SUMMA HEALTH SYSTEM
MEDICAL STAFF BYLAWS
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ARTICLE I

MEDICAL STAFF STRUCTURE DEFINITIONS

ALLIED HEALTH PROFESSIONAL or AHP: an individual other than a licensed Physician (allopathic or osteopathic), Podiatrist, Dentist, or Psychologist who functions in a medical support role to or who exercises independent judgment within the area of his/her professional competence and is qualified to render direct or indirect medical, surgical, dental, podiatric, or psychological care under the supervision of or in collaboration with a Practitioner who has been accorded Privileges for such care in the Hospital. These AHPs may include, but are not limited to, physician’s assistants, advanced nurse practitioners, or other individuals whose scope of practice has been recognized by the Hospital. AHPs are entitled to due process in accordance with the AHP policies and procedures. AHPs are not Appointees of the Medical Staff.

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

BOARD OR GOVERNING BODY: the Board of the Hospital.

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 to provide those diagnostic, therapeutic, medical, dental, surgical, or psychological services specifically delineated.

CONSULTING PEER REVIEW: Physicians, Dentists, Podiatrists, and Psychologists who 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 System for the purpose of rendering an opinion on the quality of health care provided to patients at the System or otherwise perform related peer review services as specifically requested.

DENTIST: an individual with a D.D.S. degree, or its equivalent, who is fully licensed to practice dentistry and whose practice is in the area of oral and maxillofacial surgery or the area of general dentistry or a specialty thereof.

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: a Practitioner who has been appointed to the Medical Staff, who is current in dues payments, and who is not under any form of suspension pursuant to the Bylaws, Manuals, or any other policy of the Medical Staff or Hospital.

HOSPITAL: Summa Health System.

HOSPITAL PRESIDENT: the President of the Hospital.
MAIL: Unless otherwise specified, includes either electronic (e-mail or electronic posting) or regular.

MANUAL(S): those documents generated by the Medical Staff and approved by the Board which serve to implement the Medical Staff Bylaws and which are considered to be a part of the Bylaws, including Policies and Procedures and Rules and Regulations.

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

MEDICAL STAFF: Physicians, Dentists, Podiatrists, and Psychologists who have been granted Prerogatives and Privileges pursuant to these Bylaws.

MEDICAL STAFF CABINET: consists of the Medical Staff President, the Medical Staff Vice President, the Medical Staff Past President, the Vice President of Medical Affairs, Assistant Vice President of Medical Affairs, and the Vice President of Medical Education and the Chair of the Department Chairs Committee.

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.

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: includes observations status and, in the inpatient setting, an inpatient admission, consultation (resulting in not less than a progress note), or surgery/invasive procedure; and in the outpatient setting, surgery/invasive procedure.

PHYSICIAN: an individual with an M.D. or D.O. degree who is fully licensed to practice medicine.

PODIATRIST: an individual with a D.P.M. degree, who is fully licensed to practice podiatry.

PRACTITIONER: unless otherwise expressly provided, any Physician, Dentist, Psychologist, or Podiatrist.

PREROGATIVE: a participatory right granted, by virtue of Medical Staff category or otherwise, 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 Manuals and Medical Staff policies.

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

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.

SPECIAL NOTICE: written notification sent by certified mail, return receipt requested, or by personal delivery 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 content requires. The captions or headings are for convenience only and are not intended to limit or define the scope or effect of any provision of these Bylaws.

Whenever an individual is authorized to perform a duty by virtue of his/her position, then the term shall also include the individual’s designee.
ARTICLE II
PURPOSES AND RESPONSIBILITIES

2.1 The purposes of the Medical Staff organization are:

   a. To serve as the primary means for accountability to the Board, for the appropriateness of the professional performance and ethical conduct of its Appointees and to strive toward the continual improvement of the quality of patient care, treatment, and services delivered in the Hospital consistent with the recognized standard 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, Allied Health Professionals, residents, medical students, and other providers leading to continual advancement in professional knowledge and skill in cooperation with affiliated schools of medicine.

   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.

   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

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 authorized to practice in the Hospital through the following measures.

      (1) Review and evaluation of the quality of patient care provided through valid and reliable patient care evaluation procedures.

      (2) An organizational structure and mechanisms that allow ongoing monitoring of patient care practices.

      (3) A credentials program, including mechanisms of appointment, reappointment and the matching of Clinical Privileges to be exercised or specified services to be
performed with the verified credentials and current demonstrated performance of the Practitioner.

(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 all 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 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 amendments to and in compliance with these Bylaws, Manuals, policies, and procedures of the Medical Staff and with Hospital policies and procedures.

j. To exercise the authority granted by these Bylaws in order to fulfill the foregoing responsibilities.
ARTICLE III
APPOINTMENT AND PRIVILEGES

3.1 NATURE OF APPOINTMENT

Appointment to the Medical Staff confers on the Appointee only such Prerogatives of appointment as specified within these Bylaws. The granting of appointment to the Medical Staff does not confer or imply the granting of Clinical Privileges for the provision of patient care.

3.1-1. PREROGATIVES OF APPOINTMENT

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.

3.2 APPOINTMENT PROCESS

3.2-1. The granting of Clinical Privileges to provide patient care and/or Membership shall be in accordance with the Credentialing Policies. Unless otherwise stated in these Bylaws or the Credentialing Policies, the admission of patients to inpatient services or performance of outpatient procedures requires the granting of privileges as specified in these Bylaws.

3.2-2. The appointment process is as follows:

a. All Practitioners shall submit a complete application to the Credentialing Office. The Credentialing Office will build the Practitioner’s file in accordance with the Credentialing Policies and conduct primary source verification.

b. Completed files for credentialing and privileging will be forwarded and vetted by the appropriate Department Chair.

c. Completed and department-vetted applications will be reviewed and recommended for appointment and privileges by the Medical Staff Credentials Committee.

d. The Practitioner’s application and credentialing and privileging is forwarded to the Board (Credentials Committee of the Care Delivery Board) for final action.

e. Notification to the Practitioner of a decision to grant membership and/or privileges will be made in writing but does not require Special Notice. Notification to the Practitioner of a decision to deny or restrict membership and/or privileges requires Special Notice.

3.2-3. Temporary Privileges - Requests for temporary privileges may be considered when a specific and urgent patient care need exists such as:

a. A Practitioner takes a leave of absence and another Practitioner needs to cover that Practitioner’s practice;

b. Emergency care of patients; specific medical skills are needed to care for a patient that no one else on the Medical Staff posses; or

c. An applicant has a complete credentials file that meets all criteria for granting temporary privileges and is awaiting review and approval of the medical executive committee and Board.
d. An Applicant’s request for temporary privileges may only be granted if the Applicant’s file meets all of the following criteria:

(i) no current or previous challenge to licensure or registration,
(ii) no history of involuntary termination or suspension of medical staff privileges or membership at any other organization, and
(iii) no history of prior limitation, restriction, reduction, denial or loss of clinical privileges

e. Temporary privileges require the recommendation of the Department Chair and both of the following: Medical Staff President, or authorized designee and Chief Executive Officer or authorized designee.

