

# Medical Staff Bylaws

SUMMA HEALTH SYSTEM

A Medical Staff Document

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## ARTICLE I

### DEFINITIONS

**ADVANCED PRACTICE PROVIDER or APP:** Those physician assistants, advanced practice registered nurses, and other qualified, eligible healthcare professionals, as reflected in the Advanced Practice Provider Policy, who have applied for and/or been granted Privileges to practice at the Hospital either independently or in collaboration with or under the supervision of a Physician, Dentist, or Podiatrist, as applicable, with Medical Staff appointment and Privileges at the Hospital.

**ADVERSE:** A recommendation or action of the Medical Executive Committee or Board that denies, limits (*i.e.* suspension, restriction, *etc.*), or terminates Medical Staff appointment and/or Privileges on the basis of professional conduct or clinical competence or as otherwise defined in these Medical Staff Bylaws.

**APPOINTEE:** A Practitioner who has been granted appointment to the Medical Staff.

**BOARD or GOVERNING BODY:** The Board of the Hospital. Reference to the Board or Governing Body shall include any Board committee or individual authorized by the Board to act on its behalf in certain matters.

**CLINICAL DEPARTMENT or DEPARTMENT:** The Medical Staff Departments as designated in these Bylaws. The head of each Department shall be designated as the Department Chair.

**CLINICAL PRIVILEGES or PRIVILEGES:** The permission granted by the Board to a Practitioner or APP to provide designated patient care, treatment, and/or services at/for the Hospital within defined limits based upon the Practitioner's or APP's professional license, education, training, experience, competence, ability, character, and judgment.

**DENTIST:** An individual with a D.D.S. or D.M.D. degree who is fully licensed to practice dentistry in the State of Ohio, unless otherwise provided in the Medical Staff Bylaws or Policies, and whose practice is in the area of oral and maxillofacial surgery or the area of general dentistry or a specialty thereof.

**EX OFFICIO:** Appointment to a body by virtue of an office or position held and, unless otherwise expressly provided, without voting rights. Whenever an individual holds a position by virtue of the individual's *Ex Officio* capacity, then the term shall also include that individual's designee unless the context of the term provides otherwise.

**EXECUTIVE SESSION:** Voting members of the Medical Executive Committee and Hospital Legal Counsel.

**FEDERAL HEALTHCARE PROGRAM:** Medicare, Medicaid, TRICARE, or any other federal or state program providing health care benefits that is funded directly or indirectly by the United States government.

**GOOD STANDING:** An Appointee who, at the time the issue is raised, has met the Medical Staff, Department, and Medical Staff committee participation requirements, as applicable, during the previous Medical Staff Year; is not in arrears in dues payments; and has not received a suspension or restriction of his/her appointment and/or Privileges in the previous twelve (12) months; provided, however, that if an Appointee has been automatically suspended in the previous twelve (12) months for failure to comply with the Hospital's/Medical Staff's policies or procedures

regarding timely completion of medical records and has subsequently taken appropriate action, such automatic suspension shall not adversely affect the Appointee's Good Standing status.

**HOSPITAL:** Summa Health System.

**HOSPITAL PRESIDENT:** the President of the Hospital.

**JOINT CONFERENCE COMMITTEE:** An *ad hoc* special-purpose Board committee consisting of an equal number of Board members (selected by the Board) and Medical Staff Appointees (selected by the MEC). Should the Board revise the Hospital's governing documents to provide for a standing Joint Conference Committee then this definition will be deemed likewise automatically amended as well.

**MAIL:** Unless otherwise specified, includes either electronic (e-mail or electronic posting) or regular mail.

**MEDICAL EXECUTIVE COMMITTEE (MEC):** The executive committee of the Medical Staff as defined in these Bylaws.

**MEDICAL STAFF:** Those Medical Staff Appointees with such Prerogatives and responsibilities as set forth in the Medical Staff category to which each has been appointed.

**MEDICAL STAFF BYLAWS or BYLAWS:** The Medical Staff Bylaws, and amendments thereto, that constitute the basic governing document of the Medical Staff.

**MEDICAL STAFF CABINET:** A standing Medical Staff committee composed of the individuals set forth in the Medical Staff Organization Policy.

**MEDICAL STAFF PRESIDENT:** The Practitioner elected by the Medical Staff to be its chief officer. The Medical Staff President shall also be the chair of the Medical Executive Committee.

**MEDICAL STAFF POLICY or POLICIES:** Those additional Medical Staff governing documents, approved by the Medical Executive Committee and the Board, that serve to implement the Medical Staff Bylaws including, but not limited to, the Credentials Policy, Organization Policy, Medical Staff Patient Care Policies, and Advanced Practice Provider Policy.

**ORAL AND MAXILLOFACIAL SURGEON:** A Dentist who engages in that part of dental practice dealing with the diagnosis, surgery, and adjunctive treatment of diseases, injuries, and defects of the oral and maxillofacial regions.

**PATIENT ENCOUNTER:** A professional contact between a Practitioner and a patient whether an admission, consultation, or diagnostic, operative, or invasive procedure at the Hospital.

**PHYSICIAN:** An individual with an M.D. or D.O. degree who is fully licensed to practice medicine in the State of Ohio unless otherwise provided in the Medical Staff Bylaws or Policies.

**PODIATRIST:** An individual with a D.P.M. degree who is fully licensed to practice podiatry in the State of Ohio unless otherwise provided in the Medical Staff Bylaws or Policies.

**PRACTITIONER:** Unless otherwise expressly provided, any Physician, Dentist, Psychologist, or Podiatrist. The term "Practitioner" shall also include Clinical Scientists/Ph.Ds to the extent applicable.

**PREROGATIVE:** A participatory right granted, by virtue of Medical Staff category, to an Appointee that is exercisable subject to the ultimate authority of the Board and to the conditions and limitations imposed in these Bylaws and Medical Staff Policies.

**PROFESSIONAL LIABILITY INSURANCE:** Professional liability insurance coverage of such kind and in such amount acceptable to the Board, as the Board may determine from time to time, by an insurance company licensed in the United States or having coverage by a company who has an underwriting agreement with a licensed U.S. insurance company to assure adequate reserves for payment of claims.

**PSYCHOLOGIST:** An individual with a doctoral degree in psychology, school psychology, or a doctoral degree deemed equivalent by the Ohio State Board of Psychology who is fully licensed to practice psychology in the State of Ohio unless otherwise provided in the Medical Staff Bylaws or Policies.

**SPECIAL NOTICE:** Written notification sent by certified mail, return receipt requested, or by personal delivery service with signed acknowledgement of receipt.

**SYSTEM:** Summa Health.

**TELEMEDICINE:** The use of electronic equipment or other communication technologies to provide or support clinical care at a distance.

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

## ARTICLE II

### PURPOSES AND RESPONSIBILITIES

#### 2.1 PURPOSES

2.1.1 These Medical Staff Bylaws govern the Hospital Medical Staff. The purposes of the Medical Staff organization are:

- (a) To serve as the primary means for accountability to the Board with respect to the quality of patient care, treatment, and/or services provided by Practitioners and APPs at/for the Hospital; for the appropriateness of the clinical performance and professional/ethical conduct of its Practitioners and APPs; and to strive toward the continual improvement of the quality of patient care, treatment, and services delivered in the Hospital consistent with the recognized standards of professional care and resources available locally.
- (b) To be the formal organizational structure through which the benefits of appointment to the Medical Staff may be obtained by individual Practitioners and the obligations of Medical Staff appointment are fulfilled.
- (c) To provide education and to maintain educational standards for Practitioners, APPs, residents, medical students, and other providers leading to continual advancement in professional knowledge and skill in cooperation with affiliated schools of medicine, *etc.*
- (d) To provide an organizational structure that allows ongoing review of patient care practices and accounts for the quality and appropriateness of services rendered by all Practitioners and APPs at/for the Hospital.
- (e) To provide a mechanism to create a uniform standard of quality patient care, treatment, and services.
- (f) To provide the means through which the Medical Staff may participate in the Hospital policy-making and planning processes.
- (g) To provide a mechanism for effective communication among the Medical Staff, Hospital Administration, and the Board.

#### 2.2 RESPONSIBILITIES

2.2.1 The responsibilities of the Medical Staff are:

- (a) To provide quality patient care.
- (b) To account to the Board for the quality of patient care, treatment, and services provided by all Practitioners and APPs authorized to practice in the Hospital through the following measures.



- (1) Review and evaluation of the quality of patient care provided through patient care evaluation procedures.
  - (2) An organizational structure and mechanisms that allow ongoing monitoring of patient care practices.
  - (3) A credentials program and mechanisms for appointment, reappointment, and the matching of Clinical Privileges to be exercised with the verified credentials and current demonstrated performance of each Practitioner or APP.
  - (4) A continuing education program based at least in part on needs demonstrated through the medical care evaluation program.
  - (5) A utilization review program to provide for the appropriate use of medical services.
- (c) To recommend to the Board programs for the establishment, maintenance, continuing improvement, and enforcement of professional standards related to the delivery of health care within the Hospital.
  - (d) To account to the Board for the quality of patient care through regular reports and recommendations concerning the implementation, operation, and results of the quality review and evaluation activities.
  - (e) To initiate and pursue corrective action with respect to Appointees (pursuant to the procedure set forth in these Bylaws) and APPs (pursuant to the procedure set forth in the Advanced Practice Provider Policy) where warranted.
  - (f) To assist in the provision of oversight in the process of analyzing and improving patient satisfaction.
  - (g) To play a leadership role in and to participate in Hospital performance improvement activities to improve quality of care, treatment, services, and patient safety.
  - (h) To provide a framework for cooperation with other community health facilities and/or educational institutions or efforts.
  - (i) To develop, administer, and recommend adoption of, amendments to, and compliance with the Medical Staff Bylaws and Policies and with applicable Hospital policies and procedures.
  - (j) To exercise the authority granted by these Bylaws in order to fulfill the foregoing responsibilities.

### 2.3 NOT A CONTRACT

The Medical Staff Bylaws and Policies are not intended to and shall not create any contractual rights between the Hospital and any Practitioner/APP. Any and all contracts of association or employment shall control contractual and financial relationships between the Hospital and Practitioners/APPs.

### 2.4 AUTHORITY OF THE MEDICAL STAFF

Subject to the authority and approval of the Board, the Medical Staff shall exercise such power as is reasonably necessary to discharge its responsibilities under the Medical Staff Bylaws and Policies.

### 2.5 TIME COMPUTATION

2.5.1 “Day(s)” shall mean calendar days including Saturdays, Sundays, and Legal Holidays.

2.5.2 “Working Day(s)” shall mean Monday through Friday excluding Legal Holidays.

2.5.3 “Legal Holiday” shall mean New Year’s Day, Labor Day, Memorial Day, Fourth of July, Thanksgiving Day, and Christmas Day.

### 2.6 USE OF DESIGNEES

Whenever an individual is authorized to perform a duty by virtue of his/her position (*e.g.*, Medical Staff President, Chief Medical Officer, Hospital President, *etc.*), then the term shall also include the individual’s designee.

## ARTICLE III

### MEDICAL STAFF APPOINTMENT AND CLINICAL PRIVILEGES

#### 3.1 NATURE OF MEDICAL STAFF APPOINTMENT AND PRIVILEGES

- 3.1.1 Appointment to the Medical Staff confers on the Appointee only such Prerogatives of appointment as specified within these Bylaws. Medical Staff appointment shall entitle the Appointee to attend Medical Staff functions, use Medical Staff facilities, and participate in the Medical Staff governance and policy development within the mechanisms defined within these Bylaws. Additional Prerogatives are provided for in the Medical Staff categories set forth in Article IV.
- 3.1.2 The granting of appointment to the Medical Staff does not confer or imply the granting of Clinical Privileges for the provision of patient care.
- 3.1.3 Appointment to the Medical Staff is separate and distinct from a grant of Privileges. A Practitioner may be granted Medical Staff appointment with Privileges, Medical Staff appointment without Privileges, or Privileges without a Medical Staff appointment.
- 3.1.4 No Practitioner, including those employed by or in a medical administrative position by virtue of a contract with the Hospital, shall admit or provide care, treatment, and/or services to patients in the Hospital unless he or she is an Appointee of the Medical Staff and has been granted Clinical Privileges, or has been granted Clinical Privileges without Medical Staff appointment, in accordance with the procedures set forth in these Bylaws or the Credentials Policy.

#### 3.2 APPOINTMENT & CLINICAL PRIVILEGING PROCESS

- 3.2.1 The granting of Medical Staff appointment and/or Clinical Privileges to provide patient care, treatment, and/or services at the Hospital shall be in accordance with these Medical Staff Bylaws and the Credentials Policy.
- 3.2.2 Unless otherwise provided in these Medical Staff Bylaws or the Credentials Policy, the Medical Staff appointment and clinical privileging process is as follows:
  - (a) All Practitioners shall submit a complete application to the Credentialing Office. The Credentialing Office will build the Practitioner's credentials file in accordance with the Credentials Policy and conduct primary source verification.
  - (b) Completed credentials files for Medical Staff appointment and/or clinical privileging will be vetted by the appropriate Department Chair.
  - (c) Completed and Department Chair-vetted applications will be reviewed by the Medical Staff Credentials Committee.
  - (d) A recommendation regarding the request for Medical Staff appointment and/or Clinical Privileges is made by the Medical Executive Committee.

- (e) The Practitioner's request for Medical Staff appointment and/or Clinical Privileges along with input from the Department Chair and Credentials Committee, and the recommendation from the MEC is forwarded to the Board for final action.
- (f) Details regarding the credentialing, appointment/reappointment, and clinical privileging processes for Practitioners are set forth in the Medical Staff Credentials Policy.

3.2.3 Granting of temporary Privileges shall be in accordance with the procedure set forth in the Medical Staff Credentials Policy.

3.2.4 Practitioners who do not possess Privileges at the Hospital may be granted disaster Privileges during any externally officially declared emergency, whether it is local, state, or national. The Hospital President, Chief Medical Officer, or the Administrator on Call may grant disaster Privileges in accordance with the procedure set forth in the Medical Staff Credentials Policy.

3.2.5 Details regarding the credentialing and privileging process for APPs are set forth in the Advanced Practice Provider Policy.

### 3.3 QUALIFICATIONS FOR MEDICAL STAFF APPOINTMENT AND PRIVILEGES

Unless otherwise provided in the Medical Staff Bylaws or Policies, only Practitioners who meet the following general qualifications (as applicable to the request for Medical Staff appointment and/or Privileges) so as to demonstrate to the satisfaction of the Medical Staff that they are ethical, professionally competent, and that patients treated by them can reasonably expect to receive quality care shall be considered for appointment and/or Privileges:

#### 3.3.1 BASELINE QUALIFICATIONS

- (a) Education and current licensure in accordance with the requirements that follow:
  - (1) A Physician applicant must hold an M.D. or D.O. degree issued by an appropriately accredited medical or osteopathic medical school and a current, valid, and unsuspended license to practice medicine issued by the State of Ohio.
  - (2) A Dentist applicant must hold a D.D.S. or D.M.D. issued by an appropriately accredited dental school and a current, valid, and unsuspended license to practice dentistry issued by the State of Ohio.
  - (3) A Podiatrist applicant must hold a D.P.M. degree issued by an appropriately accredited podiatry school and a current, valid, and unsuspended license to practice podiatry issued by the State of Ohio.

- (4) A Psychologist applicant must hold a Ph.D. or Psy.D. in psychology and a current, valid, and unsuspended license to practice psychology issued by the State of Ohio.
- (5) A Clinical Scientist who is a M.D. or D.O. shall satisfy the education and licensure requirements set forth above for Physicians. All other Clinical Scientists must hold a Ph.D in their area of practice.
- (b) If requesting Privileges, have in force and provide evidence of continuous Professional Liability Insurance coverage.
- (c) Have and maintain, if necessary for the Privileges requested, a current, valid Drug Enforcement Administration (“DEA”) registration.
- (d) Be eligible to participate in Federal Healthcare Programs.
- (e) Be able to read and understand the English language, to communicate effectively and intelligibly in English (written and verbal), and be able to prepare medical record entries and other required documentation in a legible and professional manner.
- (f) Have and maintain board certification as required by §3.3.3 subject to §3.3.4 with respect to waiver or extension of the board certification requirement.

