing Body. Applicants and members of the Medical Staff shall be governed by such Bylaws, Rules and Regulations and policies as are properly initiated and adopted. The President of the Hospital, the Governing Body, the Organized Medical Staff, the Bylaws Committee or the Medical Executive Committee has authority to recommend and initiate amendments to the Medical Staff Bylaws, Rules and Regulations; however neither the Medical Staff nor the Governing Body may unilaterally amend the Bylaws. The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff Bylaws.

16.2 BYLAWS PROCEDURE

- A. When proposed amendments or repeals are made by the President of the Hospital, the Governing Body, Bylaws Committee or the Medical Executive Committee, there will be a communication of the proposed amendment or repeal to the Organized Medical Staff at least ten (10) days before a vote is taken by the Medical Executive Committee.
- B. When the proposed amendment or repeal is proposed by the Organized Medical Staff, there will be communication of the proposed amendment or repeal to the Medical Executive Committee before a vote is taken by the Organized Medical Staff.
- C. Voting by those Medical Staff Members eligible to vote shall take place by ballot that is mailed or emailed out by the Medical Staff Office. Such ballot will contain the exact wording of the proposed change(s) to the Bylaws. The President of the Medical Staff, or their designee, will tabulate properly authenticated and timely received ballots.
- D. Medical Staff Bylaws will be adopted, amended or repealed by the following actions:
 - 1. The affirmative vote of fifty-one percent (51%) of the total of those Medical Staff Members who are eligible to vote provided at least ten (10) day written notice, accompanied by the proposed Bylaws and/or amendments, has been given of the intention to take such action; and
 - 2. The affirmative vote of a majority of the Governing Body.

16.3 RULES AND REGULATIONS PROCEDURE

When proposed amendments to the Rules and Regulations are made by the President of the Hospital, the Governing Body, Bylaws Committee or the Medical Executive Committee, there will be a communication of the proposed amendment to

the Organized Medical Staff at least ten days (10) days before a vote is taken by the Medical Executive Committee.

When the proposed amendment is proposed by 10% of the Organized Medical Staff, there will be communication of the proposed amendment to the Medical Executive Committee. If the Medical Executive Committee does not pass the proposed amendment at its next meeting, it shall notify the Organized Medical Staff. The Medical Executive Committee and the Organized Medical Staff each have the option of invoking or waiving the conflict management provisions of these Bylaws.

- A. If conflict management is not invoked within ten (10) days, it shall be deemed waived. In this circumstance, the Organized Medical Staff's proposed Rules and Regulations shall be submitted for vote, and if approved by the Organized Medical Staff pursuant to this Section the proposed Rules and Regulations shall be forwarded to the Governing Body for action. The Medical Executive Committee may forward comments to the Organized Medical Staff and the Governing Body regarding the reasons it declined to approve the proposed Rules and Regulations.
- B. If conflict management is invoked, the proposed Rules and Regulations shall not be voted upon or forwarded to the Governing Body until the conflict management process has been completed and the results of the conflict management process shall be communicated to the Organized Medical Staff and the Governing Body.
- C. With respect to proposed Rules and Regulations generated by petition of the Organized Medical Staff, approval of the Organized Medical Staff requires the affirmative vote of fifty-one percent (51%) of the total of those Organized Medical Staff members who are eligible to vote, and who are present at the meeting or who have cast his/her vote by absentee ballot, provided at least ten (10) day written notice, accompanied by the proposed Rules and Regulations and/or amendments, has been given of the intention to take such action and the affirmative vote of a majority of the Governing Body.

16.4 DELEGATION OF AUTHORITY

The Organized Medical Staff delegates the responsibility regarding the approval, amendment or repeal of the Medical Staff Rules and Regulations to its elected and appointed Members of the Medical Executive Committee.

16.5 URGENT PROVISIONAL RULES AND REGULATIONS AMENDMENT PROCESS

The Medical Executive Committee and the Governing Body may adopt such provisional amendments to these Rules and Regulations that are, in the Medical Executive Committee's and Governing Body's judgments, necessary for legal or regulatory compliance. After adoption, these provisional amendments to the Rules and Regulations will be communicated to the Organized Medical Staff. If the Organized Medical Staff approves of the provisional

amendment, the amendment will stand. If the Organized Medical Staff does not approve of the provisional amendment, the matter will be referred to the Medical Staff Conference Committee. However, the approved Rules and Regulations shall remain in effect until such time as a superseding Rules and Regulations meeting the requirements of the law or regulation that precipitated the initial urgency has been approved. The Governing Body shall have the final authority on the amendment.

16.6 EFFECT AND OBLIGATION OF MEDICAL STAFF DOCUMENTS

These Bylaws describe the fundamental principles of Medical Staff self-governance and accountability to the Governing Body. Accordingly, the key standards for Medical Staff membership, appointment, reappointment and privileging are set out in these Bylaws. Additional provisions including, but not limited to, detailed procedures for implementing these Medical Staff standards may be set out in the Medical Staff Rules and Regulations, or in the Medical Staff's Policies and Procedures adopted or approved as described below. Applicants and Members of the Medical Staff will be governed by such Rules and Regulations and Policies and Procedures as are properly initiated and adopted.

The Medical Staff Bylaws, Rules and Regulations, Policies and Procedures are compatible with each other and compliant with law and regulations. The Medical Staff complies with and enforces the Medical Staff Bylaws, Rules and Regulations, and Policies and Procedures by taking action or by recommending action to the Governing Body as appropriate and as provide for in these Bylaws. The Governing Body upholds the Medical Staff's Bylaws, Rules and Regulations and Policies and Procedures which it has approved.

16.7 TECHNICAL CORRECTIONS

The Medical Executive Committee has the power to adopt such corrections to the Bylaws and Rules and Regulations as are, in its judgment, technical modifications or clarifications, such as reorganization or renumbering, or corrections necessary to correct punctuation, spelling, or other errors of grammar or expression or inaccurate cross-references. The Medical Executive Committee may delegate this responsibility to the President of the Medical Staff or his/her designee. Substantive amendments are not permitted by this Section. Corrections may be effective by motion and acted upon in the same manner as any other motion before the Medical Executive Committee. After approval, such corrections will be communicated in writing to the Medical Staff and the Governing Body. Such corrections are effective upon approval by the Governing Body; however, they may be rescinded by vote of the Medical Staff or Governing Body within ninety (90) consecutive days after adoption by the Medical Executive Committee.

MEDICAL STAFF BYLAWS
APPROVED & ADOPTED:

MEDICAL STAFF:

By: Thayne Alred, MD
 President of the Medical Staff

08/18/2015
Date

GOVERNING BODY:

By: Dennis Chack
 Chairperson

08/18/2015
Date

MARYMOUNT HOSPITAL:

By: Richard Parker, MD
 President

08/18/2015
Date

APPROVED AS TO FORM:

By: Lisa M. Barrett
 Legal Counsel

08/18/2015
Date