3.2-4 Expedited Privileges - To expedite initial appointments in membership and granting of privileges, reappointment to membership or renewal or modification of privileges all of the following criteria must be met:

a. The Applicant’s credentials file is complete and meets all criteria for granting privileges and is awaiting review and approval of the Medical Executive Committee and the Board.

b. The medical staff executive committee has not made a final recommendation that is adverse or has limitations.

c. The following situations are evaluated on a case-by-case basis and usually result in ineligibility for the expedited process:

(i) current or previous challenge to license or registration;
(ii) history of involuntary termination or suspension of medical staff privileges or membership at any other organization;
(iii) history of prior limitation, restriction, reduction, denial or loss of clinical privileges
(iv) an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

d. Expedited privileges require the recommendation of the Department Chair and two of the following: Vice President Medical Affairs, Assistant Vice President Medical Affairs, Medical Staff President, or authorized designee.

3.2-5 Disaster Privileges - Practitioners who do not possess medical staff privileges at the Hospital may be granted disaster privileges during any officially declared emergency, whether it is local, state or national. The Chief Executive Officer, Vice President of Medical Affairs or the Administrator on Call may grant temporary emergency privileges in accordance with the Credentialing Policies.

3.3 QUALIFICATIONS FOR APPOINTMENT

3.3-1 GENERAL QUALIFICATIONS

Only Practitioners who meet the following general qualifications shall be considered for appointment and/or Privileges:

a. Document (1) current licensure, (2) adequate experience, education, and training, (3) current professional competence, (4) good judgment, and (5) the ability to exercise the Privileges requested with or without a reasonable accommodation, (as applicable to the request for appointment and/or Privileges) so as to demonstrate to the satisfaction of the Medical Staff that they are professionally and ethically competent and that patients treated by them can reasonably expect to receive quality medical care.
b. As applicable to their application, are determined to (1) adhere to the ethics of their respective professions, (2) be able to work cooperatively with others so as not to adversely affect patient care or disrupt Hospital operations, (3) be willing to participate in and properly discharge those responsibilities defined by the Medical Staff, and (4) to be in practice and in residence within a reasonable distance of the Hospital in order to provide continuous care to his/her patients (or otherwise have established arrangements satisfactory to the Board), and (5) have read and agreed to abide by the Bylaws, Manuals, policies, and procedures of the Medical Staff.

c. If requesting Privileges, have in force and provide evidence of continuous Professional Liability Insurance coverage.

d. Meet the membership requirements of a Department within the System.

e. For good cause shown, the Medical Executive Committee may recommend to the Board waiver of any general qualification required for Medical Staff appointment and/or Privileges.

3.3-2 PARTICULAR QUALIFICATIONS

a. A Physician applicant must hold an M.D. or D.O. degree issued by an appropriately accredited medical or osteopathic school and, except for applicants who are not requesting Privileges, must also hold a valid and unsuspended license to practice medicine issued by the State of Ohio.

b. A Dentist applicant must hold a D.D.S. or equivalent degree issued by an appropriately accredited dental school and, except for applicants who are not requesting Privileges, must also hold a valid and unsuspended license to practice dentistry issued by the State of Ohio.

c. A Podiatrist applicant must hold a D.P.M. degree issued by an appropriately accredited podiatry school, and except for applicants, who are not requesting Privileges, must hold a valid and unsuspended license to practice podiatry issued by the State of Ohio.

d. A Psychologist applicant must hold a Ph.D. or Psy.D. in psychology and, except for applicants who are not requesting Privileges, must hold a valid and unsuspended license to practice psychology issued by the State of Ohio.

3.4 SPECIALTY CERTIFICATION-APPOINTEES TO THE ACTIVE AND AFFILIATE STAFF

a. Applicants to the active and affiliate Medical Staff categories must also meet the following qualifications:

(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 applicant’s specialty, 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 certification examination, the five (5) year interval shall begin at the completion of the practice period.

The expectation is the Practitioner is certified in the area or subspecialty that he/she practices.

Failure to attain certification within the required time shall require the physician to
present a request for an extension or waiver to the Medical Executive Committee for review.

(2) Comply with requirements for mandatory re-certification as specified by their applicable national board.

(3) Verification of certification/re-certification shall be reviewed for each Appointee upon initial appointment and during the reappointment process.

(i) Current Certification. If the appointee is actively board certified the appointee will continue the reappointment process.

(ii) New Resident Graduates. New resident graduates who were not board certified upon appointment and have not obtained certification as set forth in (1) above will be required to present a request for an extension or waiver to the Medical Executive Committee for review.

(iii) New Applicants without Certification. New applicants whose boards have lapsed will be required to present a request for an extension or waiver to the Medical Executive Committee for review.

(iv) Appointees who Fail to Recertify or Experience a Lapse in Certification. Appointees who fail to recertify or whose certification has lapsed at reappointment, will have until the next appointment 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.

b. Specialty Certification Requirement Waivers and Extensions

During either the appointment or re-appointment process, the requirement for certification may be modified under the following conditions:

(1) Medical Executive Committee Extensions. The certification and recertification requirements may be waived on a temporary basis for a specified period of time to allow a Practitioner/Appointee an opportunity to obtain appropriate certification or recertification. The Practitioner/Appointee must request an extension from the Medical Executive Committee. The request for extension should include information about the Practitioner/Appointee’s quality of care, prior actions (i.e., conduct review board, complaints, and compliments), special circumstances, physician recommendations and references, and shall be provided by the Practitioner/Appointee’s Department Chair or his/her designee. The Practitioner/Appointee may come to the meeting of the Medical Executive Committee to present his/her request for an extension but is not required to attend the meeting. After review of the Practitioner/Appointee’s case, the Medical Executive Committee may grant an appropriate extension, along with an outlined action plan, which may be re-evaluated at a designated time-frame. If the Practitioner/Appointee does not follow the outlined plan, further action may be taken by the Medical Executive Committee, including the denial or termination of the Practitioner/Appointee’s membership and privileges. Such an extension requires the affirmative vote of a three-fourth (3/4) majority of the voting members of the Medical Executive Committee and the approval of the Board.

(2) Permanent Waiver. The certification and recertification requirements may be permanently waived upon the request of a Practitioner/Appointee. A request for permanent waiver should include information about the Practitioner/Appointee’s quality of care, prior actions (i.e., conduct review board, complaints, and compliments), special
circumstances, and physician recommendations and references. After the review of the Practitioner/Appointee’s case, the Medical Executive Committee may approve the permanent waiver based upon an affirmative vote of a three-fourth (3/4) majority of its voting members, and the approval of the Board.

(i) Once taken, such action supersedes all individual certification and recertification requirements contained in any other Medical Staff policy, rule or regulation.

(3) Denial of a Request for an Extension or Waiver of the Board Certification or Recertification Requirements. An Appointee who is not granted an extension or waiver will be permitted to resign from the medical staff. If the Appointee does not voluntarily resign from the medical staff, the Appointee’s membership and privileges will be terminated. A Practitioner who is not granted an extension or waiver will be denied medical staff membership and privileges.

3.5 NONDISCRIMINATION

No aspect of Medical Staff appointment or Clinical Privileges shall be denied on the basis of sex; sexual preference; race; age; creed; color; national origin; handicap; or on the basis of any other criterion unrelated to the delivery of quality patient care in the Hospital, to professional qualifications; to the Hospital’s purposes, needs, and capabilities; or to community need.