### 3.3.2 ADDITIONAL QUALIFICATIONS

- (a) Documentation of adequate training and experience.
- (b) Evidence of good judgment.
- (c) Documentation and demonstration of current professional competence (*i.e.*, ability to exercise the Privileges requested with or without a reasonable accommodation).
- (d) Adherence to the ethics of their respective professions.
- (e) Ability to work cooperatively with others so as not to adversely affect patient care or disrupt Hospital operations.
- (f) Willingness to participate in and properly discharge those responsibilities defined by the Medical Staff.
- (g) Agreement to abide by the Medical Staff Bylaws and Policies.
- (h) Satisfaction of the membership requirements of the applicable Medical Staff Department.

### 3.3.3 BOARD CERTIFICATION-APPOINTEES TO THE ACTIVE AND AFFILIATE MEDICAL STAFF WITH PRIVILEGES

- (a) Physicians, Podiatrists, and Oral Surgeons who are applicants/Appointees to the active and affiliate Medical Staff categories with Clinical Privileges must also meet the following qualification:
  - (1) Be certified by a primary board or hold appropriate sub-specialty certification within their field of practice, where a specialty board exists, or become board certified within five (5) years of appropriate residency and/or fellowship training completion or within the amount of time specified by the Physician's, Podiatrist's, or Oral Surgeon's specialty board, whichever is less. The certification must be recognized by the American Board of Medical Specialties or the American Osteopathic Association. If a period of clinical practice is required prior to taking the certification examination, the five (5) year interval shall begin at the completion of the practice period. The expectation is that the Physician, Podiatrist, or Oral Surgeon be certified in the area of his/her primary practice. Failure to attain certification within the required time shall require the Physician, Podiatrist, or Oral Surgeon to present a request for an extension or waiver to the Medical Executive Committee for review in accordance with the procedure set forth in Section 3.3.4 below.
  - (2) Comply with requirements for mandatory re-certification as specified by their applicable national board.
- (b) Verification of certification/re-certification shall be reviewed for each Physician, Podiatrist, or Oral Surgeon who is required to be board certified upon initial appointment/grant of Privileges and during the reappointment/regrant of Privileges process.
  - (1) Current Certification. If the Appointee is actively board certified the Appointee will continue the reappointment/regrant of Privileges process.
  - (2) New Graduates. New graduates who were not board certified upon initial appointment/grant of Privileges and who have not obtained certification within the time period set forth in (a)(1) above will be required to present a request for an extension or waiver to the Medical Executive Committee for review.
  - (3) New Applicants without Certification. New applicants who are not board certified and who do not meet the exception set forth in (a)(1) above or whose boards have lapsed will be required to present a request for an extension or waiver to the Medical Executive Committee for review.
  - (4) Appointees who Fail to Recertify or Experience a Lapse in Certification. Appointees who fail to recertify, or whose certification has lapsed at reappointment/regrant of Privileges, will have until the next appointment/Privilege cycle to obtain

recertification. If the Appointee fails to recertify in that time period, the Appointee will be required to present a request for an extension or waiver to the Medical Executive Committee for review.

- (c) During the appointment/reappointment and grant/regrant of Privileges process, the board certification and recertification requirements may (i) be permanently waived, or (ii) an extension may be granted on a temporary basis for a specified period of time to allow a Physician, Podiatrist, or Oral Surgeon an opportunity to obtain appropriate certification or recertification in accordance with the procedure set forth in Section 3.3.4 below. Once taken, such action supersedes all individual certification and recertification requirements contained in these Medical Staff Bylaws.

### 3.3.4 PROCEDURE FOR GRANTING A WAIVER OR EXTENSION

- (a) A Practitioner who does not satisfy the board certification qualification for Medical Staff appointment and/or Privileges outlined in Section 3.3.3 may request a waiver or extension, as applicable.
- (b) A request for a waiver or extension will be submitted by the Practitioner to the MEC in writing for consideration. The Practitioner who is requesting the waiver or extension bears the burden of demonstrating that his/her qualifications are equivalent to, or exceed, the criterion/criteria in question; or, that there are other extraordinary circumstances that justify a waiver or extension.
- (c) In reviewing the request for a waiver or extension, the MEC may consider: the specific qualifications of the Practitioner; information supplied by the Practitioner with respect to the request for a waiver or extension; input from the applicable Department Chair; additional information as requested by the MEC including, but not limited, to information regarding the Practitioner's quality of care, prior actions (*e.g.*, complaints and compliments regarding his/her professional conduct), special circumstances, Practitioner recommendations/references; and, the best interests of the Hospital and the communities it serves.
- (d) A recommendation to grant the request for a waiver or extension requires an affirmative seventy-five percent (75%) vote of the voting members of the MEC. If the MEC votes to recommend a waiver or extension, the MEC's recommendation (which may be set forth in MEC minutes) will be forwarded to the Board for action. The MEC's recommendation may include an action plan to be reevaluated by the MEC at a designated time.
- (e) A waiver or extension may be granted at the sole discretion of the Board upon a favorable recommendation of the MEC, in extraordinary circumstances, based upon a determination that such waiver or extension will serve the best interests of patient care. Any recommendation to grant a waiver or extension will include the basis for such.

- (f) Once a waiver is granted, it shall remain in effect from the time it is granted until the Practitioner's resignation/termination of Medical Staff appointment/Privileges. Thereafter, if the Practitioner subsequently reapplies for appointment and/or Privileges, he/she must satisfy the then current qualifications or reapply for the waiver.
- (g) Once an extension is granted, it shall remain in effect for such time period as recommended by the MEC and approved by the Board; provided, however, that such extension may not exceed the end date of the Practitioner's current Medical Staff appointment/Privilege period.
- (h) An application for Medical Staff appointment and/or Privileges that does not satisfy the board certification qualification, and for which the Practitioner has requested a waiver or extension, will not be processed until a waiver or extension is granted by the Board. A situation involving an applicant who does not satisfy the board certification qualification, and who is not otherwise granted an extension or waiver, will result in the Hospital's inability to continue to process the applicant's request for Medical Staff appointment and Privileges for failure to meet baseline qualifications.
- (i) An Appointee who does not satisfy the board certification qualification, and who is not otherwise granted an extension or waiver, will have his/her Medical Staff appointment and Privileges automatically terminated for failure to meet baseline qualifications.
- (j) No Practitioner is entitled to a waiver or extension. A determination by the Board not to grant a Practitioner's request for a waiver or extension; or, the Hospital's inability to process an application; or termination of a Practitioner's appointment and Privileges based upon failure to satisfy the board certification qualification does not create any procedural rights nor does it create a reportable event for purposes of federal or state law.

### 3.4 NONDISCRIMINATION

No applicant shall be denied Medical Staff appointment and/or Privileges on the basis of: race; color; sex (including pregnancy); sexual orientation; gender identity; gender expression; transgender status; age (40 and older); religion; marital, familial, or health status; national origin; ancestry; disability; genetic information; veteran or military status; or any other characteristic(s) or class protected by applicable law.

### 3.5 BASIC RESPONSIBILITIES OF PRACTITIONERS GRANTED MEDICAL STAFF APPOINTMENT AND/OR PRIVILEGES

3.5.1 A Practitioner who is granted appointment to the Medical Staff and/or Privileges is responsible for fulfilling such responsibilities as are set forth in these Bylaws, the Medical Staff Policies, and the Medical Staff category, if any, to which the Practitioner is appointed.



3.5.2 Unless otherwise provided in the Medical Staff Bylaws or Policies, the ongoing responsibilities of each Practitioner shall include the following responsibilities consistent with the Medical Staff appointment and/or Privileges granted to each such Practitioner:

- (a) Providing patients with the quality of care meeting the professional standards of the Medical Staff.
- (b) Managing and coordinating the patient's care, treatment, and services.
- (c) Abiding by the Medical Staff Bylaws, Policies, and applicable Hospital policies and procedures.
- (d) Discharging, in a cooperative manner, such reasonable responsibilities and assignments imposed upon the Practitioner by virtue of Medical Staff appointment, including committee assignments.
- (e) Preparing and completing, in a timely, legible, and complete fashion, medical records for all patients to whom the Practitioner provides care, treatment, and/or services in the Hospital and preparing any other records as required by the Medical Staff and/or the Hospital.
- (f) Abiding by the ethical principles of the Ohio State Medical Association or any other applicable professional association. The Principles of Medical Ethics adopted by the American Medical Association, the Ohio State Medical Association, and the Summit County Medical Society, and the Principles of Professional Ethics adopted by the American Dental Association, the Ohio State Dental Association, the Summit County Dental Society and the ethics of any other applicable society shall govern the professional conduct of Practitioners. The principles of professional ethics adopted by local and/or state professional associations pertaining to Advanced Practice Providers shall govern their professional conduct except when these may conflict with the principles of the American Medical Association, in which case the principles of the American Medical Association shall be applicable.
- (g) Aiding, as requested and/or required by the Department Chairs, in any Medical Staff approved educational programs for medical students, interns, residents, Practitioners/APPs, nurses, and other personnel.
- (h) Working cooperatively with Practitioners, APPs, nurses, Hospital administration, and others so as not to adversely affect patient care or Hospital operations.
- (i) Retaining responsibility within his/her area(s) of professional competence for the continuous care and supervision of each patient in the Hospital for whom he/she is providing care, treatment, and/or services, or arrange for a qualified substitute having the same or greater level of Privileges to provide such care and supervision.

- (j) Participating in continuing education programs as determined by the Medical Staff or the Medical Executive Committee and as otherwise required to maintain current licensure.
- (k) Admitting and/or caring for patients in the Hospital within the scope of his/her Privileges and being regularly involved in Medical Staff functions as determined by the Medical Staff.
- (l) Keeping the Medical Staff informed by notifying the Credentialing Office if/when any information set forth in the Practitioner's current Medical Staff application changes including, but not limited to, any action, proposed action, or investigation regarding the Practitioner's license, DEA registration, privileges at other facilities, changes in Professional Liability Insurance coverage, or any other action, proposed action, or investigation that could affect his/her Medical Staff standing and/or Clinical Privileges at this Hospital.
- (m) Completing orientation requirements upon initial appointment/grant of Privileges.
- (n) Meeting the general qualifications for appointment as set forth in §3.3.
- (o) Discharging such other Medical Staff obligations as may be established from time to time by the Medical Staff or the Medical Executive Committee.
- (p) Cooperating in any relevant or required review of a Practitioner's (including his/her own) credentials, qualifications, or compliance with the Medical Staff Bylaws or Policies; and refraining from directly or indirectly interfering, obstructing, or hindering any such review, whether by threat of harm or liability, by withholding information, or by refusing to perform or participate in assigned responsibilities or otherwise.
- (q) Cooperating and participating, as requested by the Medical Staff, in quality assurance activities and utilization review activities whether related to oneself or others.
- (r) Abiding by the terms of the Hospital's Corporate Responsibility Program and HIPAA Notice of Privacy Practices prepared and distributed to patients as required by the federal patient privacy regulations.

3.5.3 Failure to satisfy any of the aforementioned responsibilities may be grounds for denial of Medical Staff reappointment/regrant of Privileges or corrective action pursuant to these Bylaws.

### 3.6 MEDICAL HISTORY AND PHYSICAL EXAMINATION

3.6.1 A medical history and physical examination (H&P) must be completed and documented for each patient no more than 30 days before or 24 hours after

admission or registration, but prior to surgery or a procedure requiring anesthesia services. The following elements are required for the H&P:

- (a) Medical History
  - (1) Chief complaint/reason for admission
  - (2) Details of present illness
  - (3) Relevant past, social, and family history
  - (4) Review of systems
- (b) Physical Examination
- (c) Conclusions or impressions drawn from medical history and physical and diagnosis or diagnostic impression
- (d) Plan of care

3.6.2 An updated examination of the patient, including any changes in the patient's condition, must be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the H&P is completed within 30 days before admission or registration.

3.6.3 The H&P, and any updates thereto, must be placed in the patient's medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.

3.6.4 The H&P must be completed and documented by a Physician, an oral maxillofacial surgeon, or other qualified licensed individual in accordance with Ohio law who holds the necessary Privileges.

3.6.5 Additional information regarding H&Ps including, but not limited to, requirements with respect to completion of H&Ps for procedures using conscious sedation, are set forth in applicable Hospital or Medical Staff policies.

### 3.7 ADMINISTRATIVE AND PROFESSIONAL SERVICE AGREEMENT OFFICERS

A Practitioner employed by the Hospital in a purely administrative capacity with no clinical duties is subject to the regular personnel policies of the Hospital and to the terms of his/her contract or other conditions of employment and need not be an Appointee to the Medical Staff or have Clinical Privileges. Conversely, a Practitioner with a professional service agreement with the Hospital, who is responsible for any Hospital department or program with clinical responsibilities, must be an Appointee with appropriate Clinical Privileges pursuant to the applicable procedures set forth in these Bylaws and the Medical Staff Credentials Policy.

## ARTICLE IV

### CATEGORIES OF THE MEDICAL STAFF

#### 4.1 CATEGORIES

The categories of the Medical Staff shall be as follows: Active with Privileges, Active without Privileges, Affiliate, Scientific, Retired, and Consulting Peer Review.

#### 4.2 ACTIVE MEDICAL STAFF WITH PRIVILEGES

4.2.1 Qualifications. The Active Medical Staff with Privileges shall consist of Practitioners who:

- (a) Meet the qualifications for Medical Staff appointment and Privileges set forth in §3.3.
- (b) Actively participate and substantially contribute to the activities of the Hospital/Medical Staff in an ongoing and consistent manner.
- (c) Meet one of the following:
  - (1) Routine Patient Encounters at the Hospital; OR,
  - (2) Major involvement in medical education; OR,
  - (3) Extensive activities related to medical research.

4.2.2 Prerogatives. An Appointee to the active Medical Staff with Privileges may:

- (a) Exercise the Clinical Privileges granted to him/her pursuant to the Medical Staff Bylaws and Policies.
- (b) Hold Medical Staff office subject to the qualifications set forth in Section 8.2.
- (c) Serve as a Department Chair.
- (d) Serve as a Medical Staff committee member or chair.
- (e) Attend meetings of the Medical Staff and the Department and Medical Staff committees of which he/she is a member; attend educational programs.
- (f) Vote on Medical Staff matters; vote on matters of the Department in which he/she is a member; vote on matters of Medical Staff committees of which he/she is a member or chair.

4.2.3 Responsibilities. An Appointee to the active Medical Staff with Privileges shall:

- (a) Fulfill the basic responsibilities set forth in §3.5.

- (b) Actively participate in quality assurance, utilization review, and other quality evaluation and monitoring activities required by the Medical Staff.
- (c) Perform service responsibilities and teaching duties as assigned.
- (d) Discharge other Medical Staff and Hospital functions including consultation and monitoring of Practitioners/APPs as may be required from time to time by the Appointee's Department or the Medical Executive Committee.
- (e) Pay Medical Staff dues in an amount established by the Medical Staff.

#### 4.3 ACTIVE MEDICAL STAFF WITHOUT PRIVILEGES

4.3.1 Qualifications. The active Medical Staff without Privileges shall consist of Practitioners who:

- (a) Satisfy, to the extent applicable, the qualifications set forth in §3.3 of these Bylaws unless otherwise recommended by the MEC and approved by the Board.
- (b) Meet one of the following:
  - (1) Work exclusively in an administrative capacity for the Hospital for which Clinical Privileges are not needed; OR,
  - (2) Do not have Patient Encounters/require Clinical Privileges at the Hospital but provide clinical services to patients in the community the Hospital serves.

4.3.2 Prerogatives. An Appointee to the active Medical Staff without Privileges may:

- (a) Not be granted Clinical Privileges.
- (b) Hold Medical Staff office subject to the qualifications set forth in §8.2.
- (c) Not serve as a Medical Staff Department Chair.
- (d) Serve as a Medical Staff committee member or chair.
- (e) Vote on Medical Staff matters.
- (f) Vote on matters of the Department of which he/she is a member.
- (g) Vote on matters of Medical Staff committees of which he/she is a member or chair.
- (h) Visit their hospitalized patients and review their patients' Hospital medical records (subject to patient consent and applicable Hospital patient privacy/confidentiality policies) but may not admit patients, attend patients,

write orders, progress notes, or other notations in the medical record, or participate in the provision or management of care, treatment, and/or services to patients at the Hospital.

4.3.3 Responsibilities. An active Appointee without Privileges shall:

- (a) Fulfill the basic responsibilities set forth in §3.5 to the extent applicable to a request for Medical Staff appointment without Privileges.
- (b) Pay Medical Staff dues in an amount established by the Medical Staff.

4.4 AFFILIATE MEDICAL STAFF

4.4.1 Qualifications. The affiliate Medical Staff shall consist of Practitioners who:

- (a) Meet the qualifications for Medical Staff appointment and Privileges set forth in §3.3.
- (b) Are appointees in good standing of the active medical staff with clinical privileges at another accredited Ohio hospital requiring performance improvement/quality assessment activities similar to this Hospital. The Practitioner shall hold at such other hospital the same privileges, without restriction, that he/she is requesting at this Hospital. An exception to this qualification may be recommended by the Medical Executive Committee and approved by the Board, in its sole discretion, for good cause provided the Practitioner is otherwise qualified by education, training, and experience to competently provide the requested care, treatment, and/or services.
- (c) Meet one (1) of the following requirements:
  - (1) Requesting Medical Staff appointment and Privileges for the sole purpose of providing back-up coverage to another Practitioner on the Medical Staff; OR,
  - (2) Requesting Medical Staff appointment and Privileges for the sole purpose of providing recurring locum tenens coverage at the Hospital; OR,
  - (3) Practitioners who provide clinical services to patients in the community the Hospital serves, who utilize the Hospital's hospitalist services, and who are requesting appointment and Clinical Privileges for the limited purpose of providing outpatient treatment to patients at the Hospital for which Privileges are needed; OR,
  - (4) Requesting Medical Staff appointment and Privileges for the sole purpose of providing specialty/consulting services in a specialty area in which there is a need at the Hospital; OR,

- (5) Requesting Medical Staff appointment and Privileges for the sole purposes of serving as a preceptor.

4.4.2 Prerogatives. Affiliate Appointees may:

- (a) Exercise the Privileges granted.
- (b) Not hold Medical Staff office.
- (c) Not serve as a Department Chair.
- (d) Serve as a Medical Staff committee member or chair with the exception of the MEC.
- (e) Not vote on Medical Staff matters.
- (f) Not vote on Department matters.
- (g) Vote on matters of Medical Staff committees of which he/she is a member or chair.

4.4.3 Responsibilities. An Appointee to the affiliate Medical Staff shall:

- (a) Fulfill the basic responsibilities set forth in §3.5.
- (b) Participate, as directed by his/her Department, in quality assurance, utilization review, and other quality evaluation and monitoring activities required by the Medical Staff.
- (c) Perform service responsibilities and teaching duties as assigned.
- (d) Pay Medical Staff dues in an amount established by the Medical Staff.

4.5 SCIENTIFIC MEDICAL STAFF

4.5.1 Qualifications. The scientific Medical Staff shall consist of Practitioners who:

- (a) Satisfy, to the extent applicable, the qualifications set forth in §3.3 unless otherwise recommended by the MEC and approved by the Board.
- (b) Are involved actively in medical research but who are not engaged in the clinical practice of medicine.

4.5.2 Prerogatives. The scientific Medical Staff may:

- (a) Exercise the Clinical Privileges granted.
- (b) Not hold Medical Staff office.
- (c) Not serve as a Medical Staff Department chair.

- (d) Serve as a Medical Staff committee member with the exception of the MEC.
- (e) Not serve as a Medical Staff committee chair.
- (f) Not vote on Medical Staff matters.
- (g) Vote on matters of the Department of which he/she is a member.
- (h) Vote on matters of Medical Staff committees of which he/she is a member.

4.5.3 Responsibilities. An Appointee to the scientific Medical Staff shall:

- (a) Fulfill the basic responsibilities set forth in §3.5 to the extent applicable.
- (b) Attend meetings of the Medical Staff and the Department and Medical Staff committee(s) of which he/she is a member; attend educational programs.
- (c) Perform service responsibilities and teaching duties as assigned.
- (d) Pay Medical Staff dues in an amount established by the Medical Staff.

4.6 RETIRED MEDICAL STAFF

4.6.1 Qualifications. The retired Medical Staff shall consist of Practitioners who:

- (a) Have been Appointees of the Medical Staff immediately prior to appointment to the retired Medical Staff.
- (b) Have retired from practice at the Hospital and desire to continue their affiliation with the Hospital for educational purposes.

4.6.2 Prerogatives. An Appointee to the retired Medical Staff may:

- (a) Not be granted Clinical Privileges.
- (b) Not hold Medical Staff office.
- (c) Not serve as a Medical Staff Department chair.
- (d) Serve as a Medical Staff committee member (with the exception of the MEC) and vote on matters of Medical Staff committees of which he/she is a member.
- (e) Not serve as a Medical Staff committee chair.
- (f) Not vote on Medical Staff matters.
- (g) Attend meetings of the Medical Staff Department of which he was a member before his/her retirement but may not vote on Department matters.



4.6.3 Responsibilities. An Appointee to the retired Medical Staff shall have no responsibilities and shall not be required to pay Medical Staff dues.

#### 4.7 CONSULTING PEER REVIEW MEDICAL STAFF

4.7.1 Qualifications. The consulting peer review Medical Staff shall consist of Practitioners who:

- (a) Agree to perform such duties as are reasonably requested of them relating to the review of selected medical record components, organization information, and peer review materials retained by the Hospital for the purpose of rendering an opinion on the quality of health care provided to patients at the Hospital or otherwise perform related peer review services as specifically requested.
- (b) Practice either locally or in another city/state in which he or she has a current, valid license to practice; and, is a member of the active medical staff in good standing at another accredited hospital; OR, is a Practitioner who is a recognized expert in his/her field who has retired from active practice within the last twelve (12) months.
- (c) Possess skills needed at the Hospital for a specific peer review project or for peer review consultation on an occasional basis when requested by Hospital administration, the Board, or a Medical Staff committee.
- (d) Meet such other qualifications, if any, as set forth in the Medical Staff Peer Review Policy, as such policy may be amended from time to time, or as otherwise recommended by the MEC and approved by the Board.

4.7.2 Prerogatives. A consulting peer review Appointee may:

- (a) Review selected medical record components, organization information, and peer review materials retained by the Hospital for the purpose of rendering an opinion on the quality of health care provided to patients at the Hospital or otherwise perform related peer review services as specifically requested.
- (b) Attend Medical Staff, Department, and Medical Staff committee meetings but is not entitled to vote on Medical Staff, Department, or committee matters.
- (c) Not hold Medical Staff office.
- (d) Not be assigned to a Department or serve as a Department Chair.
- (e) Not serve as a Medical Staff committee chair.
- (f) Not be granted Clinical Privileges.

4.7.3 Responsibilities. Consulting peer review Appointees shall:

- (a) Fulfill such obligations as recommended by the MEC and approved by the Board.
- (b) Accept such meeting invitations as are appropriate to carry out his/her peer review functions.
- (c) Be willing to accept assignments for the limited purpose of evaluating Practitioners' credentials and otherwise reviewing selected medical records in order to render an opinion on the professional conduct or clinical competence of a Practitioner
- (d) Not be required to pay Medical Staff dues.

4.7.4 Appointment to this Medical Staff category shall be solely for the purpose of conducting peer review in a particular case or situation and shall terminate upon the Practitioner's completion of his/her duties in connection with the peer review matter without any procedural rights pursuant to Article VII.

#### 4.8 MODIFICATION OF APPOINTMENT CATEGORY

The Medical Executive Committee, on its own or pursuant to a request by an Appointee, may recommend a change in the Medical Staff category of a Practitioner consistent with the requirements of these Bylaws.

## ARTICLE V

### COLLEGIAL INTERVENTION & INFORMAL REMEDIATION

#### 5.1 COLLEGIAL INTERVENTION & INFORMAL REMEDIATION

- 5.1.1 Any Practitioner/APP may provide information to Medical Staff or Hospital leaders regarding the professional conduct or clinical competence of another Practitioner/APP.
- 5.1.2 Prior to initiating corrective action against an Appointee for professional conduct or competency concerns, the Hospital President, the Chief Medical Officer, a Medical Staff officer, or Department Chair may elect, but is not obligated, to attempt to resolve the concern(s) informally. Any such informal, collegial attempts shall be documented and retained in the Appointee's quality peer review file.
- 5.1.3 An appropriately designated Medical Staff committee may enter into a voluntary remedial agreement with an Appointee, consistent with the Medical Staff's professional practice policies, to resolve potential clinical competency or conduct issues. If the affected Appointee fails to abide by the terms of an agreed-to remedial agreement, the affected Appointee will be subject to the formal corrective action procedures set forth in §6.1.
- 5.1.4 Nothing in this Section shall be construed as obligating the Hospital or Medical Staff to engage in collegial intervention or informal remediation prior to implementing formal corrective action on the basis of a single incident.

#### 5.2 IMPAIRED PRACTITIONERS

The collegial intervention/informal remediation procedure for addressing impaired Practitioners is set forth in the Medical Staff Practitioner Effectiveness Policy as such Policy may be amended from time to time.

#### 5.3 CODE OF CONDUCT

The collegial intervention/informal remediation procedure for addressing code of conduct violations is set forth in the Medical Staff Code of Conduct Policy as such Policy may be amended from time to time.

## ARTICLE VI

### FORMAL CORRECTIVE ACTION, SUMMARY SUSPENSION, AND AUTOMATIC SUSPENSION/TERMINATION

#### 6.1 FORMAL CORRECTIVE ACTION

##### 6.1.1 CRITERIA FOR INITIATION

- (a) A corrective action investigation may be requested whenever the activities, professional conduct, or clinical competence of an Appointee is or considered reasonably likely to be:
  - (1) Inconsistent with his/her responsibilities as set forth in these Bylaws or the Medical Staff Policies.
  - (2) Detrimental to patient safety or to the delivery of quality patient care at the Hospital.
  - (3) Disruptive to the operation of the Hospital or Medical Staff.
  - (4) Injurious to the name, welfare, or interest of the Hospital or Medical Staff.
  - (5) Unethical or below the applicable professional standards of care.
  - (6) Detrimental to the health or safety of any Practitioner, APP, Hospital employee, or any other person at the Hospital.
  - (7) Otherwise in violation of the Medical Staff governing documents or Hospital policies/procedures.

##### 6.1.2 CORRECTIVE ACTION REQUESTS

- (a) A request for a corrective action investigation of an Appointee may be submitted by:
  - (1) Any Medical Staff committee (which request may be reflected by committee minutes)
  - (2) A Medical Staff officer
  - (3) A Department Chair
  - (4) The Hospital President
  - (5) The Chief Medical Officer
  - (6) The Board (or chair thereof)

- (b) All requests for corrective action investigations shall be submitted in writing (which request may be reflected in committee minutes) to the Medical Executive Committee, and supported by reference to the specific activities or conduct that constitute the grounds for the request. In the event that the request for corrective action is initiated by the Medical Executive Committee, it shall reflect the basis for its recommendation in its minutes. The Medical Staff President shall promptly notify the Hospital President, in writing, of all requests for corrective action investigations received by the Medical Executive Committee and shall continue to keep him/her fully informed of all action taken in conjunction therewith.
- (c) Upon receipt of a request for corrective action, the Medical Executive Committee, in Executive Session, may take one of the following actions:
  - (1) If, in the opinion of the Medical Executive Committee, there is certainty that no basis exists for the request for a corrective action investigation, the Medical Executive Committee may close the matter and direct the Medical Staff President to notify the individual/group requesting the investigation and the Hospital President of such determination of the Medical Executive Committee and advise them that no further action will be taken at this time.
  - (2) Defer action on the request for investigation in order to obtain further information.
  - (3) Determine that no formal corrective action is warranted and remand the matter for informal resolution (*i.e.*, collegial intervention/voluntary remediation) consistent with Article V and applicable Medical Staff Policies.
  - (4) Initiate a formal corrective action investigation in accordance with the procedure set forth in this section.

### 6.1.3 CORRECTIVE ACTION INVESTIGATION

- (a) A matter shall be deemed to be under formal investigation upon the following event, whichever occurs first:
  - (1) The start of a Medical Executive Committee meeting at which a request for corrective action is being presented.
  - (2) The Appointee is notified by an authorized Hospital or Medical Executive Committee representative (either verbally or by Special Notice) that a request for corrective action has been submitted to the MEC.
- (b) For the sole purpose of determining whether there is a potential reportable event, the matter will be deemed to be under formal corrective action until

the end of the Medical Executive Committee meeting at which the issue is presented; provided, however, that if the MEC determines to proceed with a formal corrective action investigation, the matter shall remain under formal investigation until such time as the MEC rejects the request for corrective action, closes the investigation, or a final decision is rendered by the Board. The affected Appointee shall be provided with written notice, by Special Notice, of a determination by the MEC to go forward with a corrective action investigation.

- (c) The MEC may conduct a corrective action investigation itself; assign the task to a Medical Staff officer, a Department Chair, or a standing or *ad hoc committee*; or may refer the matter to the Board for investigation and resolution.
- (d) The investigative process is not a hearing and shall not entitle the Appointee to the procedural rights set forth in Article VII. Appearances by the Appointee before the investigating individual/group shall be preliminary in nature, shall not constitute a hearing, and none of the procedural rules provided in Article VII shall apply. The Appointee shall, therefore, not be entitled to be represented by legal counsel at such preliminary appearances unless otherwise permitted at the sole discretion of the investigating individual/group.
- (e) The investigating individual/group will proceed with its investigation in a prompt manner. The investigative process may include, without limitation, a meeting with the Appointee involved who may be given an opportunity to provide information in a manner and upon such terms as the investigating individual/group deems appropriate; with the individual or group who made the request; and/or with other individuals who may have knowledge of, or information relevant to, the events involved.
- (f) If the corrective action investigation is conducted by a group or individual other than the MEC or the Board, that group or individual shall submit a written report of the investigation, which may be reflected by committee minutes, to the MEC as soon as practical after its receipt of the assignment to investigate. The report should contain such detail as is necessary for the MEC to rely upon it including recommendations for appropriate corrective action or no action at all (and the basis for such recommendations).
- (g) The Medical Executive Committee may, at any time, terminate the investigative process and proceed with action as provided below.

#### 6.1.4 ACTION FOLLOWING COMPLETION OF INVESTIGATION

- (a) As soon as practical following completion of its report (which may be reflected by committee minutes); or following receipt of a report from the investigating individual or group, the MEC shall act upon the request for corrective action. The MEC's action may include, without limitation:

- (1) A determination that no corrective action be taken.
  - (2) Issuance of a warning, a letter of admonition, or a letter of reprimand.
  - (3) Recommendation of a limitation, suspension, or termination of all, or any part, of the Appointee's Clinical Privileges.
  - (4) Such other recommendation or action as permitted and deemed appropriate under the circumstances.
- (b) If the recommendation of the MEC is Adverse to the Appointee (as detailed in §7.3), the Medical Staff President shall promptly notify the affected Appointee, by Special Notice, and the Appointee shall be entitled, upon timely and proper request, to the procedural rights set forth in Article VII. The Medical Staff President shall hold the Adverse recommendation until the Appointee has exercised or waived his/her procedural rights after which the final MEC recommendation, together with all accompanying information, shall be forwarded to the Board for action.
- (c) If the MEC (i) initially referred the corrective action investigation to the Board; or (ii) fails to act on a request for corrective action within a reasonable time as determined by the Board, the Board may proceed with its own investigation or determination, as applicable to the circumstances. In the case of (ii), the Board shall make such determination after informing the MEC of the Board's intent and allowing a reasonable period of time for response by the MEC.
- (1) If the Board's decision is not Adverse to the Appointee, the action shall be effective as its final decision and the Hospital President shall inform the Appointee of the Board's decision by Special Notice.
  - (2) If the Board's decision is Adverse to the Appointee, the Hospital President shall inform the Appointee, by Special Notice, and the Appointee shall be entitled, upon timely and proper request, to the procedural rights set forth in Article VII.
- (d) The commencement of corrective action procedures against an Appointee shall not preclude the summary suspension or automatic suspension or automatic termination of the Medical Staff appointment and/or all, or any portion, of the Appointee's Privilege in accordance with the procedures set forth in §6.2, §6.3, or §6.4 of this Article.

## 6.2 SUMMARY RESTRICTION OR SUSPENSION

### 6.2.1 CRITERIA FOR INITIATION

- (a) Whenever a Practitioner's conduct appears to require that immediate action be taken to protect or reduce the substantial likelihood of injury or imminent

danger to the life, health, or well-being of any patient, employee, or other person present in the Hospital, the following individuals/groups, who may consult with each other for guidance, may summarily suspend or restrict the appointment status and all, or any portion, of the Clinical Privileges of such Practitioner:

- (1) Medical Staff President
  - (2) Chief Medical Officer
  - (3) Respective Department Chair
  - (4) Hospital President
  - (5) MEC
  - (6) Board (or Board chair)
- (b) Such summary suspension shall be deemed an interim action and not a final professional review action. It shall not imply any final findings of responsibility for the situation that caused the summary suspension. Such summary suspension shall be effective immediately upon imposition.
- (c) The person or group who imposed the summary suspension shall promptly notify the Practitioner, by Special Notice, of imposition of the summary suspension or restriction.
- (d) The person or group who imposed the summary suspension shall promptly notify the Medical Staff President, the Chief Medical Officer, the Department Chair, and the Hospital President of the summary suspension.