3.6 BASIC RESPONSIBILITIES OF MEDICAL STAFF APPOINTMENT

The ongoing responsibilities of each Appointee, except those specifically excluded within these Bylaws, shall include:

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 Manuals, policies, and procedures, and applicable Hospital policies and procedures.

d. Discharging in a cooperative manner such reasonable responsibilities and assignments imposed upon the Appointee by virtue of Medical Staff appointment, including committee assignments.

e. Preparing and completing in a timely, legible, and complete fashion medical records for all the patients to whom the Appointee provides care 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, and/or any other applicable association or organizational ethical principles.

g. Aiding, as requested and/or required by the Department Chairs, in any Medical Staff-approved educational programs for medical students, interns, residents, Physicians and Dentists, Podiatrists, nurses, and other personnel.

h. Working cooperatively with Practitioners, Allied Health Professionals, 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 services, or arrange for a qualified substitute to provide such care and supervision.

j. Participating in continuing education programs as determined by the Medical Staff or the Medical Executive Committee.

k. Admitting and/or caring for patients in the System 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 of any action taken regarding the Practitioner’s license, DEA registration, privileges at other facilities, changes in Professional Liability Insurance coverage, or any other action that could affect his/her Medical Staff standing and/or Clinical Privileges at this Hospital.

m. Review Medical Staff orientation materials upon initial appointment to the Medical Staff.

n. Meeting the general qualifications for appointment as set forth in this Article.

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. A medical history and physical examination must be recorded and placed in the patient record within 24 hours of the patient’s admission or before an invasive procedure. The following elements are required for a history and physical:

   (1) Medical History

   (a) chief complaint/reason for admission
   (b) details of present illness
   (c) relevant past, social and family history
   (d) review of systems

   (2) Physical Examination

   (3) Conclusions or impressions drawn from medical history and physical

   (4) Diagnosis or diagnostic impression

   (5) Plan of care.

The medical history and physical examination 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.

3.7 ADMINISTRATIVE AND PROFESSIONAL SERVICE AGREEMENT OFFICERS

A Practitioner employed by the Hospital in a purely administrative capacity with no clinical duties or Privileges 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. 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 Clinical Privileges pursuant to the procedure set forth in these Bylaws.
ARTICLE IV
CATEGORIES OF THE MEDICAL STAFF

4.1 CATEGORIES

The categories of the Medical Staff shall include the following: Active, Affiliate, Consulting Peer Review, Scientific, and Retired.

4.2 ORGANIZATIONAL AND VOTING RIGHTS/RESPONSIBILITIES

The following rights shall apply to the categories of appointment.

a. Organizational Rights/Responsibilities

   (1) Active and affiliate Appointees may regularly engage in the professional activities of the Medical Staff subject to the scope of the Practitioner’s license, the policies and code of regulations of the Hospital, and the Bylaws, Manuals, policies, and procedures of the Medical Staff.

   (2) Active and affiliate Appointees may exercise the Clinical Privileges granted to them pursuant to these Bylaws.

   (3) Only active Appointees may hold office in the Medical Staff organization. Active and affiliate Appointees may serve and chair Medical Staff committees; may attend and participate in any Department of which they are a member, unless precluded from doing so by these Bylaws or otherwise by resolution of the Medical Executive Committee and/or Board. Retired Appointees may attend meetings of the Medical Staff and the Department of which they are a member, including open committee meetings and educational programs, and may serve on Medical Staff committees if appointed.

   (4) The request for Clinical Privileges will require submission of all pertinent documentation as requested by the Department Chair, Privileges Committee, and the Medical Executive Committee in accordance with the Credentialing Policies.

   (5) Consulting Peer Review Appointees shall perform such duties as are requested of them related to the review and critique of medical records and/or other related peer review matter.

b. Voting Rights

   (1) Active Medical Staff – Subject to §§ 4.9 and 12.7, an active Appointee may vote on any matter presented at a Medical Staff meeting and any Department or committee meeting to which the Appointee is assigned.

   (2) Affiliate, Scientific, and Retired Staff – Subject to §§ 4.9 and 12.7, an affiliate, scientific or retired Appointee may only vote on matters presented to Medical Staff committees to which the Appointee has been appointed and on matters presented at Department meetings as determined by the Department.

4.3 QUALIFICATIONS FOR APPOINTMENT
a. Appointees of the active and affiliate Medical Staff shall consist of Practitioners who:
   (1) Meet the general qualifications for appointment set forth in Article III.
   (2) Have been appointed by the Board upon recommendation of the Medical Executive Committee.

b. Appointees of the retired Medical Staff shall consist of Practitioners who:
   (1) Have been Appointees to the Medical Staff immediately prior to appointment to the retired Medical Staff.
   (2) Have been appointed by the Board upon recommendation of the Medical Executive Committee.

c. Members of the scientific Medical Staff shall consist of Practitioners who:
   (1) Are involved actively in specific fields related to the practice of medicine, but who are not engaged in the clinical practice of medicine.
   (2) Have been appointed by the Board upon the recommendation of the Medical Executive Committee.

d. Members of the consulting peer review Medical Staff shall consist of Practitioners who:
   (1) Have been in the active practice either locally or in another city and state in which he/she has a valid license to practice; posses specialized skills needed at the Hospital for a specific project or on an occasional basis when requested by Hospital administration, the Board, or a Medical Staff committee.
   (2) Have been appointed by the Board upon the recommendation of the Medical Executive Committee.

4.4 ACTIVE MEDICAL STAFF

4.4-1 Composition. The Active Medical Staff shall consist of Physicians, Dentists, Podiatrists, and Psychologists, who actively participate and substantially contribute to the activities of the Hospital's organization in an ongoing and consistent manner. These activities may include, but shall not be limited to, any one or more of the following:
   a. Patient Encounters.
   b. Involvement in the Medical Staff organization through committee assignments, leadership roles, and significant participation in Medical Staff activities.
   c. Major involvement in medical education.
   d. Extensive activities related to medical research.

4.4-2 Responsibilities. An Appointee to the active Medical Staff shall:
   a. Fulfill the basic responsibilities set forth in § 3.6.
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 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.

4.5 AFFILIATE MEDICAL STAFF

4.5-1 Composition. The affiliate Medical Staff shall consist of Physicians, Dentists, Podiatrists, and Psychologists who are periodically active within the Hospital organization but do not meet the definition of active Medical Staff.

4.5-2 Responsibilities. An Appointee to the affiliate Medical Staff shall:

   a. Fulfill the basic responsibilities set forth in §3.6;

   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.

4.6 SCIENTIFIC MEDICAL STAFF

4.6-1 Composition. The scientific Medical Staff shall consist of scientists who may be Physicians, Dentists, Podiatrists, Psychologists or other specially trained individuals possessing special expertise in health care, the practice of medicine, medical education, and/or medical research.

4.6-2 Responsibilities. An Appointee to the scientific Medical Staff shall:

   a. Fulfill the basic responsibilities set forth in §3.6.

   b. Attend meetings of the Medical Staff and the Department of which he/she is a member, including open committee meetings and educational programs.

   c. Perform service responsibilities and teaching duties as assigned.

   d. Pay Medical Staff dues in an amount established by the Medical Staff.

4.7 RETIRED MEDICAL STAFF

4.7-1 Composition. The retired Medical Staff shall consist of Physicians, Dentists, Podiatrists, and Psychologists who have retired from practice at the Hospital and desire to continue their affiliation with the Hospital for educational purposes.

   a. Responsibilities. An Appointee to the retired Medical Staff shall have no responsibilities and shall not be required to pay Medical Staff dues.
4.8 CONSULTING PEER REVIEW MEDICAL STAFF

4.8-1 Composition. The consulting peer review Medical Staff shall consist of Physicians, Dentists, Podiatrists, Scientists and Psychologists who 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.

4.8-2 Responsibilities. Consulting peer review Appointees shall only have those responsibilities to which they contractually agree. They shall not be required to pay Medical Staff dues.