#### 6.2.2 MEDICAL EXECUTIVE COMMITTEE ACTION

- (a) As soon as possible, but in no event later than three (3) working days after a summary suspension is imposed, the MEC (if the MEC was not involved in the imposition of the summary suspension), shall convene to review and consider the action taken and the need, if any, for corrective action pursuant to §6.1 above. The MEC may invite the Practitioner whose appointment and/or Clinical Privileges have been summarily restricted or suspended to attend the meeting. Such a meeting of the MEC shall not be considered a "hearing" as contemplated in Article VII even if the Practitioner involved attends the meeting, and no procedural requirements shall apply.
- (b) Following such a meeting, the Medical Executive Committee may vote to affirm, remove, or modify the summary suspension or restriction provided that the summary restriction/suspension was not imposed by the Board or the Hospital President (on behalf of the Board). In the case of a summary suspension imposed by the Board or Hospital President (on behalf of the Board), the MEC shall provide its recommendation to the Board as to whether such summary suspension should be modified, continued, or



terminated. The Board may accept, modify, or reject the MEC's recommendation.

- (c) Not later than fourteen (14) days following the original imposition of the summary suspension, the Practitioner shall be notified, by Special Notice, of the Medical Executive Committee's decision; or, in the case of a summary suspension imposed by the Board or the Hospital President (on behalf of the Board), of the MEC's recommendation as to whether such summary suspension should be terminated, modified, or sustained and of the Practitioner's rights, if any, pursuant to Article VII.
  - (1) If the summary suspension is not lifted by the conclusion of the fourteenth (14<sup>th</sup>) day of its imposition, an Appointee shall have the right to proceed under Article VII. The terms of the summary suspension shall remain in effect pending the outcome of any hearing and appeal initiated by the Appointee pursuant to Article VII.
  - (2) Lifting the summary suspension within fourteen (14) days of its original imposition on the ground that corrective action was not required shall not be deemed Adverse and a statement to that effect shall be placed in the Practitioner's file.
- (d) In the event Board action is required, the Board members will meet sufficiently in advance of the fourteen (14) day deadline to resolve.

### 6.2.3 PATIENT COVERAGE

- (a) Immediately upon imposition of a summary suspension or restriction, the Medical Staff President and/or applicable Department Chair(s) shall have authority to designate an Appointee, other than the Department Chair, with appropriate Privileges to provide for medical coverage of the hospitalized patients of the suspended Practitioner.
- (b) The patients' wishes shall be considered in the selection of an alternate Practitioner. The affected Practitioner shall confer with the alternate Practitioner to the extent necessary to safeguard the patients.
- (c) A Practitioner(s) who imposed the summary suspension or restriction, shall not assume direct responsibility for the care of the suspended Practitioner's patients.

## 6.3 AUTOMATIC SUSPENSION OR LIMITATION

- 6.3.1 The following events shall result in an automatic suspension or limitation of a Practitioner's appointment and/or Privileges, as applicable, without recourse to the procedural rights set forth in Article VII:

- (a) Licensure. Action by any federal or state authority suspending or limiting a Practitioner's professional license shall result in an automatic comparable suspension/limitation on the Practitioner's Medical Staff appointment and Privileges. Whenever a Practitioner's licensure is made subject to probation, the Practitioner's Medical Staff appointment and Privileges shall automatically become subject to the same terms of the probation.
- (b) Controlled Substance Authorization. Whenever a Practitioner's prescriptive authority, federal Drug Enforcement Administration (DEA) registration, or state controlled substance certificate is suspended, limited or revoked, the Practitioner shall automatically and correspondingly be suspended, limited, or divested of the right to prescribe medications covered by the prescriptive authority or registration/certificate, as of the time such action becomes effective and through its term. Whenever a Practitioner's prescriptive authority, DEA registration, or state controlled substance certificate is made subject to probation, the Practitioner's right to prescribe such medications shall automatically become subject to the same terms of the probation.
- (c) Professional Liability Insurance Coverage. If a Practitioner's Professional Liability Insurance coverage lapses, falls below the required minimum, is terminated, or otherwise ceases to be in effect, in whole or in part, the Practitioner's Medical Staff appointment and Privileges shall be automatically suspended until such time as the Practitioner presents proof, in writing, that such insurance has been restored or until the Practitioner's appointment and Privileges are automatically terminated pursuant to §6.4.1(b) below. The Practitioner shall provide the Hospital with a certified copy of the insurance certificate from the insurance company and a written statement explaining the circumstances of the Practitioner's non-compliance with the Professional Liability Insurance requirements, any limitations on the new policy, and a summary of relevant activities during the period of no coverage to establish current competency. For purposes of this section, the failure of a Practitioner to provide proof of Professional Liability Insurance shall constitute a failure to meet the requirements of this paragraph.
- (d) Federal Healthcare Program. Whenever a Practitioner is suspended from participating in a Federal Healthcare Program, the Practitioner's appointment and Privileges shall be immediately and automatically suspended.
- (e) Health Screenings/Immunizations. Failure to provide documentation of required immunizations and/or health screenings in accordance with the requirements set forth in the applicable Medical Staff Policy will result in automatic suspension of the Practitioner's appointment and/or Privileges to the extent and in the manner provided for such Medical Staff Policy.
- (f) Medical Records. Whenever a Practitioner fails to complete medical records as provided for in the Delinquent Medical Records Policy, the Practitioner's

Medical Staff appointment and Privileges shall be automatically suspended as provided for in such Policy.

- 6.3.2 During such period of time when a Practitioner's appointment and/or Privileges, as applicable, are suspended pursuant to §6.3-1 (a)-(e), he/she may not exercise any Prerogatives of appointment or exercise any Privileges at the Hospital, participate in on-call coverage, schedule surgery, or otherwise provide professional services within the Hospital for patients.
- 6.3.3 During such period of time when a Practitioner's appointment and/or Privileges are limited pursuant to §6.3-1(f), he/she is subject to the same limitations noted above except that such Practitioner may:
- (a) Conclude the management of any patient under his/her care in the Hospital at the time of the effective date of the automatic suspension of Privileges.
  - (b) Attend an obstetrical patient who has been under his/her active care and management and who is admitted to the Hospital in labor.
  - (c) Attend to the management of any patient under his/her care whose admission or outpatient procedure was scheduled prior to the effective date of the automatic suspension.
  - (d) Attend to the management of any patient under his/her care requiring emergency care and intervention. For the purpose of this provision, "emergency" is defined as a situation where death or serious bodily harm is likely to occur to the patient unless medical treatment is initiated.
- 6.3.4 At the next regularly scheduled meeting following the imposition of an automatic suspension, the Medical Executive Committee shall convene to determine if corrective action is necessary in accordance with §6.1 of these Bylaws. The lifting of the action or inaction that gave rise to an automatic suspension or limitation on Privileges shall result in the automatic reinstatement of the Practitioner's appointment and/or Privileges provided, however, that the Practitioner shall be obligated to provide such information as the Medical Staff Office shall reasonably request to assure that all information in the Practitioner's credentials file is current.

#### 6.4 AUTOMATIC TERMINATION

- 6.4.1 The following events shall result in an automatic termination of appointment and Privileges without recourse to the procedural rights set forth in Article VII. Reapplication shall be subject to the provisions of the Medical Staff Credentials Policy.
- (a) Licensure. Action by any federal or state authority terminating a Practitioner's professional license shall result in an automatic termination of the Practitioner's appointment and Privileges.

- (b) Professional Liability Insurance. In the event that proof of Professional Liability Insurance coverage is not provided to the Hospital within thirty (30) days of a Practitioner's automatic suspension pursuant to §6.3.1(c), the Practitioner's Medical Staff appointment and Privileges shall automatically terminate as of the thirty-first (31st) day.
- (c) Federal Healthcare Program. Whenever a Practitioner is excluded from participating in a Federal Healthcare Program, the Practitioner's appointment and Privileges shall be automatically terminated.
- (d) Plea of Guilty to Certain Offenses. If a Practitioner pleads guilty or no contest to or is found guilty of a felony or other serious offense that involves (i) violence or abuse upon a person, conversion, embezzlement, or misappropriation of property; (ii) fraud, bribery, evidence tampering, or perjury; or (iii) a drug offense, the Practitioner's appointment and Privileges shall be immediately and automatically terminated.
- (e) Failure to Pay Dues/Assessments. Failure to pay Medical Staff dues or fines in accordance with the requirements set forth in the applicable Medical Staff Policy shall result in an automatic termination of the Practitioner's appointment and Privileges in the manner provided for in such Medical Staff Policy.
- (f) Immunizations and Health Screenings. In the event that documentation of required immunizations and/or health screenings is not provided in accordance with the requirements set forth in the applicable Medical Staff Policy following an automatic suspension of appointment and/or Privileges pursuant to §6.3.1(e), the Practitioner's appointment and Privileges will automatically terminate in the manner provided for in such Medical Staff Policy.
- (g) Failure to Complete Hospital Training. Failure to complete Hospital training (*e.g.*, I'm 4 Safety, *etc.*) in accordance with the requirements set forth in the applicable Medical Staff Policy shall result in automatic termination of the Practitioner's appointment and Privileges in the manner provided for in such Medical Staff Policy.
- (h) Medical Records. Whenever a Practitioner fails to complete medical records as provided for in the Delinquent Medical Records Policy, the Practitioner's Medical Staff appointment and Privileges shall be automatically terminated as provided for in such Policy.

## 6.5 DUTY TO NOTIFY

A Practitioner has a responsibility, pursuant to Section 3.5.2 (l) to notify the Credentialing Office if/when any information set forth in the Practitioner's current Medical Staff application changes. Failure to do so, in and of itself, constitutes grounds for corrective action.

## 6.6 SCIENTIFIC MISCONDUCT

All requests for investigations involving allegations of scientific misconduct shall be conducted in accordance with the applicable Hospital/Medical Staff policies and procedures.

## ARTICLE VII

### HEARING AND APPEAL PROCEDURES

#### 7.1 APPLICABILITY

7.1.1 The purpose of this Article is to provide a mechanism for resolution of matters Adverse (as such term is defined in these Bylaws) to Appointees who have, or applicants who have requested, Medical Staff appointment and Privileges at the Hospital.

7.1.2 For purposes of this Article, the term “Practitioner” may include either an applicant or an Appointee as may be applicable under the circumstances.

#### 7.2 EFFECT OF ADVERSE RECOMMENDATIONS AND ACTIONS

7.2.1 By MEC: Unless otherwise provided in the Medical Staff Bylaws or Policies, when a Practitioner receives Special Notice of an Adverse recommendation of the MEC the Practitioner shall be entitled to a hearing and appellate review, if applicable, in accordance with the procedures set forth in this Article.

7.2.2 By Board: Unless otherwise provided in the Medical Staff Bylaws or Policies, when a Practitioner receives Special Notice of an Adverse recommendation or action of the Board, and such decision is not based upon a prior Adverse recommendation of the MEC with respect to which the Practitioner was entitled to a hearing, the Practitioner shall be entitled to a hearing and appellate review, if applicable, in accordance with the procedures set forth in this Article.

#### 7.3 GROUNDS FOR HEARING

7.3.1 Except as otherwise specified in these Bylaws or the Medical Staff Policies, any one (1) or more of the following actions or recommended actions shall, if deemed Adverse (as such term is defined in these Bylaws), constitute grounds for a hearing.

- (a) Suspension of Medical Staff appointment in excess of fourteen (14) days.
- (b) Revocation or denial of Medical Staff appointment.
- (c) Denial of requested Clinical Privileges.
- (d) Suspension or restriction/limitation/reduction of Clinical Privileges, as part of a formal corrective action process, in excess of fourteen (14) days.
- (e) Imposition of a focused professional practice evaluation, as part of a formal corrective action process, resulting in a restriction/limitation on previously exercised Privileges in excess of fourteen (14) days.
- (f) Revocation of Clinical Privileges.

7.3.2 A recommendation or action listed in §7.3.1 shall be deemed Adverse (as such term is defined in these Bylaws) only when it has been:

- (a) Recommended by the MEC; or,
- (b) Taken by the Board under circumstances where no prior right to a hearing existed.

7.3.3 Recommendations or actions pertaining to a Practitioner's Medical Staff appointment and/or Clinical Privileges that are based on any matter which does not relate to the clinical competence or professional conduct of a Practitioner shall not give rise to any hearing or appellate review rights unless otherwise specified in the Medical Staff Bylaws or Policies.

#### 7.4 RECOMMENDATIONS/ACTIONS THAT DO NOT GIVE RISE TO A HEARING

7.4.1 The following recommendations or actions are not deemed to be Adverse and shall not constitute grounds for or entitle the Practitioner affected thereby to a hearing:

- (a) The issuance of a warning, letter of admonition, or letter of reprimand.
- (b) The denial, suspension, termination, or reduction of temporary, disaster, *locum tenens*, emergency, or telemedicine Privileges.
- (c) An action that does not relate to the clinical competence or professional conduct of a Practitioner.
- (d) Any action recommended/taken by the MEC or the Board against a Practitioner where the action was recommended/taken solely for administrative or technical failings of the Practitioner (*e.g.*, failure of a Practitioner to satisfy baseline qualifications for Medical Staff appointment and/or Privileges or to provide requested information, *etc.*).
- (e) Ineligibility for Medical Staff appointment, reappointment, or the Privileges requested, because a Department has been closed or the Hospital is presently a party to an exclusive contract for such services.
- (f) Ineligibility for Medical Staff appointment and/or requested Privileges because of the Hospital's lack of facilities, equipment, or support services; because the Hospital has elected not to perform or does not provide the service or the procedure for which Privileges are sought; or, inconsistency with the Hospital's strategic plan.
- (g) An automatic suspension or automatic termination of appointment and/or Privileges as defined in §6.3.1 and §6.4.1.
- (h) Imposition of focused or ongoing professional practice evaluation as part of the routine peer review process.

- (i) Termination of the Practitioner's employment or other contract for services unless the employment or services contract provides otherwise.
- (j) Voluntary agreement not to exercise Privileges or resignation of Medical Staff appointment and/or Privileges when such voluntary agreement or resignation is not in return for the MEC or Board refraining from conducting a corrective action investigation based upon the Practitioner's professional conduct or clinical competence.
- (k) Any other action not specifically listed in §7.3.1.

## 7.5 REQUEST FOR HEARING

### 7.5.1 NOTICE OF ADVERSE RECOMMENDATION/ACTION

- (a) A Practitioner against whom an Adverse recommendation or action has been made/taken shall promptly be given Special Notice thereof by the Hospital President or Medical Staff President stating the following:
  - (1) A professional review action has been taken or is proposed to be taken against the Practitioner and the nature of/reasons for the Adverse recommendation or action including a concise statement of the basis for the recommended denial of Medical Staff appointment/Privileges; or, in the case of a corrective action, the Practitioner's alleged acts or omissions including, when appropriate, a list of specific or representative patient records, by medical record number, and any other information forming the basis for the Adverse recommendation or action that is the subject of the hearing.
  - (2) The Practitioner has thirty (30) days following the date of receipt of the *Notice of Adverse Recommendation or Action* in which to request a hearing and that request must be in writing, directed to the Medical Staff President, and sent by Special Notice.
  - (3) If the Practitioner fails to request a hearing within the time and in the manner stated above, he/she shall have waived his/her right to any procedural due process rights pursuant to this Article and the Adverse recommendation/action shall be referred to the Board for final decision. In such event, the Practitioner shall be informed of the Board's final decision by Special Notice.
  - (4) A summary of the Practitioner's hearing rights.

### 7.5.2 EXHAUSTION OF REMEDIES

If an Adverse action described in §7.3.1 is taken or recommended by the MEC or Board, the applicant or Appointee must exhaust the remedies afforded by these Bylaws before resorting to legal action. If a Practitioner resorts directly to legal



action as a result of an Adverse recommendation or action described in §7.3.1, he/she will be deemed to have waived the hearing and appeal rights of this Article.