4.9 LIMITATION OF PREROGATIVES

Regardless of the category of appointment to the Medical Staff, unless otherwise required by law, Dentists, Podiatrists, and Psychologists:

   a. Shall only have the right to vote on matters within the scope of their licensure. In the event of a dispute over voting rights, the issue shall be resolved by the chair of the meeting, subject to final decision by the Medical Executive Committee.

   b. Shall exercise Clinical Privileges only within the scope of their licensure and as set forth in the Credentialing Policies under the section entitled “Appointment/Reappointment to the Medical Staff and Delineation of Clinical Privileges.”

4.10 MODIFICATION OF APPOINTMENT CATEGORY

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

4.11 EFFECT OF THIS ARTICLE

Qualifications for Medical Staff appointment as set forth in this Article shall be applicable to all Physicians, Dentists, Podiatrists, and Psychologist who apply for appointment and/or seek to modify their appointment category on or after the effective date of these Bylaws. All Physicians, Dentists, Podiatrists, and Psychologists who were members of the Medical Staff of Akron City Hospital and/or Saint Thomas Hospital on January 1, 1993 shall remain in the Hospital in the Medical Staff category to which they were transferred. Such Appointees shall be subject to the qualification requirements for re-appointment as delineated in the Bylaws that were in effect on the date he/she joined the Akron City Hospital or Saint Thomas Hospital Medical Staff so long as the Physician, Dentist, Podiatrist, or Psychologists continues to meet the quality assurance criteria established by the Medical Staff.
ARTICLE V
INVESTIGATIONS, CORRECTIVE ACTION, AND SUSPENSION

5.1 CORRECTIVE ACTION

5.1-1 CRITERIA FOR INITIATION

Any person may provide information to the Medical Executive Committee regarding the conduct, performance, or competence of a Practitioner. Whenever the activities, professional conduct, or competence of a Practitioner may be inconsistent with his/her responsibilities as set forth in these Bylaws; or detrimental to the quality of patient care, disruptive to the order, dignity, business or harmony of the Hospital; or injurious to the name, welfare or interest of the Hospital; or otherwise in violation of these Bylaws, Manuals, policies or procedures of the Medical Staff or Department rules or regulations, an investigation of such activities may be requested.

5.1-2 REQUESTS AND INVESTIGATIONS

A request for investigation of an Appointee may be submitted by any Appointee to the Medical Staff, any Medical Staff committee (which request may be reflected by minutes of a committee), the System President, or the Board (or any member thereof). All requests for investigation(s) shall be submitted in writing to the Medical Executive Committee, and supported by reference to the specific activities or conduct that constitute the grounds for the request. The Medical Staff President shall promptly notify the Hospital President, in writing, of all requests for investigation received by the Medical Executive Committee and shall continue to keep him/her fully informed of all action taken in conjunction therewith. Upon receipt of a request, the Medical Executive Committee, in executive session, may take one of the following actions:

a. If, in the opinion of the Medical Executive Committee, there is certainty that no basis exists for the request for an investigation, the Medical Executive Committee may direct the Medical Staff President to notify the individual/entity 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.

b. The Medical Executive Committee may defer action on the request for investigation if inadequate information is provided. In such event, the Medical Staff President shall so inform the Hospital President and the individual who has requested the investigation, and initiate one of the following:

   (1) The Medical Executive Committee may assign one non-interested member of the Medical Executive Committee to obtain further information regarding the request, and report back to the Committee if such action is justified by the nature and scope of the activities which are the subject of the allegation.

   (2) The Medical Executive Committee may initiate further review by means of the Medical Staff Code of Conduct Policy [1.28].

   (3) The Medical Staff President, with approval of the Medical Executive Committee, may appoint an ad hoc committee (consisting of one (1) or more
individuals) to investigate the basis of the allegations and to make a written report to the Medical Executive Committee with findings and recommendations.

(4) The Medical Executive Committee may refer the matter to the Board for investigation. In such event, the Board’s investigatory process shall be substantially similar to that set forth in these Bylaws except that the Board may draw upon such individuals as the Board deems appropriate to investigate and act upon the matter.

5.1-3 AD HOC COMMITTEE

a. Composition.

(1) An ad hoc committee may be formed for the purpose of investigating complaints regarding Appointees that have been referred by the Medical Executive Committee.

(2) The ad hoc committee members and chair shall be selected by the Medical Staff President subject to the approval of the Medical Executive Committee.

(3) The ad hoc committee shall include a minimum of three (3) Active Appointees, and shall not include any current members of the Medical Executive Committee or the Board, and shall not include any member(s) who has requested the investigation.

b. Proceedings

(1) When the ad hoc committee is appointed, the Medical Staff President shall (a) notify the Appointee who is the subject of the investigation as to the nature and purpose of the investigation, and (b) provide the ad hoc committee with written directives as to the scope and charge of the committee.

(2) The ad hoc committee shall meet initially to discuss the procedure to be followed with respect to the investigation. The ad hoc committee may request assistance from the Medical Staff office or the Hospital’s legal counsel, or the System’s legal counsel, and may request that a medical consultant who is not a member assist the committee in reviewing the allegations. The committee retains broad discretion to take whatever action is appropriate to provide a full and complete investigation of the issues.

(3) The ad hoc committee may review records or any other documents; interview Practitioners, Allied Health Professionals and/or Hospital or System staff members, request an external review of medical records; and/or take any other steps that are in conformance with these Bylaws that will lead to evidence which will support or refute the allegations that have been made.

(4) The ad hoc committee shall meet as often as necessary at the call of the chair to provide a timely and complete review of the allegations.
The ad hoc committee shall make a written record of its proceedings.

c. **Interview**

(1) After conducting a preliminary investigation, the ad hoc committee shall invite the Appointee whose conduct is in question to appear before the committee.

(2) At the meeting with the ad hoc committee, the Appointee whose conduct is in question will have the opportunity to refute, explain, or discuss any allegations that are the subject matter of the investigation.

(3) This appearance before the ad hoc committee shall not constitute a hearing; shall be preliminary in nature, none of the procedural rules provided in these Bylaws with respect to hearings or appeals shall apply, and therefore the Appointee shall not be entitled to be represented by legal counsel.

5.1-4 **TERMINATION OF INVESTIGATION**

At any time prior to the conclusion of the investigation by the ad hoc committee, the Medical Staff President, upon approval of the Medical Executive Committee, may terminate the investigation and dismiss the ad hoc committee. Such action by the Medical Executive Committee may be taken if it deems that the purpose for which the ad hoc committee was formed no longer exists, or that a recurrence of the behavior of the Appointee who is the subject of the investigation is unlikely and that the delegation from the Board to monitor the quality of care provided by Appointees has been fulfilled. The Medical Executive Committee shall document the reason for its action in its minutes.

5.1-5 **FINDINGS AND RECOMMENDATIONS OF THE AD HOC COMMITTEE**

At the conclusion of the ad hoc committee's investigation, the chair shall deliver, to the Medical Executive Committee in executive session, a written report which shall include findings and recommendations. The report will be filed in the Medical Staff Office.

a. **Documentation:** The committee shall list all documents reviewed and the names (and titles) of all people interviewed.

b. **Findings:** The committee's findings shall consist of a listing of the scope and results of the investigation.

c. **Recommendations:** The committee's recommendations may include any of the following:

(1) **No corrective action.** This is appropriate when the committee finds that there was not credible evidence to support the allegations.