## 7.6 SCHEDULING THE HEARING

### 7.6.1 TIME AND PLACE FOR HEARING

- (a) Upon receipt of a timely and proper request for hearing, the Medical Staff President shall deliver such request to the Hospital President and shall notify the members of the Medical Executive Committee (if the request for a hearing was prompted by an Adverse recommendation/action of the MEC) or the Board chair (if the request for hearing was prompted by an Adverse recommendation/action of the Board). Within fourteen (14) days after receipt of such request, the Medical Staff President or Board chair, as applicable, shall schedule and arrange for a hearing and notify the Hospital President and the members of the Medical Executive Committee or Board, as applicable, as to the hearing date.
- (b) The Medical Staff President shall give written notice, by Special Notice, to the Practitioner of the time, place, and date of the hearing not less than thirty (30) days prior to the date of the hearing unless such time period is waived, in writing, by the Practitioner. Such *Notice of Hearing* shall also include a list of witnesses the Medical Executive Committee (or Board as applicable) intends to call at the hearing. The *Notice of Hearing* shall further include the time frame set forth in Section 7.9.1 (a) within which the Practitioner must provide the MEC or Board, as applicable, with his/her list of witnesses and the manner in which to do so. The *Notice of Hearing* shall also outline a schedule for exchange of documents, consistent with Section 7.9.1 (b), upon which each party expects to rely at the hearing.
- (c) When a request for a hearing is received from a Practitioner who is currently under a summary suspension then in effect, the hearing shall be held as soon as the arrangements may reasonably be made provided the Practitioner waives the thirty (30) day advance notice requirement.

### 7.6.2 FAILURE TO APPEAR OR PROCEED

Under no circumstances shall the hearing be conducted without the personal presence of the Practitioner requesting the hearing. Failure of the Practitioner to personally attend and proceed with the requested hearing shall result in the Practitioner being deemed to have waived his/her rights as provided in §7.5.1(a)(3).

## 7.7 JUDICIAL REVIEW PANEL

- 7.7.1 The body whose Adverse recommendation or action gave rise to the hearing, in its sole discretion, shall determine whether the hearing will be conducted by:

- (a) A hearing officer who may be a Practitioner, an individual from outside the Hospital, (such as an attorney), or other individual qualified to conduct the hearing. The hearing officer is not required to be a Medical Staff Appointee.

OR

- (b) A hearing panel of not less than three (3) qualified individuals who may be: Practitioners with Clinical Privileges at the Hospital; other individuals affiliated with the Hospital; Practitioners or individuals not affiliated with the Hospital; or a combination thereof. When a hearing panel is utilized and when competency of the Practitioner is at issue, at least one (1) panel member should be a Practitioner working in the same specialty area as the Practitioner in question. The hearing panel shall designate one of its members as chair. A majority of the hearing panel members must be present throughout the hearing and panel deliberations.

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

7.7.3 Unless where clearly noted otherwise, for purposes of this Article, the term “Judicial Review Panel” or “JRP” shall refer to whichever option (a hearing officer or hearing panel) has been chosen from the above.

## 7.8 POSTPONEMENTS AND EXTENSIONS

7.8.1 Prior to the commencement of the hearing, the Medical Staff President, in conjunction with the triggering body, shall resolve all requests for postponements and extensions of time based upon a showing of good cause.

7.8.2 Once a hearing has commenced, the presiding officer shall resolve all requests for postponements and extensions of time based upon a showing of good cause.

## 7.9 HEARING PROCEDURE

### 7.9.1 PRE-HEARING PROCEDURE

- (a) Within ten (10) days after the Practitioner’s receipt of the Notice of Hearing, the Practitioner shall provide, by Special Notice to the Medical Staff President, a list of witnesses expected to testify on the Practitioner’s behalf.
- (b) While neither side in a hearing shall have any right to the discovery of documents, the parties shall exchange documents to be introduced at the hearing sufficiently in advance of the hearing, but in no event less than

seven (7) days prior to the hearing, in order that the parties may properly prepare.

- (c) Each party remains under a continuing obligation to provide to the other party any documents or witnesses identified after the initial exchange that a party intends to introduce at the hearing. The introduction of any documents not provided prior to the hearing, or the admissibility of testimony to be presented by a witness not so listed, shall be at the discretion of the presiding officer.
- (d) It shall be the duty of the affected Practitioner and the Medical Executive Committee or Board, as applicable, to exercise reasonable diligence in notifying the presiding 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 hearing. Objections to any pre-hearing decisions may be succinctly made at the hearing.

#### 7.9.2 REPRESENTATION

- (a) Both the Practitioner and the Medical Executive Committee or Board, as applicable, may be represented in any phase of the hearing by an attorney.
- (b) In the absence of legal counsel, the Practitioner shall be entitled to be accompanied by and represented at the hearing by another person of the Practitioner's choice provided that such individual agrees in writing to maintain the confidentiality of the peer review proceedings.
- (c) The Medical Staff President (with approval of the Medical Executive Committee) or the Board chair, as applicable, shall designate one of its members to represent the MEC or Board at the hearing.
- (d) At such time as either side is represented by legal counsel, the represented side shall give notice to the other of the name, address, and telephone number of legal counsel. Thereafter, all notices required herein may be sent to the designated legal counsel by regular mail, telefax, email, or such other method as is mutually agreed to by the parties. Each party shall be responsible for compensating its own legal counsel.

#### 7.9.3 THE PRESIDING OFFICER

- (a) The presiding officer at the hearing shall be the hearing officer or, if a hearing panel is appointed, the chair of the panel. The body whose Adverse recommendation or action gave rise to the hearing may elect, in lieu of using the hearing panel chair as the presiding officer, to appoint another qualified individual (such as an attorney) as the presiding officer. If an individual other than the hearing panel chair is selected as the presiding officer, such individual shall not be entitled to vote on the hearing panel's recommendation.

- (b) The presiding officer shall act to ensure that all participants in the hearing have a reasonable opportunity to be heard and to present all oral and documentary evidence and that decorum is maintained. He/she shall be entitled to determine the order of procedure during the hearing. He/she shall have the authority and discretion, in accordance with these Bylaws, to make all rulings on questions that pertain to matters of law, procedure, and to the admissibility of evidence.

#### 7.9.4 RECORD OF THE HEARING

- (a) The JRP shall maintain a record of the hearing by use of a court reporter. The record of hearing shall include all exhibits introduced at the hearing and all written statements submitted on behalf of the parties within the time limits set by the presiding officer.
- (b) The JRP shall require that oral evidence be taken only on oath or affirmation administered by a person designated by such body and entitled to notarize such documents in the State of Ohio. The Hospital shall be responsible for the cost of the court reporter and the Practitioner shall be obligated to pay any reasonable charges associated with the cost of obtaining a copy of the transcript of proceedings.

#### 7.9.5 RIGHTS OF BOTH SIDES

At the hearing, both sides shall have the right (as such rights may be further detailed in this Article) to:

- (a) Be present during the hearing.
- (b) Be represented by an attorney or other person of the party's choice.
- (c) Present evidence determined relevant by the presiding officer regardless of its admissibility in a court of law.
- (d) Have a record of the hearing made, copies of which may be obtained by the Practitioner upon payment of any reasonable charges associated with the preparation thereof.
- (e) Call and examine witnesses.
- (f) Introduce exhibits.
- (g) Cross-examine any witness on any matter relevant to the issues.
- (h) Impeach (challenge the credibility of) any witness.
- (i) Rebut any evidence.
- (j) Be appraised of whether the JRP will be a hearing officer or a hearing panel.

- (k) Submit a written statement at the close of the hearing.
- (l) Upon completion of the hearing, receive a copy of the written recommendation of the hearing officer/panel (including a statement of the basis for the recommendation), and the written decision of the Board (including a statement of the basis for the decision) which may be set forth in Board minutes.

#### 7.9.6 PRACTITIONER TESTIMONY

If the Practitioner does not testify in his/her own behalf at the hearing, he/she may be called and examined as if under cross-examination.

#### 7.9.7 HOSPITAL EMPLOYEES

- (a) Neither the Practitioner, nor his/her attorney, nor any other person on behalf of Practitioner shall contact a Hospital employee while the employee is working. The Practitioner (or his/her attorney or other agent) may contact the Hospital President (or legal counsel to the MEC/Board if representation is obtained) to request assistance in talking with Hospital employees.
- (b) Hospital employees will be encouraged to participate in the peer review process; however, such participation is voluntary and the Hospital shall not coerce or otherwise demand participation unless participation is part of the employee's job description. Upon request, Hospital employees may be accompanied by legal counsel (who may be the counsel that represents the MEC/Board) when meeting with the Practitioner (or his/her attorney or other agent).

#### 7.9.8 ADMISSIBILITY OF EVIDENCE

- (a) The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant evidence shall be admitted by the presiding officer if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.
- (b) Each party shall have the right to submit a memorandum concerning issues of procedure, law, or fact prior to and during the hearing.
- (c) The JRP may question the witnesses and request that additional witnesses be called if deemed appropriate.

#### 7.9.9 BASIS OF DECISION

- (a) The decision of the JRP shall be based on all of the evidence produced at the hearing. This evidence may consist of, but is not limited to, the following:

- (1) Oral testimony of witnesses.
- (2) Written memoranda/statements regarding procedure, legal, and/or medical facts and authorities presented in connection with the hearing.
- (3) Any material contained in the Medical Staff files regarding the Practitioner who is the subject of the hearing that is introduced at the hearing.
- (4) Any and all applications, references, and accompanying documents introduced at the hearing.
- (5) All officially noticed matters.
  - (i) In reaching a decision, the JRP may take official note at any time for evidentiary purposes of any generally accepted technical or scientific principles relating to the matter at hand and of any facts that may be judicially noticed by Ohio courts.
  - (ii) The parties to the hearing shall be informed of the principles or facts to be noticed and the same shall be noted in the hearing record.
  - (iii) The parties shall be given the opportunity to request that a principle or fact be officially noticed or to refute any officially noticed principle or fact by evidence or by written or oral presentation of authority in such manner as determined by the JRP/presiding officer.
- (6) Any other evidence deemed admissible by the presiding officer.

#### 7.9.10 BURDEN OF PROOF

- (a) At the hearing, the MEC or Board, as applicable, and the Practitioner may make opening statements. In all cases it shall be incumbent on the body whose Adverse recommendation or action triggered the hearing to come forward initially with evidence in support of its recommendation/action. Thereafter, the Practitioner who requested the hearing shall come forward with evidence in support of his/her position.
- (b) The MEC or Board, as applicable, shall have the right to present rebuttal witnesses following the presentation of the Practitioner's case.
- (c) The parties may make closing statements following the introduction of all of the evidence and submit written statements at the close of the hearing.
- (d) After all of the evidence has been submitted by both sides, the JRP shall rule against the Practitioner who requested the hearing unless it finds that

the Practitioner has proved, by clear and convincing evidence, that the grounds for the recommendation of the body whose Adverse recommendation/action triggered the hearing lacked any substantial factual basis or that such basis, or the conclusions drawn therefrom, was arbitrary or capricious.

#### 7.9.11 RECESS AND ADJOURNMENT

- (a) The presiding officer may recess and reconvene the hearing, without additional notice, for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation at such times and intervals as may be reasonable and warranted with due consideration for reaching an expeditious conclusion to the hearing.
- (b) Upon conclusion of the presentation of oral and written evidence the hearing shall be closed. The hearing shall not be declared finally adjourned until the JRP has received the hearing transcript and any closing written statements to be submitted by the parties, whichever is later. The JRP shall thereafter, at a time convenient to the JRP, conduct deliberations outside the presence of the parties.

#### 7.9.12 REPORT AND RECOMMENDATION OF THE JUDICIAL REVIEW PANEL

- (a) Within fifteen (15) working days after final adjournment of the hearing or such other time as is agreed to by the parties, the JRP shall render a written report and recommendation that shall be delivered to the body whose Adverse recommendation or action prompted the hearing along with a copy of the hearing record (to include all documentation introduced at the hearing and considered by the JRP).
- (b) The report shall contain a concise statement of the facts and findings supporting the recommendation being made.
- (c) Not later than its next regular meeting, the triggering body shall review the JRP's report and recommendation and shall make a final recommendation/proposed decision in which it shall affirm, modify, or reverse its initial Adverse recommendation/action. It shall forward its final recommendation/action to the Hospital President.
  - (1) When the MEC's final recommendation is favorable to the Practitioner, the Board may adopt or reject all, or any portion, of the MEC's recommendation or refer the matter back to the MEC for additional consideration. Any such referral shall state the reason(s) for the requested reconsideration, set a time limit within which a subsequent recommendation must be made, and may include a directive that an additional hearing be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation, and any new evidence in the matter, the Board shall take action.

- (2) A favorable determination by the Board (whether as the triggering body or in affirmance of a favorable recommendation by the MEC) shall be effective as the Board's final decision and the matter shall be considered closed.
- (3) If the final recommendation of the MEC or the proposed decision of the Board is Adverse to the Practitioner after exhaustion of his/her hearing rights, the Practitioner shall be entitled, upon timely and proper request, to an appellate review before a final decision is rendered on the matter by the Board.
- (d) Upon receipt of the final recommendation/action, the Hospital President shall forward a copy of the same (which may be set forth in meeting minutes), together with the JRP's report and recommendation (including a statement of the basis therefore), to the affected Practitioner. In the event of an Adverse result, the notice shall also inform the Practitioner of his/her right to request an appellate review by the Board (as set forth in §7.10) before a final decision regarding the matter is rendered. If the report and recommendation continues to be Adverse, no documents shall be forwarded to the Board until the affected Practitioner has either waived his/her right to appeal to the Board or has requested an appeal pursuant to §7.10.

## 7.10 APPEALS TO THE BOARD

### 7.10.1 REQUEST FOR APPEAL

- (a) Within ten (10) working days after receipt of notice of an affirmed Adverse recommendation/decision by the triggering body, the affected Practitioner may request an appellate review by the Board.
- (b) If the Practitioner requests appellate review, the request must be delivered, by Special Notice, to the Hospital President with a brief statement as to the grounds for appeal. If the Practitioner wishes an attorney to represent him/her at any appellate review appearance permitted, his/her request for appellate review shall so state. The request shall also state whether the Practitioner wishes to present oral arguments to the appellate review body.
- (c) A Practitioner who fails to request an appellate review in the manner and within the time period set forth in subsections (a) and (b) waives any right to such review and the matter shall thereafter be presented to the Board at its next regularly scheduled meeting for a final decision.

### 7.10.2 GROUNDS FOR APPEAL

- (a) The grounds for appeal from the hearing shall be:
  - (1) Substantial failure of the JRP or the triggering body to comply with the procedures required by the Bylaws in the conduct of the hearing so as to deny procedural due process and a fair hearing.



- (2) Action taken arbitrarily, capriciously, or with prejudice.
- (3) The decision was not supported by substantial, credible evidence based upon the hearing record.

### 7.10.3 TIME, PLACE, AND NOTICE

In the event of a timely and proper request for appeal, the Board shall schedule and arrange for an appellate review. The Board shall cause the Practitioner to be given notice of the time, place, and date of the appellate review. The date of the appellate review shall be not less than fourteen (14) days from the date of receipt of the request; provided, however, that when a request for appellate review is from a Practitioner who is under summary suspension which is then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made provided the Practitioner waives the fourteen (14) day advance notice requirement. The time for appellate review may be extended by the chair of the Board, for good cause, provided the rights of either party will not be impaired.

### 7.10.4 NATURE OF APPELLATE REVIEW

- (a) The Board shall determine whether the appellate review shall be conducted by the Board as a whole or by an *ad hoc* or standing Board committee. If a Board committee is appointed, one (1) of its members shall be designated as chair by the Board chair. The chair of the appellate review body shall preside over the appellate review including determining the order of procedure, making all required rulings, and maintaining decorum during all proceedings. A majority of the appellate review body must be present throughout the appellate review and deliberations.
- (b) The proceedings by the review body shall be in the nature of an appellate review based upon the record of the hearing before the JRP, the JRP's report and recommendation, and all subsequent actions therefrom.
- (c) The appellate review body shall also consider any written statements or oral arguments permitted. Each party shall have the right to present a written statement in support of its position. Such statement must be submitted to the Hospital President with a copy to the opposing party not less than seven (7) days prior to the review date or by such date as is otherwise designated by the appellate review body. At the discretion of the appellate review body, each party may be permitted to present oral arguments.
- (d) The Practitioner and members of the appellate review body shall have access to the hearing record, the reports and recommendations of the JRP and the MEC or Board, as applicable, and all material, favorable or unfavorable, that was introduced at the hearing and considered in making the Adverse recommendation or taking the Adverse action against the Practitioner.