(2) **Informal corrective action.** This is appropriate when the committee finds that unacceptable conduct did occur or may have occurred but that the particular act of misconduct is not as grave or serious as to warrant formal corrective action. Informal corrective action consists of action taken at the Department level without approval by the Medical Executive Committee, and without impairing an Appointee’s Privileges and/or Medical Staff
standing. An example of this form of action would be a letter from the appropriate Department Chair or chair of an appropriate Departmental committee indicating the conduct that did or may have occurred, and advising the individual Appointee to take immediate action to correct the conduct. This form of action shall not constitute grounds for a hearing as the term is used in Article VI. Any action beyond informal corrective action shall only be taken with the approval of the Medical Executive Committee and in accordance with these Bylaws.

(3) Formal corrective action: Any one or more of the actions listed in § 6.2-2 of these Bylaws.

(4) Any other action that appears warranted by the findings, and is in accordance with these Bylaws.

5.1-6 REVIEW BY THE MEDICAL EXECUTIVE COMMITTEE

The Medical Executive Committee, in executive session, shall review the findings and recommendations of the ad hoc committee. The Medical Executive Committee may invite the Appointee whose conduct is in question to appear before it to discuss the ad hoc committee's recommendations prior to taking action. This appearance shall not constitute a hearing, shall be preliminary in nature and none of the procedural rules provided in these Bylaws with respect to hearings and appeals shall apply. Therefore, the Appointee is not entitled to be represented by legal counsel. The Medical Executive Committee shall make a record of all such appearances before it.

5.1-7 RECOMMENDATION BY THE MEDICAL EXECUTIVE COMMITTEE

The Medical Executive Committee, meeting in Executive Session, may concur with the recommendations of the ad hoc committee, recommend imposition of a different form of corrective action or recommend no corrective action. The Medical Staff President shall promptly notify the affected Appointee by Special Notice, and advise the Hospital President of the right to proceed under Article VI. The President of the Medical Staff shall also inform the Board of the recommendation. The recommendation of the Medical Executive Committee shall be held in abeyance pending exhaustion or waiver of rights under Article VI. Thereafter, the procedure followed shall be that provided in Article VI. If the Medical Executive Committee's recommended action is favorable to the Medical Staff Appointee, such recommendation shall be transmitted to the Board. Thereafter, the procedure to be followed shall be that provided in the Credentialing Policies.

5.2 SUMMARY RESTRICTION OR SUSPENSION

5.2-1 CRITERIA FOR INITIATION

a. Whenever a Appointee’s conduct appears to require that immediate action be taken to protect the life or well-being of any patient(s) or to reduce the substantial likelihood of present or future injury or damage to the Hospital, its employees, or to patients, the Medical Staff President, the Vice President of Medical Affairs, the respective Department Chair, the Hospital President, or any of their respective designees, may summarily suspend or restrict the appointment status or all or any portion of the Clinical Privileges of such Appointee. 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 suspension. Such summary
suspension shall be effective immediately upon imposition.

1. In the event that a qualified individual as defined above, is considering suspension of a Practitioner for misconduct, he or she may convene the Internal Review Board as provided in § 5.2-1(d), in order to provide guidance prior to imposing a suspension. When the Internal Review Board is called for this purpose, it shall meet with the affected Practitioner prior to rendering final guidance.

2. In the alternative, the qualified individual as defined above, who is considering suspension of a Practitioner for misconduct, may consult with the Vice President of Medical Affairs or his/her designee for guidance.

b. The person who imposed the suspension shall promptly notify the Appointee by Special Notice of imposition of the suspension or restriction.

c. The person who imposed the suspension shall promptly notify the Medical Staff President, the Vice President of Medical Affairs, the Department Chair, and the Hospital President of the suspension.

d. An Internal Review Board, which consists of the available members of the Medical Staff Cabinet, the Department Chair, and the Hospital legal counsel, will review the issues surrounding the summary suspension within two (2) working days of such summary suspension. This meeting shall be in addition to any other proceeding or action under these Bylaws. The Appointee whose appointment and/or Clinical Privileges have been summarily restricted or suspended shall be invited to respond to the summary suspension before the Internal Review Board. Such meeting shall not constitute a hearing and none of the procedural rights provided in Article V shall apply.

e. Following the meeting, the Internal Review Board will vote to uphold the summary suspension, overrule the summary suspension, or refer the matter to the Medical Executive Committee’s Executive Session for further investigation. In the event of a referral, any documentation assembled by the Internal Review Board shall also be forward to the Medical Executive Committee.

f. The actions of the Internal Review Board will be processed as follows:

(1) Internal Review Board Recommends Upholding Summary Suspension
   i) The Appointee may request an informal meeting with the Medical Executive Committee pursuant to § 5.2-2.
   ii) If the Practitioner does not request a meeting, the Medical Executive Committee shall be notified of the Internal Review Board’s recommendation at its next regularly scheduled meeting.

(2) Internal Review Board Overrules, effective immediately the Summary Suspension
   i) The Internal Review Board will notify Practitioner of action and refer the matter to the next regularly scheduled Medical Executive Committee in Executive Session.
   ii) The Medical Executive Committee (in Executive Session) shall review the recommendations of the Internal Review Board. The Medical Executive Committee may concur with the
recommendations, recommend imposition of a different limitation or action, or recommend no corrective action.

(3) Internal Review Board continues to investigate the matter further and will report to the Medical Executive Committee (in executive session) within ten working days.

i) The Medical Executive Committee meeting (in executive session) shall review the recommendations of the Internal Review Board. The Medical Executive Committee may concur with the recommendations, recommend imposition of a different limitation or action, or recommend no corrective action.

5.2-2 INFORMAL MEETING

a. The Practitioner whose appointment and/or Clinical Privileges have been summarily restricted or suspended shall be entitled to request a meeting with the Medical Executive Committee in executive session. Such meeting shall be held within five (5) working days of such request. Such meeting shall not constitute a hearing and none of the procedural rights provided in Article VI shall apply. The Medical Executive Committee shall make a written record of all such appearances.

b. Following such a meeting, the Medical Executive Committee may vote to affirm, remove, or modify the summary suspension or restriction. The Practitioner shall be notified, by Special Notice, of the Medical Executive Committee's decision. If the summary suspension is not lifted by the conclusion of the fourteenth (14th) calendar day of its imposition, the Appointee shall have the right to proceed under Article VI. 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 VI.

5.2-3 PATIENT COVERAGE

a. Immediately upon imposition of a summary suspension or restriction, the Medical Staff President and/or Department Chair(s) shall have authority to designate an Appointee other than themselves to provide for medical coverage of the hospitalized patients of the suspended Appointee at the time of such suspension or restriction. The patients’ wishes shall be considered in the selection of an alternate Practitioner.

b. If an Appointee imposed the suspension or restriction, he/she shall not assume direct responsibility for the care of such patients.

5.3 AUTOMATIC SUSPENSION OR LIMITATION

5.3-1 IMPOSITION OF AUTOMATIC SUSPENSION OR LIMITATION AND SUBSEQUENT PROCESS

The following events shall result in an automatic suspension or limitation of appointment and Privileges without recourse to the procedural rights set forth in Article VI:
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 privileges. Whenever a Practitioner’s licensure is made subject to probation, the Practitioner’s right to practice shall automatically become subject to the same terms of the probation.

b. Controlled Substance Authorization. Whenever a Practitioner’s federal or state controlled substance certificate is suspended, limited or revoked, the Practitioner shall automatically and correspondingly be divested and/or limited of the right to prescribe medications covered by the certificate, as of the time such action becomes effective and through its term. Whenever a Practitioner’s state or federal 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 Privileges that would be affected shall be automatically suspended or restricted as applicable until the matter is resolved and/or adequate Professional Liability Insurance coverage is restored and the Hospital is provided with a written statement from the Practitioner (i) explaining the circumstances of the previous insurance being canceled or not renewed and any limitations on the new policy; and (ii) providing a summary of relevant activities during the period of no coverage to establish current competency.