### 7.10.5 CONSIDERATION OF NEW OR ADDITIONAL EVIDENCE

- (a) If a party wishes to introduce new/additional evidence not raised or presented during the original hearing and not otherwise reflected in the record, the party must make such request in writing at the time he/she submits a request for appellate review pursuant to §7.10-1.
- (b) The party may introduce such evidence at the appellate review only if expressly permitted by the appellate review body, in its sole discretion, and only upon a clear showing by the party requesting consideration of the evidence that it is new, relevant evidence not previously available at the time of the hearing or that a request to admit relevant evidence was previously erroneously denied.
- (c) In the exceptional circumstance where the appellate review body determines to hear such evidence, the appellate review body shall further have the ability to recess appellate review and remand the matter back to the JRP.
- (d) In such event, the hearing shall be reopened as to this evidence only and the evidence shall be subject to submission and cross-examination and/or counter-evidence.
- (e) The JRP shall then prepare a supplemental report and submit it to the triggering body. The triggering body will then notify the appellate review body, in writing, through the Hospital President as to whether the triggering body will or will not be amending its recommendation or action and the nature of the amendment or reason for non-amendment.
- (f) The Hospital President shall then provide a copy of the JRP's supplemental report and the triggering body's recommendation/action to the Practitioner and the appellate review process shall recommence.

#### 7.10.6 RECESSES, POSTPONEMENTS, EXTENSIONS, AND ADJOURNMENT

- (a) During the appellate review procedure, postponements and extensions of time beyond the times expressly permitted in these Bylaws may be requested by either party and may be permitted by the appellate review body, or its chair, on a showing of good cause provided the rights of either party will not be impaired.
- (b) The appellate review body, or its chair, may recess the appellate review proceeding and reconvene the same, without additional notice, if such recess is deemed necessary for the convenience of the participants, to obtain new/additional evidence, or for consultation.
- (c) The appellate review shall be closed upon conclusion of oral statements, if permitted. The appellate review body shall then deliberate outside the presence of the parties at such time and in such location as is convenient. The appellate review shall be adjourned at the conclusion of the appellate review body's deliberations.

#### 7.10.7 ACTION FOLLOWING ADJOURNMENT OF APPELLATE REVIEW

- (a) If the appellate review is conducted by the Board as a whole, it may affirm, modify, or reverse its prior decision; accept or reject the recommendation of the MEC; or refer the matter back to the MEC for further review and recommendation. Such referral may include a request that the MEC arrange for a further hearing to resolve disputed issues and a specified time period in which to do so and report back to the Board.
- (b) If the appellate review is conducted by a Board committee, such committee shall, within ten (10) days after adjournment of the appellate review, issue a written report recommending that the Board affirm, modify, or reverse its prior decision; accept or reject the recommendation of the MEC; or, refer the matter back to the MEC for further review and recommendation. Such referral may include a request that the MEC arrange for a further hearing to resolve disputed issues and a specified time period in which to do so and report back to the Board.

#### 7.10.8 FINAL DECISION OF BOARD

- (a) Within thirty (30) days after adjournment of the appellate review (or such other time as agreed upon by the parties) the Board shall reach a decision.
  - (1) If this decision is in accordance with the MEC's last recommendation, or the Board's last action in the matter, it shall be immediately effective and final and shall not be subject to further hearing or appellate review.
  - (2) If this decision is contrary to the MEC's last recommendation, or the Board's last action in the matter, the Board shall refer the matter to the Joint Conference Committee prior to issuing notice of its final decision. This committee shall make its written recommendation to the Board within ten (10) days of receipt of the Board's request. The Board shall then make its final decision. The Board's final decision shall be immediately effective, and the matter shall not be subject to any further referral or review.
- (b) The Hospital President will promptly send a copy of the Board's written decision, with a statement of the basis for the decision, (which decision/basis may be set forth in Board minutes) to the affected Practitioner, by Special Notice, and to the Medical Staff President/MEC.
- (c) The Hospital President shall report any final action taken by the Board pursuant to these Bylaws to the appropriate authorities as required by law and in accordance with applicable Hospital procedures regarding the same.

7.11 RIGHT TO ONE HEARING ONLY

Except as otherwise provided in this Article, no Practitioner shall be entitled as a matter of right to more than one (1) evidentiary hearing and one (1) appeal to the Board on any matter which may be the subject of a hearing and appeal without regard to whether such subject is a result of action by the Medical Executive Committee or the Board or a combination of acts of such bodies.

7.12 WAIVER

If at any time after receipt of notice of an Adverse recommendation, action, or result, the affected Practitioner fails to satisfy a request, make a required appearance, or otherwise comply with this Article, he/she shall be deemed to have voluntarily waived all rights to which he/she might otherwise have been entitled with respect to the matter involved.

7.13 RELEASE

By requesting a hearing or appellate review under these Medical Staff Bylaws, the Practitioner agrees to be bound by the provisions set forth in Article XII regarding confidentiality, reporting immunity, and release of liability.

## ARTICLE VIII

### MEDICAL STAFF OFFICERS

#### 8.1 IDENTIFICATION

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

#### 8.2 QUALIFICATIONS

##### 8.2.1 Officers must:

- (a) Be Appointees to the active Medical Staff at the time of their nomination and election/succession, and must remain active Appointees in Good Standing during their term of office.
- (b) Be Practitioners who demonstrate executive and administrative ability through experience and prior participation in Medical Staff leadership activities at the Hospital.
- (c) Have at least two (2) years of continuous active Medical Staff appointment maintained in Good Standing during his/her tenure at the Hospital.

#### 8.3 NOMINATIONS

##### 8.3.1 A Nominating Committee shall be composed of:

- (a) The Medical Staff officers
- (b) One (1) elected member of the MEC selected by the Medical Staff President
- (c) The chair of the Department Chairs Committee
- (d) The Chief Medical Officer

8.3.2 Nominations for the office of Medical Staff Vice President may be made by any Appointee eligible to vote provided that the name of the candidate is submitted, in writing, to the chair of the Nominating Committee at least ten (10) days prior to the election, is endorsed by the signature of at least ten (10) Appointees who are eligible to vote, and bears the candidate's written consent.

8.3.3 The Nominating Committee shall meet in a timely manner prior to the election and accept nominations as outlined in §8.3.2 above. There shall be no less than two (2) nominations for the office of Medical Staff Vice President. In the event not enough nominations are received to meet this requirement, the Nominating Committee shall be charged with identifying suitable candidates for the office.

8.3.4 A complete list of qualified nominees for the office of Medical Staff Vice President shall be mailed to each Appointee eligible to vote with notice of the election.

8.3.5 At any one (1) time, the Medical Staff President and Vice President shall not be from the same Department.

#### 8.4 ATTAINMENT OF OFFICE

8.4.1 The Medical Staff President attains office through automatic succession following completion of his/her term as Medical Staff Vice President.

8.4.2 The Past Medical Staff President attains office through automatic succession following completion of his/her term as Medical Staff President.

8.4.3 The office of Medical Staff Vice President is an elected position.

(a) Election of the Medical Staff Vice President shall be held every other year. Only Appointees accorded the Prerogative to vote shall be eligible to vote. Voting shall be by electronic ballot. Election to the position shall be dependent upon receiving a plurality of the votes cast by the voting members of the Medical Staff and received by the deadline date set forth in the notice advising of the purpose for which the vote is to be taken.

(b) If there is a tie vote on the first ballot, a runoff election shall be held at the annual Medical Staff meeting between the two candidates who tied. The candidate receiving the greatest number of votes shall then be elected.

#### 8.5 TERM OF OFFICE

8.5.1 Each officer shall serve a two (2) year term, commencing on the first day of the calendar year following his/her election/automatic succession.

8.5.2 Each officer shall serve until the end of his/her term and until a successor is elected (in the case of the Medical Staff Vice President) or assumes office (in the case of the automatic succession of the Medical Staff President and Past Medical Staff President), unless he/she resigns or is removed from office.

8.5.3 With the limited exceptions set forth in §8.6.2 and §8.6.3, officers may not serve in more than one (1) office at a time.

#### 8.6 VACANCY

8.6.1 In the event that the Medical Staff President position becomes vacant, the Vice President shall assume the position of President for the duration of the term. The Vice President shall thereafter serve his/her term as Medical Staff President.

8.6.2 In the event that the Vice President position becomes vacant, the Medical Executive Committee, at its next regularly scheduled meeting or at any special meeting called for this purpose, shall select a qualified active Medical Staff Appointee to serve in the vacant position for the duration of the term. In the interim, the Past Medical Staff President shall assume the duties of the Vice President.

8.6.3 In the event the office of President and Vice President become vacant simultaneously, the Medical Executive Committee, at its next regularly scheduled meeting or at any special meeting called for this purpose, shall select qualified active Medical Staff Appointees to serve in the vacant positions for the duration of the term. In the interim, the Past President shall assume the duties of the President and Vice President.

## 8.7 RESIGNATION & REMOVAL OF OFFICERS

### 8.7.1 RESIGNATION

- (a) A Medical Staff officer may resign his/her position at any time by providing written notice to the Medical Executive Committee. Such resignation shall take effect on the date of receipt or at any later time specified in the written resignation notice.

### 8.7.2 REMOVAL

- (a) Except as otherwise provided, removal of a Medical Staff officer may be initiated by any one (1) or more of the following:
  - (1) The Medical Executive Committee acting on its own recommendation; or
  - (2) A petition signed by twenty-five percent (25%) of the active Medical Staff Appointees; or
  - (3) A recommendation from the Board.
- (b) Removal may be accomplished by a majority vote of the active Medical Staff Appointees present at any regular or special meeting at which a minimum of at least 100 active Appointees are present. The officer who is the subject of the removal action shall be given ten (10) days prior written notice of a meeting at which a vote on removal shall be taken. The officer shall be afforded the opportunity to speak on his/her own behalf prior to proceeding with a vote regarding the officer's removal.
- (c) Permissible grounds for removal of a Medical Staff officer shall include:
  - (1) Failure to perform the duties of the position held in a timely and appropriate manner.
  - (2) Imposition of an automatic suspension, a summary suspension, or a corrective action investigation pursuant to these Bylaws resulting in a final Adverse decision.
  - (3) Conduct or statements disparaging or damaging to the best interests of the Medical Staff or the Hospital or to their goals, programs, or public image.

- (4) A condition or situation that renders an officer incapable of fulfilling the duties of the office.
- (d) Failure to remain an active Appointee during his/her term of office; or, the imposition of an automatic termination of Medical Staff appointment and Privileges shall result in automatic removal of the Practitioner from his/her office.
- (e) Removal from office shall not entitle the affected Practitioner to any hearing or appeal rights regarding the issue of removal.

## 8.8 DUTIES OF OFFICERS

### 8.8.1 PRESIDENT OF THE MEDICAL STAFF

The Medical Staff President shall serve as the chief officer of the Medical Staff. The duties of the Medical Staff President shall include, but not be limited to:

- (a) Being accountable to the Board, in conjunction with the Medical Executive Committee, for the quality and efficiency of clinical services provided within the Hospital and for the effectiveness of quality assurance and other quality review, evaluation, and monitoring functions delegated to the Medical Staff by means of regular reports and recommendations based on the results of those activities.
- (b) Aiding in coordinating the activities of the Hospital administration and of nursing and other patient care services with those of the Medical Staff.
- (c) Communicating and representing the opinions, policies, concerns, and needs of the Medical Staff to the Board, the Hospital President, and other officials as appropriate.
- (d) Being responsible for the enforcement of the Medical Staff Bylaws and Policies, for implementation of sanctions where indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested and initiated against a Practitioner.
- (e) Calling, presiding at, and being responsible for the agenda of all general and special meetings of the Medical Staff.
- (f) Serving as chair of the Medical Executive Committee, the Medical Staff Cabinet, and as an *Ex Officio* member of all other Medical Staff committees.
- (g) Selecting, subject to notification to the Medical Executive Committee, Medical Staff committee members and chairs unless otherwise provided in the Medical Staff Bylaws or Policies.



- (h) Assuming all duties of the Past Medical Staff President commencing on the first day of the calendar year following completion of his/her term as Medical Staff President.

#### 8.8.2 MEDICAL STAFF VICE PRESIDENT

The Medical Staff Vice President shall serve as the deputy chief officer of the Medical Staff. The duties of the Vice President include, but are not limited to:

- (a) Assisting the Medical Staff President as directed in carrying out the duties identified in §8.8-1.
- (b) Serving as a member of the Medical Executive Committee.
- (c) Serving as a member of the Credentialing Committee of the Board and as a Medical Staff representative to such other Medical Staff, Hospital, and/or Board committees as appropriate.
- (d) Assuming all duties of the Medical Staff President in case of a temporary absence of the President; and, in the case of a permanent absence or removal of the President, assuming the duties of the President as set forth in §8.6.1.
- (e) Assuming all duties of the Medical Staff President commencing on the first day of the calendar year following completion of his/her term as Vice President.
- (f) Supervising the following tasks: proper notice of all Medical Staff meetings and preparation of minutes for all Medical Executive Committee and Medical Staff meetings; notification of all Appointees of proposed amendments to these Bylaws and of substantive amendments to the Medical Staff Policies; and, the collection and accounting of any funds that may be collected in the form of Medical Staff dues and assessments.

#### 8.8.3 PAST MEDICAL STAFF PRESIDENT

The Past Medical Staff President shall serve in a consulting capacity to the other officers of the Medical Staff providing continuity and advice. The duties of the Past Medical Staff President include, but are not limited to:

- (a) Assisting and advising the officers of the Medical Staff concerning their duties and responsibilities.
- (b) Serving as a member of the Medical Executive Committee.

#### 8.9 MEDICAL STAFF REPRESENTATIVES TO BOARD

Candidates for Medical Staff representation on the Board shall be selected by a process determined by the Medical Staff Cabinet. A Physician will serve on the System Committee on Governance providing formal evaluation of potential Physician representatives to the Board.

## ARTICLE IX

### CLINICAL DEPARTMENTS

#### 9.1 ORGANIZATION OF CLINICAL DEPARTMENTS

9.1.1 The Medical Staff shall be divided into clinical Departments. Each Department shall be organized as a separate component of the Medical Staff and shall have a chair selected and entrusted with the authority, duties, and responsibilities specified in §9.7.

9.1.2 The current Medical Staff Departments are:

- (a) Department of Anesthesia
- (b) Department of Cardiovascular Disease
- (c) Department of Emergency Medicine
- (d) Department of Family Medicine
- (e) Department of Medicine
- (f) Department of Obstetrics and Gynecology
- (g) Department of Orthopaedics
- (h) Department of Pathology/Laboratory Medicine
- (i) Department of Psychiatry
- (j) Department of Radiology
- (k) Department of Surgery
- (l) Department of Urology

9.1.3 A Department may be further divided into Medical Staff Divisions in order to carry out its functions.

9.1.4 The Medical Executive Committee and Board must approve the creation, elimination, modification, or combination of Departments and their Divisions.

#### 9.2 ASSIGNMENT TO DEPARTMENTS AND DIVISIONS

9.2.1 Each Practitioner shall be assigned to the Department/Division that most appropriately reflects the Practitioner's professional education, training, experience, and current clinical practice.

9.2.2 A Practitioner may be assigned to more than one Department and Division based upon the Clinical Privileges granted to the Practitioner.

### 9.3 FUNCTIONS OF DEPARTMENTS

9.3.1 The general functions of the Medical Staff Departments are as set forth in the Medical Staff Organization Policy.

### 9.4 DEPARTMENT CHAIR

#### 9.4.1 QUALIFICATIONS

Each Department shall have a chair who shall be an active Appointee with appropriate Clinical Privileges who is qualified by training, experience, and demonstrated ability in at least one (1) of the clinical areas within the Department. Each Department Chair shall have and maintain certification by an appropriate specialty board or demonstrate comparable competence affirmatively established through the credentialing process.

#### 9.4.2 SELECTION

- (a) Permanent Department Chairs shall be selected by a search committee appointed by the Board chair. The voting members of a Department may recommend, by majority vote, internal candidates for consideration by the Board appointed Department Chair search committee. A Department Chair shall serve until he/she resigns or is removed from his/her position.
- (b) Interim Department Chairs shall be selected jointly by the Medical Staff President, the Medical Staff Vice President, the Chief Medical Officer, and the Hospital President.
- (c) Selection of an interim or permanent Department Chair shall be subject to the review and recommendation of the Medical Executive Committee by majority vote at its next regularly scheduled meeting at which a quorum is present.
- (d) Selection of an interim or permanent Department Chair shall be subject to approval by the Board.

### 9.5 RESIGNATION & REMOVAL OF DEPARTMENT CHAIRS

#### 9.5.1 RESIGNATION

A Department Chair may resign his/her position at any time by providing written notice to the Medical Executive Committee. Such resignation shall take effect on the date of receipt or at any later time specified in the written resignation notice.

#### 9.5.2 REMOVAL

- (a) Except as otherwise provided, removal of a Department Chair may be initiated:

- (1) By a petition signed by at least twenty-five percent (25%) of the applicable Department members eligible to vote; OR,
  - (2) Upon recommendation of the Medical Executive Committee; OR,
  - (3) Upon recommendation of the Board.
- (b) Removal may be accomplished:
- (1) By a two-thirds (2/3) written vote of the applicable Department members eligible to vote and present at any regular or special Department meeting at which a majority is present subject to subsection (d) below.
  - (2) By a two-thirds (2/3) written vote of the Medical Executive Committee at any regular or special meeting at which a quorum is present subject to subsection (d) below.
  - (3) By majority vote of the Board at a meeting at which a quorum is present.
- (c) The Department Chair who is the subject of the removal action shall be given ten (10) days prior written notice of a meeting at which a vote on removal shall be taken. The Department Chair shall be afforded the opportunity to speak on his/her own behalf prior to proceeding with a vote regarding the Department Chair's removal.
- (d) Removal of a Department Chair shall not be effective until ratified by the Board.
- (e) Permissible grounds for removal of a Department Chair shall include:
- (1) Failure to continuously satisfy the qualifications for the position; provided, however, that failure to remain an active Appointee with Privileges during the term of his/her position shall be addressed pursuant to subsection (f) below.
  - (2) Failure to perform the duties of the position held in a timely and appropriate manner.
  - (3) Imposition of an automatic suspension, a summary suspension, or a corrective action investigation pursuant to these Bylaws resulting in a final Adverse action.
  - (4) Conduct or statements disparaging or damaging to the best interests of the Medical Staff or Hospital or to their goals, programs, or public image.
  - (5) A condition or situation that renders a Practitioner incapable of fulfilling the duties of the Department Chair position.

- (f) Failure to remain an active Appointee with Privileges during the term of his/her position; or, the imposition of an automatic termination of Medical Staff appointment and Privileges shall result in automatic removal of the Practitioner from his/her position.
- (g) Removal from a Department Chair position shall not entitle the removed Appointee to any hearing or appeal rights regarding the issue of removal.

#### 9.6 VACANCIES IN A DEPARTMENT CHAIR POSITION

Any vacancy that occurs in a Department Chair position shall be filled on an interim basis in the manner provided in §9.4.2(b). An interim Department Chair shall serve until such time as a new permanent Department Chair is selected.

#### 9.7 DUTIES OF DEPARTMENT CHAIR

9.7.1 Each Department Chair shall have the following authority, duties, and responsibilities.

- (a) Overseeing all clinically related activities of the Department.
- (b) Overseeing all administratively related activities of the Department, unless otherwise provided for by the Hospital, including assisting in the preparation of administrative reports such as budgetary and strategic planning pertaining to the Department as may be required by the Medical Executive Committee.
- (c) Integration of the Department into the primary functions of the Hospital.
- (d) Coordination and integration of interdepartmental and intradepartmental services.
- (e) Assisting with development and implementation of policies and procedures that guide and support the provision of care, treatment, and services.
- (f) Continuing surveillance of the professional performance of all individuals who have delineated Clinical Privileges in the Department.
- (g) Recommending to the Medical Executive Committee the criteria for Clinical Privileges in the Department.
- (h) Recommending Clinical Privileges for each member of the Department.
- (i) Determining the qualifications and competence of Advanced Practice Providers who are granted Clinical Privileges within the respective Department.
- (j) Continuous assessment and improvement of the quality of care, treatment, and services provided including improving organization performance activities within their Department, intra/inter-disciplinary monitoring and

evaluation of patient care, and collaboration with other Medical Staff Departments and Hospital departments as necessary.

- (k) Maintenance of quality control programs, as appropriate.
- (l) Orientation and continuing education of all persons in the Department.
- (m) Making recommendations for space and other resources needed by the Department.
- (n) Assessing and recommending to the relevant Hospital authority off-site sources for needed patient care, treatment, and services not provided by the Department or Hospital.
- (o) Acting as presiding officer at Department meetings and maintaining an accurate record of all proceedings of the Department.
- (p) Reporting to the Medical Executive Committee and to the Medical Staff President regarding all professional and administrative activities within the Department.
- (q) Being a member of the Medical Executive Committee, and giving guidance on the overall medical policies of the Medical Staff and Hospital, and making specific recommendations and suggestions regarding his/her Department including recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and/or services.
- (r) Enforcing:
  - (1) The Medical Staff Bylaws and Policies.
  - (2) Hospital policies and procedures.
- (s) Monitoring research activities within the Department.
- (t) In concert with the Vice President of Medical Education, assisting in the development, implementation, and monitoring of graduate medical education.

## ARTICLE X

### MEDICAL STAFF COMMITTEES

#### 10.1 DESIGNATION

10.1.1 The standing committees of the Medical Staff shall be the Medical Executive Committee and such other committees as set forth in these Bylaws and the Medical Staff Policies.

10.1.2 Special or *ad hoc* committees may be created by the Medical Executive Committee to perform specified tasks.

10.1.3 All Medical Staff committees shall be responsible to the Medical Executive Committee unless otherwise specified in the Medical Staff Bylaws or Policies.

#### 10.2 MEDICAL EXECUTIVE COMMITTEE

##### 10.2.1 COMPOSITION

(a) The Medical Executive Committee shall consist of the following voting members; and, at all times, a majority of the voting members shall be active Physician Appointees:

- (1) The Medical Staff President who shall chair the MEC.
- (2) The Medical Staff Vice President
- (3) Chairs of the Departments
- (4) Four (4) At-Large Representatives to the Medical Staff. (See §10.2.2(d))
- (5) One (1) young Physician At-Large Representative to the Medical Staff. (See §10.2.2(e))
- (6) The immediate past Medical Staff President
- (7) The Chief Medical Officer The Vice President of Medical Education

(b) The Medical Executive Committee shall consist of the following *Ex Officio* non-voting members:

- (1) The Hospital President and System CEO
- (2) Other representatives as appointed at the discretion of the chair of the Medical Executive Committee.

##### 10.2.2 SELECTION & REMOVAL OF MEDICAL EXECUTIVE COMMITTEE MEMBERS

- (a) The officers of the Medical Staff shall be selected in accordance with §8.4 and removed in accordance with §8.7.2.
- (b) The Department Chairs shall be selected in accordance with §9.4.2 and removed in accordance with §9.5.2.
- (c) No Practitioner may serve as both a Department Chair and as an officer of the Medical Staff or in an At-Large position at the same time. No more than two (2) of the members, elected by the active Medical Staff, serving on the Medical Executive Committee at any one (1) time shall be from the same Department (not including the young Physician At-Large Representative). At any one time, the Medical Staff President and Vice President may not be from the same Department.
- (d) At-Large Representatives
  - (1) The four (4) At-Large Representatives shall meet the same qualifications as set forth in §8.2.
  - (2) At-Large Representatives shall be nominated in the same manner as described in §8.3 of these Bylaws for the nomination of the Medical Staff Vice President.
  - (3) Election of two (2) At-Large Representatives shall be held every year. Only Appointees accorded the Prerogative to vote shall be eligible to vote. Voting shall be by electronic ballot.
  - (4) Election to the first position shall be dependent upon receiving a plurality of the votes cast by the voting members of the Medical Staff and received by the deadline date set forth in the notice advising of the purpose for which the vote is to be taken.
    - (i) If there is a tie vote between the Practitioners receiving the highest number of votes and provided the Practitioners are from different Departments, then the Practitioners who tie shall be awarded the two (2) At-Large Representative seats.
    - (ii) If there is a tie vote between Practitioners receiving the highest number of votes and the Practitioners are from the same Department, a runoff election shall be held at the annual Medical Staff meeting between the candidates who tied. The candidate receiving the greatest number of votes shall then be elected to the first At-Large Representative seat.
  - (5) Subject to subsection (d)(4)(i) and (ii) above, election to the second position shall be awarded to the Practitioner (who shall be from a different Department than the Practitioner elected to the first seat) receiving the next highest number of votes cast by the voting



members of the Medical Staff and received by the deadline date set forth in the notice advising of the purpose for which the vote is to be taken. If there is a tie vote between Practitioners receiving the next highest number of votes, a runoff election shall be held at the annual Medical Staff meeting between the candidates who tied.

- (6) At-Large Representatives shall serve overlapping two (2) year terms on the Medical Executive Committee.
  - (7) No more than one (1) At-Large Representative serving on the Medical Executive Committee at any one (1) time shall be from the same Department.
  - (8) At-Large Representatives may resign or be removed in the same manner as described in §8.7 for the resignation/removal of Medical Staff officers.
  - (9) Vacancy in an At-Large Representative position shall be filled in in the same manner in which the original selection is made.
- (e) Young Physician At-Large Representative
- (1) To be qualified to run for this position, a candidate shall have completed his/her medical training within the preceding five (5) years and shall be a Physician Appointee to the active Medical Staff for less than five (5) years at the time of election.
  - (2) The young Physician At-Large Representative shall be nominated and elected in the same manner as described in §8.3 and §8.4.3 of these Bylaws for nomination and election of the Medical Staff Vice President.
  - (3) The young Physician At-Large Representative shall serve a one (1) year term on the Medical Executive Committee.
  - (4) The young Physician At-Large Representative may resign or be removed in the same manner as described in §8.7 for resignation/removal of Medical Staff officers.
  - (5) Vacancy in the young Physician At-Large Representative position shall be filled in the same manner in which the original selection was made.

### 10.2.3 QUORUM

At all meetings of the Medical Executive Committee, a simple majority of the committee's voting membership shall constitute a quorum for the transaction of business. The affirmative vote of a majority of the MEC members present at any meeting at which there is a quorum shall be necessary to act, except as otherwise provided in these Bylaws and the Medical Staff Policies.

#### 10.2.4 DUTIES

The duties of the Medical Executive Committee shall include, but are not limited to:

- (a) Representing and acting on behalf of the Medical Staff in the intervals between Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws.
- (b) Making recommendations to the Board regarding Medical Staff appointment/reappointment, grant/regrant of Privileges, and termination of appointment and/or Privileges.
- (c) Reviewing Bylaws and Medical Staff Policies and recommending amendments to same.
- (d) Requesting evaluations of Practitioners and Advanced Practice Providers when there is doubt about the individual's ability to safely and competently perform the Privileges requested.
- (e) Coordinating and implementing the professional and organizational activities of Medical Staff Departments and committees.
- (f) Receiving and acting upon reports and recommendations from Departments, subdivisions, committees, and any other appropriate groups.
- (g) Recommending action to the Board and/or Hospital President on matters of a medical-administrative nature.
- (h) Recommending and enforcing the mechanism to review credentials and delineation of individual Clinical Privileges, the organization of quality assurance activities and mechanisms, corrective action and fair hearing procedures, as well as other matters relevant to the operation of an organized Medical Staff.
- (i) Evaluating the medical care rendered to patients in the Hospital.
- (j) Participating in the development of Medical Staff and Hospital policies, practices, and planning.
- (k) Promoting ethical conduct and competent clinical performance on the part of all Practitioners and APPs including the initiation of and participation in Medical Staff corrective action or review measures when warranted.
- (l) Developing continuing education activities and programs for the Medical Staff.
- (m) Designating such committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the Medical Staff and reviewing appointments to those committees by the Medical Staff President.

- (n) Reporting to the Medical Staff at each regular Medical Staff meeting.
- (o) Assisting in obtaining and maintaining accreditation of the Hospital.
- (p) Developing and maintaining methods for the protection and care of patients and others in the event of internal or external disaster.
- (q) Advising administration and the Board of actions taken that could affect the operations of the Hospital.
- (r) Developing and adopting policies and procedures to identify and separately manage matters of individual Practitioner/APP health apart from the Medical Staff corrective action function. The policies and procedures shall be designed to: provide (either through internal process or by referral to a Practitioner/APP wellness program approved by the Medical Executive Committee) education about Practitioner/APP health; address prevention of physical, psychiatric, or emotional illness; and facilitate confidential diagnosis, treatment, and rehabilitation of Practitioners/APPs who suffer from a potentially impairing condition.
- (s) Advising the Board as to the Medical Executive Committee's recommendation as to whether to execute an exclusive contract in a previously open clinical service; to renew or modify an exclusive contract in a particular clinical service; or to terminate an exclusive contract in a particular service.
- (t) Communicating the actions of the Medical Executive Committee as appropriate.

#### 10.2.5 MEETINGS

- (a) Regular Meetings
  - (1) The Medical Executive Committee, in regular, special, or executive session, shall meet as often as necessary but at least eight (8) times per year and shall maintain a record of its proceedings and actions.
  - (2) All regular meetings of the Medical Executive Committee shall be called by the chair and notice of such regular meeting shall be provided to each Medical Executive Committee member.
  - (3) Attendance at meetings of the Medical Executive Committee is mandatory. A member of the Medical Executive Committee may send another active Appointee as a designee, and he/she shall have the same rights as the committee member. The Medical Executive Committee must be informed of any such designee at the beginning of the meeting.
- (b) Special Meetings

- (1) Special meetings may be held for any purpose identified within these Bylaws or for any other purpose appropriate to the Medical Staff.
- (2) Special meetings may be called by the chair or by four (4) or more members of the Medical Executive Committee.
- (3) Notice of such special meetings shall be provided to all members of the Medical Executive Committee at least two (2) days prior to such a meeting unless such notice is waived by the member by attendance at the meeting or waived by written waiver to the Medical Staff Office.
- (4) No business shall be transacted at any special Medical Executive Committee meeting except that stated in the notice calling the meeting.

## ARTICLE XI

### MEETINGS OF THE MEDICAL STAFF, DEPARTMENTS/DIVISIONS, AND MEDICAL STAFF COMMITTEES

#### 11.1 GENERAL INFORMATION

11.1.1 Requirements with respect to meetings of the Medical Staff, Department/Divisions, and standing Medical Staff committees are set forth in the Medical Staff Organization Policy as such policy may be amended from time to time.

11.1.2 Information regarding meetings of the Medical Executive Committee are set forth in Article X of these Medical Staff Bylaws.

11.1.3 Information regarding meetings of the Nominating Committee are set forth in Section 8.3 of these Medical Staff Bylaws.

## ARTICLE XII

### CONFIDENTIALITY, IMMUNITY, AND RELEASES

#### 12.1 SPECIAL DEFINITIONS

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

- (a) Information: Any record of proceedings, minutes, records, reports, memoranda, statements, recommendations, data, and other disclosures whether in written or oral form relating to any of the subject matters specified in §12.6
- (b) Representative: The Board and any officer, director, or committee or delegated representative thereof; the Hospital President or his/her designee; the Medical Staff organization and any Appointee, officer, Department or committee thereof; and any individual authorized by any of the foregoing to perform specific information gathering or disseminating functions.
- (c) Third Parties: Any and all individuals and organizations providing information to any Representative.

#### 12.2 AUTHORIZATIONS AND CONDITIONS

12.2.1 By applying for or exercising Medical Staff appointment/reappointment and/or Clinical Privileges within this Hospital, a Practitioner:

- (a) Authorizes Representatives to solicit, provide, and act in accordance with these Bylaws and the Medical Staff Policies upon Information bearing upon the Practitioner's professional ability and qualifications.
- (b) Agrees to be bound by the provisions of this Article and to waive all legal claims against any Representative who acts in accordance with the provisions of this Article.
- (c) Acknowledges that the provisions of this Article are express conditions to his/her application for, and acceptance of, Medical Staff appointment/reappointment and grant/regrant of Clinical Privileges at this Hospital.

#### 12.3 CONFIDENTIALITY OF INFORMATION

Information with respect to any Practitioner submitted, collected, or prepared by any Representative of this Hospital or representative of any other health care facility or organization or medical staff for the purpose of: achieving and maintaining quality patient care; evaluating, monitoring, and improving patient care; reducing morbidity and mortality; evaluating the qualifications and clinical competence/performance of a

Practitioner or acting upon matters relating to corrective action; contributing to teaching or clinical research activities; or determining that healthcare services were professionally indicated and performed in accordance with the applicable standards of care shall, to the fullest extent permitted by law, be confidential. Such information shall not be disclosed or disseminated to anyone other than a Representative nor be used in any way except as provided herein or except as otherwise required/permitted by law. Such confidentiality shall also extend to Information of like kind that may be provided by/to any Third Parties engaged in an official, authorized activity for which the Information is needed. The Information so provided shall not become part of any particular patient's medical record or general Hospital records, but will remain in the Practitioner's peer review file.