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. Medical Records. A suspension may be imposed for failure to complete medical records consistent with the requirements of the Medical Staff.

5.3-2 IMPACT OF AUTOMATIC SUSPENSION/LIMITATION

During such period of time when a Practitioner’s Privileges are suspended pursuant to § 5.3-1, 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.

During such period of time when a Practitioner Privileges are limited pursuant to § 5.3-1 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 suspension of Privileges.

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

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 suspension.
d. Attend to the management of any patient requiring emergency care and intervention.

5.3-3 ACTION FOLLOWING IMPOSITION

As soon as practical after the imposition of an automatic suspension, the Medical Executive Committee shall convene to determine if further corrective action is necessary in accordance with § 5.2 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 to the extent the suspension or limitation remained in effect for a period of more than thirty (30) days, the Practitioner shall be obligated to provide such information as the medical Staff Office shall reasonably request to assure that all information in the Practitioner’s credentials file is current.

5.4 AUTOMATIC TERMINATION

5.4-1 IMPOSITION OF AUTOMATIC TERMINATION

The following events shall result in an automatic termination of appointment and Privileges without recourse to the procedural rights set forth in Article VI. Reapplication shall be subject to the provisions of the Medical Staff Credentialing Manual.

a. Licensure. Action by any federal or state authority terminating a Practitioner’s professional license, if such license is not reinstated within thirty (30) days of its termination, shall result in an automatic termination of the Practitioner’s appointment and Privileges.

b. Professional Liability Insurance. If a Practitioner’s Professional Liability Insurance coverage lapses, falls below the required minimum, is terminated, or otherwise ceases to be in effect for a period greater than thirty (30) days, the Practitioner’s 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 an Appointee pleads guilty to or 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. Provided, however, if the behavior which triggered the conviction is based on Practitioner impairment, then the matter shall be handled in accordance with Medical Staff Policies and Procedures.

e. Failure to Pay Dues/Assessments. Failure to pay Medical Staff dues or fines as required within ninety (90) days after notice that such dues or fines are due shall result in an automatic termination of the Appointee’s appointment and privileges, and will be considered as a voluntary resignation.

5.4-2 MEDICAL EXECUTIVE COMMITTEE NOTIFICATION
Whenever a government agency takes action against a Practitioner that affects his/her license to practice or authorization to prescribe controlled substances, or an individual is found guilty of or pleads guilty or no contest to a felony or any other serious offense as described in § 5.4-1, he/she is responsible for notifying his/her Department Chair immediately. Failure to do so, in and of itself, constitutes separate grounds for corrective action.

5.4-3 SCIENTIFIC MISCONDUCT

All requests for investigations involving allegations of scientific misconduct shall be conducted in accordance with the Medical Staff Policy and Procedure.

5.5 IMPAIRED PRACTITIONERS

In the event that a Practitioner receives a report that another Practitioner is unable to practice his/her profession with reasonable skill and safety to patients because of a physical or mental illness, including deterioration through the aging process or loss of motor skill, or excessive use or abuse of drugs, including alcohol, the policies and procedures defined in Medical Staff Practitioner Effectiveness Policy shall apply. In the event that there is an apparent or actual conflict between the Practitioner Effectiveness Policy and the Medical Staff Bylaws, Rules and Regulations, or other policies of the hospital or its medical staff (including Article VI of the Medical Staff Bylaws), the Practitioner Effectiveness Policy shall control.
ARTICLE VI
HEARINGS AND APPEALS PROCEDURES

6.1 DEFINITIONS

For purposes of this section the following definitions shall apply:

a. The phrase “body whose decision prompted the hearing” refers to the Medical Executive Committee or the Board, which, pursuant to the Bylaws, made the recommendation or took the action which resulted in a hearing being requested.

b. The phrase “person who requested the hearing” refers to the applicant or Appointee, as the case may be, who has requested a hearing pursuant to § 6.2.

6.2 REQUEST FOR HEARING

6.2-1 NOTICE OF ADVERSE RECOMMENDATION/ACTION

a. In all cases in which a body has the authority to take and, pursuant to this authority has taken, any of the actions constituting grounds for a hearing as set forth in §§ 6.2-2, and provided the action is taken on the basis of quality of care or professional behavior concerns, the applicant or Appointee, as the case may be, shall promptly be given Special Notice of the proposed action stating the following:

(1) A professional review action has been taken or is proposed to be taken against the Practitioner and the reasons for the proposed action including a concise statement of the practitioner’s alleged acts or omissions forming the basis for the adverse recommendation or action (including, when appropriate, a list of medical by medical record number pertaining to the recommendation or action);

(2) The Practitioner has thirty (30) calendar days following the date of the receipt of such notice 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 action shall be referred to the Board for final decision.

(4) The Practitioner has those hearing rights specified in § 6.4-5 and as otherwise set forth in this Article.

6.2-2 GROUNDS FOR HEARING

a. Except as otherwise specified in these Bylaws, any one (1) or more of the following actions or recommended actions, if taken on the basis of quality of care or professional behavior concerns, shall be deemed adverse and shall constitute grounds for a hearing:
(1) Denial of Medical Staff appointment or reappointment in conjunction with a denial of Privileges.

(2) Suspension of Medical Staff appointment in excess of fourteen (14) days.

(3) Suspension of Clinical Privileges in excess of fourteen (14) days.

(4) Revocation of Medical Staff appointment.

(5) Denial of requested Clinical Privileges, as upheld/approved by the Privileges Committee of the Board.

(6) Revocation or reduction of Clinical Privileges, as upheld/approved by the Privileges Committee.

(7) Terms of probation resulting in a limitation on previously exercised Privileges in excess of fourteen (14) days.

(8) Individual application of, or individual change in, mandatory consultation requirement resulting in a limitation on previously exercised Privileges (excluding initial monitoring and proctoring for the exercise of new Privileges).

b. The following recommendations or actions shall not entitle the Practitioner affected thereby to a hearing:

(1) The issuance of a warning, letter of admonition, or letter of reprimand.

(2) The denial, termination, or reduction of temporary, disaster, locum tenens, or emergency Privileges.

(3) The implementation of any Hospital or Medical Staff policy that applies to all Practitioners or a category of Practitioners without consideration of individual circumstances. Provided, however, that in the event such a policy applies to a category of Appointees, an Appointee shall be entitled to a hearing for the sole purpose of establishing that he/she is not a member of such category, but the hearing may not contest the policy itself.

(4) An action that does not related to the quality of care or professional conduct of a Practitioner.

(5) Any other action not specifically listed in § 6.2-2.

6.2-3 EXHAUSTION OF REMEDIES

If an adverse action described in § 6.2-2 is taken or recommended, the applicant or Appointee must exhaust the remedies afforded by these Bylaws before resorting to legal action. If a Practitioner resorts to legal action as a result of an adverse action described in § 6.2-2, he/she will be deemed to have waived the hearing and appeal rights of this Article.

6.2-4 APPLICATION OF ARTICLE

a. For purposes of this Article, the term "Appointee" or “Practitioner” may include "applicant," as it may be applicable under the circumstances.
b. As provided by the Credentialing Manual, circumstances may arise in which an initial hearing is provided by the Board. In such cases, the procedures set forth herein for hearings before the Judicial Review Panel (see § 6.3-2) shall generally apply to hearings before the Board, except as reasonably modified by the Board.

6.3 SCHEDULING THE HEARING

6.3-1 TIME AND PLACE FOR HEARING

a. Upon receipt of a 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. The Medical Staff President, or his designee, shall, within a reasonable period of time after receipt of such request, schedule and arrange for a hearing, and notify the Hospital President and the members of the Medical Executive Committee as to the hearing date.

b. The Medical Staff President shall give written notice to the Practitioner of the time, place, and date of the hearing not less than thirty (30) calendar days prior to the date of the hearing unless such notice is waived in writing by the Practitioner. Such notice shall also include a list of witnesses the Medical Executive Committee (or Board as applicable) intends to call at the hearing.

c. When a request for a hearing is received from an Appointee who is currently under suspension, which is then in effect, the hearing shall be held as soon as the arrangements may reasonably be made, but not more than twenty (20) working days from the date of receipt of the request for a hearing by the Medical Staff President if the Appointee waives the thirty (30) day notice requirement.

6.3-2 JUDICIAL REVIEW PANEL

In the sole discretion of the Medical Staff President, with the approval of the Medical Executive Committee, the Judicial Review Panel will consist of one (1) of the following alternatives:

a. A hearing officer who need not be an Appointee or a Practitioner, but who is otherwise determined to be qualified (such as an attorney); or

b. A panel of not less than three (3) individuals who may or may not be Appointees or Practitioners but who are deemed qualified.

When a hearing panel described in paragraph (b) above is utilized and when competency of the Practitioner is at issue, at least one (1) committee 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.

Neither the hearing office nor any member of the hearing panel shall be a direct economic competitor of the Practitioner in question nor have played an active role in initiating or investigating the action(s) in question.

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

6.3-3 FAILURE TO APPEAR OR PROCEED
Under no circumstance shall the hearing be conducted without the personal presence of the Practitioner requesting the hearing. Failure without good cause of the Practitioner to personally attend shall result in the Practitioner being deemed to have waived his/her rights as provided in § 6.2-1(a).

6.3-4 POSTPONEMENTS AND EXTENSIONS

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. Once a hearing has commenced, the JRP [or its chair acting on its behalf] shall resolve all requests for postponements and extensions of time, based upon a showing of good cause.

6.4 HEARING PROCEDURE

6.4-1 PRE-HEARING PROCEDURE

a. Within ten (10) days of the Practitioner’s receipt of the notice of hearing, the Practitioner shall provide, by written 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 no event less than seven (7) days prior to the hearing, in order that the parties may properly prepare.

c. It shall be the duty of the affected Practitioner and the Medical Executive Committee to exercise reasonable diligence in notifying the chair of the JRP 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.

6.4-2 REPRESENTATION

a. The hearings provided for in these Bylaws are for the purpose of intra-professional resolution of matters bearing on professional conduct, professional competency, or character. Both the Practitioner and the Medical Executive Committee 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 only by another Practitioner, preferably an Appointee in Good Standing, provided that such individual agrees in writing to maintain the confidentiality of the peer review proceedings.

c. In the absence of legal counsel, the Medical Staff President, with approval of the Medical Executive Committee, shall designate an Appointee to represent the Medical Executive Committee at the hearing. If the Medical Staff President appoints himself/herself, he/she shall be entitled to be accompanied by another Practitioner, preferably an Appointee in Good Standing, provided that such individual agrees in writing to maintain the confidentiality of the peer review proceedings.
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.

6.4-3 THE PRESIDING OFFICER

The presiding officer at the hearing shall be the hearing officer or, if a committee is appointed, the chair of the committee. 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 are being 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 and to the admissibility of evidence.

6.4-4 RECORD OF THE HEARING

The JRP shall maintain a record of the hearing by use of a court reporter. 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, but the Practitioner shall be obligated to pay any reasonable charges associated with the cost of obtaining a copy of the transcript of proceedings.

6.4-5 RIGHTS OF BOTH SIDES

At the hearing, in addition to any rights set forth in this Article, both sides shall have the right: to be present, to call and examine witnesses, to introduce exhibits, to cross-examine any witness on any matter relevant to the issues, to impeach any witness and to rebut any evidence, to be apprised of whether the JRP will be a hearing officer or a committee, to submit a written statement prior to, during, and at the close of the hearing; and upon completion of the hearing, the right to receive a written recommendation from the hearing officer/committee (including the basis for the same), and to receive the written decision of the Board (including a statement of the basis for the decision). If the Practitioner does not testify in his/her own behalf, he/she may be called and examined as if under cross-examination.

6.4-6 ADMISSIBILITY OF EVIDENCE

The hearing shall not be conducted 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. Each party shall have the right to submit a memorandum of legal and/or medical points and authorities, and the JRP may request such a memorandum to be filed following the close of the hearing. The JRP members may question the witnesses, and the JRP may request that additional witnesses be called if the committee deems it appropriate.

6.4-7 BASIS OF DECISION
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:

a. Oral testimony of witnesses.

b. Briefs of memoranda of legal and/or medical points and authorities presented in connection with the hearing.

c. Any material contained in the Medical Staff files regarding the Practitioner who is the subject of the hearing.

d. Any and all applications, references, and accompanying documents.

e. All officially noticed matters.

f. Any other evidence deemed admissible by the presiding officer under § 6.4-6.

6.4-8 BURDEN OF PROOF

In all cases it shall be incumbent on the body whose recommendation or action triggered the hearing to come forward initially with evidence in support of its recommendation/action. Thereafter, the person who requested the hearing shall come forward with evidence in support of his/her position.

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 a preponderance of evidence, that the recommendation of the body whose recommendation/action triggered the hearing was arbitrary, unreasonable, or not sustained by the evidence.

6.4-9 ADJOURNMENT AND CONCLUSION

The presiding officer may adjourn and reconvene the hearing at the convenience of the participants at such times and intervals as may be reasonable and warranted, with due consideration for reaching an expeditious conclusion to the hearing. Upon conclusion of the presentation of oral and written evidence, or the receipt of written arguments, if requested, the hearing shall be closed.

6.4-10 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 report and recommendation that shall be delivered to the body whose decision prompted the hearing.

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 report and recommendation and shall make a final recommendation/proposed decision in which it shall affirm, modify, or reverse its initial recommendation/action. It shall forward its final recommendation/action to the Hospital President.
d. Upon receipt of the final recommendation/action, the Hospital President shall forward a copy of the same, together with the JRP’s report and recommendation, to the affected Practitioner. 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 § 6.5.

6.5 APPEALS TO THE BOARD

6.5-1 TIME FOR APPEAL

a. If the recommendation/action is not adverse or if the Practitioner does not request appellate review, the recommendation/action shall be presented to the Board at its next regularly scheduled meeting for decision consistent with § 6.5-6.

b. Within ten (10) working days after receipt of an adverse recommendation/decision by the triggering body, the affected Practitioner may request an appellate review by the Board.

c. If the Practitioner does request appellate review, the request must be delivered by Special Notice to the Hospital President, with a brief statement as to the grounds for appeal. Upon receipt of the request, the Hospital President, in discussion with the chair of the Board, shall set a date for such review and, by Special Notice, advise the Practitioner and the triggering body of the date of the appellate review.