#### 12.4 BREACH OF CONFIDENTIALITY

It is expressly acknowledged by each Practitioner that violation of the confidentiality provisions provided herein is grounds for corrective action pursuant to the procedure set forth in these Bylaws.

#### 12.5 IMMUNITY FROM LIABILITY

##### 12.5.1 FOR ACTION TAKEN

Each Representative shall be exempt, to the fullest extent permitted by law, from liability to any Practitioner for damages or other relief for any action taken or statements or recommendations made within the scope of his/her duties as a Representative provided that such Representative does not act on the basis of false information knowing such information to be false.

##### 12.5.2 FOR PROVIDING INFORMATION

Each Representative and any Third Parties shall be exempt, to the fullest extent permitted by law, from liability to a Practitioner for damages or other relief by reasons of providing Information (including otherwise privileged or confidential information) to a Representative concerning a Practitioner who is, or has been, an Appointee to the Medical Staff or who did or does, exercise Clinical Privileges at this Hospital provided that such Representative or Third Party does not act on the basis of false information knowing such Information to be false.

#### 12.6 ACTIVITIES AND INFORMATION COVERED

##### 12.6.1 ACTIVITIES

- (a) The confidentiality and immunity provided by this Article shall apply to all Information in connection with this Hospital's or any Third Party activities concerning, but not limited to:
  - (1) Applications for appointment or Clinical Privileges
  - (2) Appraisals for reappointment or regrant of Clinical Privileges
  - (3) Any corrective action

- (4) Hearings and appellate review
- (5) Quality assurance/performance improvement activities
- (6) Utilization review activities.
- (7) Peer review organizations.
- (8) Any other Hospital, Department, committee, or Medical Staff activities related to monitoring and maintaining quality patient care.

#### 12.6.2 INFORMATION

The Information referred to in this Article may relate to a Practitioner's professional qualifications including, but not limited to, judgment, character, the clinical ability to safely and competently exercise the Privileges requested, professional ethics, or any other matter that might directly or indirectly affect patient care and Medical Staff or Hospital operations.

#### 12.7 AUTHORIZATIONS & RELEASES

Each Practitioner shall, upon request of the Hospital, execute general and specific authorizations and releases in accordance with the expressed provisions and general intent of this Article, subject to applicable laws. Execution of such authorizations and releases shall not be deemed a prerequisite to the effectiveness and/or application of this Article.

#### 12.8 CUMULATIVE EFFECT

Provisions in these Bylaws and in application forms relating to authorizations, confidentiality of Information, and releases/immunity from liability shall be in addition to any other protections provided by law and not in limitation thereof. In the event of conflict, the superior applicable law shall be controlling.



## ARTICLE XIII

### GENERAL PROVISIONS

#### 13.1 FORMS

Application forms and any other prescribed forms required by these Bylaws or the Medical Staff Policies for use in connection with Medical Staff appointments, reappointments, delineation of Clinical Privileges, corrective action, notices, recommendations, reports, and other matters shall be subject to adoption by the Board after considering the recommendation of the Medical Executive Committee.

#### 13.2 AUTHORITY TO ACT

Any Practitioner who acts in the name of this Medical Staff without proper authority shall be subject to the corrective action process.

#### 13.3 TRANSMITTAL OF REPORTS

Reports and other information which these Bylaws or the Medical Staff Policies require the Medical Staff to transmit to the Board shall be deemed so transmitted when delivered, unless otherwise specified, to the Hospital President.

#### 13.4 INTERNAL CONFLICTS

13.4.1 In any instance where a Practitioner has or reasonably could be perceived to have a conflict of interest in any matter that comes before the Medical Staff, a Department, Division, or Medical Staff committee, the Practitioner is expected to disclose the conflict to the individual in charge of the meeting. The Practitioner may be asked and is expected to answer any questions concerning the conflict. The committee (or, in the absence of a committee, the individual in charge of the meeting) is responsible for determining whether a conflict exists and, if so, whether the conflict rises to the level of precluding the Practitioner from participating in the pending matter.

13.4.2 A Department Chair shall have the duty to delegate review of applications for appointment, reappointment, or grant/regrant of Privileges to another member of the Department or to the applicable Division Chief if the Department Chair could reasonably be perceived as not being able to review such application objectively

13.4.3 For purposes of this Section 13.4, the fact that Practitioners are competitors, partners, or employed in the same group shall not, in and of itself, automatically disqualify such Practitioners from participating in the review of applications or other Medical Staff matters with respect to their colleagues.

## ARTICLE XIV

### ADOPTION, AMENDMENT, OR REPEAL OF MEDICAL STAFF BYLAWS & POLICIES

#### 14.1 RESPONSIBILITY

14.1.1 The Medical Staff shall have the initial responsibility to formulate, adopt, and recommend to the Board, Medical Staff Bylaws, and amendments thereto, which shall be effective when approved by the Board. Such responsibility shall be exercised in good faith and in a reasonable, timely, and responsible manner reflecting the interests of providing patient care at the generally recognized professional level of quality and efficiency and of maintaining a harmony of purpose and effort with the Board, administration, and with the community.

14.1.2 The active Appointees to the Medical Staff may adopt Medical Staff Policies as necessary to carry out the Medical Staff's functions and meet its responsibilities under these Bylaws. The Medical Staff delegates this responsibility to the Medical Executive Committee.

14.1.3 The mechanisms described in this Article shall be the sole methods for the adoption, amendment, or repeal of the Medical Staff Bylaws and Policies.

#### 14.2 ADOPTION, AMENDMENT, OR REPEAL OF MEDICAL STAFF BYLAWS

##### 14.2.1 Action by the Medical Executive Committee

- (a) The Medical Executive Committee shall propose adoption, amendment, or repeal of the Medical Staff Bylaws to the Medical Staff.
  - (1) If five percent (5%) or more of the active Appointees object to the proposed changes within fourteen (14) days of notice, then the matter will be presented for discussion and vote at a general Medical Staff meeting. Written objections shall be submitted to the Medical Executive Committee in care of the Medical Staff Office.
  - (2) If less than five percent (5%) of the active Appointees object in writing to the Medical Executive Committee's proposed changes within fourteen (14) days of notice, the proposed changes will be recommended to the Board. Failure to object is deemed an affirmative vote for the proposed adoption, amendment, or repeal of the Medical Staff Bylaws.

##### 14.2.2 Action by Medical Staff

- (a) Adoption, amendment, or repeal of the Medical Staff Bylaws may originate from a petition signed by at least fifty (50) active Appointees of the Medical Staff.
- (b) When the Medical Staff proposes Bylaws changes, it will communicate the proposed change(s) to the Medical Executive Committee.

- (c) If the Medical Executive Committee recommends the Medical Staff petitioners' proposed change(s) to the Bylaws, the procedure set forth in Section 14.2.1 shall be followed.
- (d) If the Medical Executive Committee does not recommend the Medical Staff petitioners' proposed change(s) to the Bylaws, each active Appointee to the Medical Staff will be eligible to vote on the proposed change(s) via printed or secure electronic ballot in a manner determined by the Medical Executive Committee. All active Appointees of the Medical Staff shall receive at least fourteen (14) days advance notice of the proposed changes. If the Medical Staff receives an affirmative vote by a simple majority of those Appointees eligible to vote, the change(s) will be recommended to the Board. An affirmative vote will be counted by returning the ballot marked "yes" or by not returning the ballot.
- (e) If the Medical Staff votes to recommend a change(s) to the Medical Staff Bylaws that the Medical Executive Committee does not recommend, the conflict resolution process set forth in Section 14.5 shall be followed.

#### 14.2.3 Action by the Board

Adoption, amendment, or repeal of the Bylaws shall become effective as of the date approved by the Board unless the Board establishes an alternative date.

### 14.3 TECHNICAL AND EDITORIAL AMENDMENTS

The Medical Staff delegates to the Medical Executive Committee the power to adopt such amendments to the Bylaws as are, in the MEC's judgment, technical or legal modifications or clarifications, reorganization, renumbering, amendments made necessary because of punctuation, spelling, or other errors of grammar or expression, inaccurate cross-references, or to reflect changes in committee names. Such amendments shall be effective immediately and shall become permanent if not disapproved by the Board within ninety (90) days of adoption by the Medical Executive Committee. The action to amend may be taken by motion acted upon in the same manner as any other motion before the Medical Executive Committee. After approval, such amendments shall be communicated, by some reasonable mechanism, in writing to the Medical Staff and to the Board.

### 14.4 ADOPTION & AMENDMENT OF MEDICAL STAFF POLICIES

14.4.1 Adoption, amendment, or repeal of a Medical Staff Policy may be originated by the Medical Executive Committee. The Medical Executive Committee shall vote on the adoption, amendment, or repeal of a Medical Staff Policy at a regular or special Medical Executive Committee meeting called for such purpose. Following an affirmative vote by the Medical Executive Committee, a Medical Staff Policy may be adopted, amended, or repealed, in whole or in part, and such changes shall be effective when approved by the Board. Following Board approval, Medical Staff Policies shall be electronically posted.

14.4.2 Any active Appointee of the Medical Staff may challenge any Medical Staff Policy established by the Medical Executive Committee through the following process:

- (a) The active Appointee submits to the President of the Medical Staff his or her challenge to the Medical Staff Policy, in writing, including any recommended changes to the Policy.
- (b) At the Medical Executive Committee meeting that follows receipt of the challenge the Medical Executive Committee shall discuss the challenge and determine whether it will change the Medical Staff Policy.
- (c) If changes are recommended, they will be communicated to the Medical Staff. At such time, each active Appointee may submit written notification of any further challenge(s) to the Medical Staff Policy to the President of the Medical Staff within fourteen (14) days of notice.
- (d) In response to a written challenge to a Medical Staff Policy, the Medical Executive Committee may, but is not required to, appoint a task force to review the challenge and recommend potential Policy changes to address concerns raised by the challenge(s).
- (e) If a task force is appointed, the Medical Executive Committee will take final action on the Medical Staff Policy based on the recommendations of the task force.
- (f) Once the Medical Executive Committee has taken final action in response to the challenge, with or without recommendations from a task force, any active Medical Staff Appointee may elect to proceed in accordance with Section 14.4.3 below.

14.4.3 Active Appointees of the Medical Staff may recommend the adoption, amendment, or repeal of a Medical Staff Policy directly to the Board by submitting a petition signed by at least fifty (50) active Appointees of the Medical Staff. The active Appointees must first communicate the proposal to the Medical Executive Committee.

- (a) If the Medical Executive Committee recommends the Medical Staff petitioners' proposal, the proposal will be forwarded to the Board for final approval. Such changes shall be effective when approved by the Board.
- (b) If the Medical Executive Committee does not recommend the Medical Staff petitioners' proposal, each active Appointee to the Medical Staff will be eligible to vote on the proposed Medical Staff Policy adoption, amendment, or repeal via a printed or secure electronic ballot in a manner determined by the Medical Executive Committee. All active Appointees of the Medical Staff shall receive at least fourteen (14) days advance notice of the proposed changes. If the Medical Staff receives an affirmative vote by a simple majority of those Members eligible to vote, the proposal will be recommended to the Board. An affirmative vote will be counted by returning the ballot marked "yes" or by not returning the ballot.

- (c) If the Medical Staff votes to recommend a change(s) to a Medical Staff Policy that the Medical Executive Committee does not recommend, the conflict resolution process set forth in Section 14.5 shall be followed.

#### 14.5 CONFLICT RESOLUTION PROCEDURES

14.5.1 If the Medical Staff votes to recommend directly to the Board a proposal regarding the Medical Staff Bylaws or Policies that is different from what the Medical Executive Committee has recommended, the following conflict resolution process shall be followed:

- (a) The Medical Executive Committee shall have the option of appointing a task force to review the differing recommendations of the Medical Executive Committee and the Medical Staff and recommend language to the Medical Staff Bylaws or Policies that is agreeable to both the Medical Staff and the Medical Executive Committee.
- (b) Regardless of whether the Medical Executive Committee recommends modified language, the Medical Staff shall have the opportunity to recommend alternative language directly to the Board. If the Board receives differing recommendations regarding the Medical Staff Bylaws or Policies from the Medical Executive Committee and the Medical Staff, the Board shall have the option of appointing a task force to study the basis of the differing recommendations and to recommend appropriate Board action.
- (c) Regardless of whether the Board appoints such a task force, the Board shall have final authority to resolve the differences between the Medical Staff and the Medical Executive Committee.
- (d) At any point in the process of addressing a disagreement between the Medical Staff and Medical Executive Committee regarding the Medical Staff Bylaws or Policies, the Medical Staff, MEC or Board shall each have the right to recommend using an outside facilitator to assist in addressing the disagreement. The final decision regarding whether to use an outside resource and the process that will be followed in so doing is the responsibility of the Board.

#### 14.6 PROCEDURE WHEN BOARD DOES NOT ACCEPT RECOMMENDATION OF MEC/MEDICAL STAFF

If the Board has determined not to accept a recommendation regarding the Medical Staff Bylaws or Policies submitted to it by the Medical Executive Committee or the Medical Staff, the Medical Executive Committee or the Medical Staff, as applicable, may request a meeting for the purpose of discussing the Board's rationale for its contemplated action and the Medical Staff's or Medical Executive Committee's rationale for its recommendation. The Hospital President will schedule such meeting as soon as possible after receipt of a request for a conference from the Medical Staff President. The Board may then take final action.

14.7 BOARD-INITIATED ACTION REGARDING MEDICAL STAFF BYLAWS & POLICIES

The Board may adopt amendments to Medical Staff Bylaws or Policies provided the Board has first proposed its recommended changes to the Medical Staff and Medical Executive Committee and the Medical Executive Committee and the Medical Staff have declined to adopt such amendments. In such event, the Board shall then present the recommended changes to an *ad hoc* Joint Conference Committee for its recommendation prior to adoption of any such amendments.

14.8 CONFLICT BETWEEN DOCUMENTS

14.8.1 If the Hospital code of regulations or a Hospital policy conflicts with the Medical Staff Bylaws or Policies, then the Hospital code of regulations or Hospital policy, as applicable, shall control; provided, however, that such conflict shall then be referred to an *ad hoc* Joint Conference Committee for recommendation to the Board as to how such conflict can be resolved.

14.8.2 If there is a conflict between a Medical Staff Policy and the Bylaws, the Bylaws shall control. Such conflict shall then be reviewed by the Medical Executive Committee to determine how such conflict can be resolved.

### ADOPTION & APPROVAL

These Bylaws have been adopted by:

Summa Health System Medical Staff

DocuSigned by:

*Dean M. Frate, M.D.*

Dean Frate, M.D.  
President, Medical Staff

Summa Health System Board of Directors:

DocuSigned by:

*Robert Gerberry*

Robert Gerberry  
Secretary, Summa Health System Board of Directors

- 2023 Bylaws [Revised 2/23/23] (technical revision to align with organizational staffing changes)
  - 2021 Bylaws [Revised 12/9/21] (revision to align with MS Organizational Policy)
  - 2021 Bylaws [Revised 6/10/22] (technical amendment removing Dept. of Ophthalmology)
  - 2018 Bylaws [Revised 5/31/18] (full revision)
  - 2015 Bylaws [Revised 4/28/15] (change to Article IX, 9.4-1)
  - 2014 Bylaws [Revised 12/2/14] (change to Article I; Article III, 3.2-2)
  - 2013 Bylaws [Revised 10/9/13] (change to Article II, 2.1; Article III, 3.2-3,4; Article VII, 7.2,3,4)
  - 2012 Bylaws [Revised 11/12] (change to Article III, 3-4)
  - 2011 Bylaws [Revised 5/11]
  - 2008 Bylaws [Revised 11/08]
  - 2006 Bylaws [Revised 11/06] (change to Article II, 2.2 and Article 7, 7.4)
  - 2005 Bylaws [Revised 05/05] (change to Articles II, IV, VI, VIII, X)
  - 2004 Bylaws [Revised 01/04] (change to Articles IV, VII and VIII)
  - 2003 Bylaws [Revised 01/03] (change to Article VI and Article VIII)
  - 2002 Bylaws [Revised 10/02] (change to Article III, 3.1)
  - 2001 Bylaws [Revised 08/01]
  - 2000 Bylaws [Revised 01/01] (change to Article IV, 4.3-4)
  - 2000 Bylaws [Revised 08/00]
  - 1999 Bylaws [Revised 01/99]
  - 1998 Bylaws [Revised: 9/18/98]
  - 1997 Bylaws [Revised: 9/16/97]
  - 1997 Bylaws [Revised: 03/97]
  - 1996 Bylaws [Revised: 8/15/96]
- Originally saved as 94C\94Bylaws [Revised 12/15/94]

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