6.5-2 GROUNDS FOR APPEAL

The grounds for appeal from the hearing shall be:

a. 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.

b. Action taken arbitrarily, capriciously, or with prejudice.

c. The decision was not supported by substantial evidence based upon the hearing record or such additional information as may be permitted pursuant to the appeals procedure.

6.5-3 TIME, PLACE, AND NOTICE

In the event of an 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 within a reasonable period of time from the date of receipt of the request; provided, however, that when a request for appellate review is from an Appointee who is under suspension which is then in effect, the appellate review shall be held as soon as the arrangement may reasonably be made. The time for appellate review may be extended by the chair of the Board for good cause where the rights of either party will not be impaired.

6.5-4 NATURE OF APPELLATE REVIEW

The Appellate Review shall be heard by a designated committee appointed by the Board Chair.
a. The proceedings by the Board shall be in the nature of an appellate review of the record of the hearing before the JRP. New or additional matters or evidence not raised or presented during the original hearing, or in the hearing report, and not otherwise reflected in the record shall be introduced at the review only in extraordinary circumstances at the discretion of the Board based upon a determination that the matter or evidence was not, or could not, have been made available at the time of the hearing. In such event, the Board may hear the testimony or may reconvene the JRP to hear the testimony.

b. 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 designated by the Board. At the discretion of the Board, each party may be permitted to present oral arguments.

c. The System President will supply or make available to each member of the Appellate Review Committee a copy of the record of the proceedings before the JRP, any written closing arguments of the parties, and the report and recommendation of the JRP. At the conclusion of oral arguments, if allowed, the Board may thereupon, at a time convenient to itself, conduct deliberations outside the presence of the appellant parties.

d. A quorum of the Appellate Review Committee must be present throughout the review and deliberations.

e. The Board, through the Appellate Review Committee may affirm, modify, or reverse recommendation/action of the Medical Executive Committee; refer the matter back to the Medical Executive Committee with specific instructions and deadlines; or take such other action as the Board deems appropriate.

6.5-5 POSTPONEMENTS AND EXTENSIONS

During the appeals 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 Committee or its chair acting upon its behalf on a showing of good cause when the rights of either party will not be impaired.

6.5-6 FINAL BOARD DECISION

a. Within ten (10) working days of the conclusion of all proceedings, the Board shall render its decision.

b. Except where the matter is referred for further review and recommendation in accordance with § 6.5-4, the final decision of the Board following the appeal procedure set forth in this Article shall be effective immediately and shall not be subject to further review; provided, however, if the matter is referred back to the Medical Executive Committee for further review and recommendation in accordance with § 6.5-4, the Medical Executive Committee shall promptly conduct its review and make its recommendations to the Board in accordance with the instructions given by the Board. This further process and the report back to the Board shall in no event exceed thirty (30) calendar days in duration except as the parties may otherwise stipulate.
c. The Board’s final decision shall be in writing. The Hospital President shall send the Practitioner a copy of the Board’s decision by Special Notice and shall also send a copy of the Board’s decision to the Medical Executive Committee.

6.6 RIGHT TO ONE HEARING ONLY

Except as otherwise provided in this Article, no applicant or Appointee 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.
ARTICLE VII
OFFICERS

7.1 OFFICERS OF THE MEDICAL STAFF

7.1-1 IDENTIFICATION

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

7.1-2 QUALIFICATIONS

Officers must be Appointees to the active Medical Staff at the time of their nomination and election, and must remain Appointees in Good Standing during their term of office. Failure to maintain such status shall create a vacancy in the office involved.

7.1-3 NOMINATIONS

a. A Nominating Committee shall be composed of the elected officers, Vice President of Medical Affairs, Assistant Vice President of Medical Affairs, Vice President of Medical Education, and chair of the Department Chairs Committee).

   (1) The Nominating Committee shall meet in a timely manner prior to the annual Medical Staff meeting and accept nominations as outlined in this Article. There shall be no less than two (2) nominations for each position and office available. In the event not enough nominations are received to meet this qualification, the Nominating Committee shall be charged with identifying suitable candidates for the respective offices.

b. Nominations may be made for any vacant office by any voting Appointee to the Medical Staff, 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. These nominations shall be delivered to the chair of the Nominating Committee. A complete list of such nominations shall be mailed to each voting Appointee with the notice of the annual Medical Staff meeting.

c. At any one (1) time, no more than two (2) of the officers serving in the rotation who have been elected by the Medical Staff (i.e. Vice President, President) shall be from the same department.

7.1-4 ELECTIONS

The Medical Staff election of officers shall be held each year at the annual Medical Staff meeting.

a. Only Appointees accorded the Prerogative to vote for general Medical Staff officers shall be eligible to vote. Voting shall be by secret ballot. Voting by absentee ballot shall be permitted. Voting by proxy shall not be permitted.
b. Election to a position shall be dependent upon receiving a plurality of the votes cast by voting members of the Medical Staff who are either present or vote by absentee ballot.

c. If no candidate for the office receives a plurality of the vote on the first ballot, a runoff election shall be held immediately between the two (2) candidates receiving the highest number of votes. The candidate receiving the greatest number of votes shall then be elected.

7.1-5 TERM OF ELECTED OFFICE

Each officer shall serve a two (2) year term, commencing on the first day of the calendar year following his/her election. Each officer shall serve until the end of his/her term and until a successor is elected, unless he/she resigns or is removed from office. Officers may not succeed themselves in office and may not serve in more than one (1) office at a time.

7.1-6 REMOVAL OF ELECTED OFFICERS OR ANY MEMBER OF THE MEDICAL EXECUTIVE COMMITTEE

a. Except as otherwise provided, removal of a Medical Staff officer or member of the Medical Executive Committee 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; or

   (3) A recommendation from the Board.

b. Removal may be accomplished by a two-thirds (2/3) vote of the active Medical Staff present at any regular or special meeting at which a majority is present.

c. Removal of an officer or member of the Medical Executive Committee shall only be based upon his/her failure to perform the duties of the office or duties of the Medical Executive Committee as described in these Bylaws, or upon the imposition of corrective action that lasts more than thirty (30) days as described in these Bylaws.

d. Removal from office shall not entitle the affected Practitioner to any hearing or appeal rights regarding the issue of removal.

7.2 DUTIES OF OFFICERS

7.2-1 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 the nursing and other patient care services with those of the Medical Staff.

c. Communicating and representing the opinions, policies, concerns, needs and grievances of the Medical Staff to the Board, the Hospital President, and other officials as appropriate.

d. Being responsible for the enforcement of Medical Staff Bylaws, Manuals, policies, procedures, 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, with approval of the Medical Executive Committee, Medical Staff committee members and chairs.

h. Appointing, subject to the approval of the Medical Executive Committee, committee members and chairs.

7.2-2 VICE MEDICAL STAFF PRESIDENT

The Vice Medical Staff 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 § 7.2-1.

b. Serving as a member of the Medical Executive Committee.

c. Serving as a member of the Privileges 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 until a successor is selected in accordance with these Bylaws.

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. Supervise the following tasks: proper notice of all Medical Staff meetings, and preparing minutes for all Medical Executive Committee and Medical Staff meetings; notifying all Appointees of proposed amendments to these Bylaws, and of substantive amendments to the Manuals, policies, and procedures; the
collection and accounting of any funds that may be collected in the form of staff dues and assessments.

7.2-3 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.

7.3 VACANCY

a. In the event that the Medical Staff President’s position becomes vacant, the Vice President shall assume the position of President.

b. 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 an active Medical Staff Appointee to serve the duration of the term. In the interim, the Past Medical Staff President will fulfill the joint roles.

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

7.4 OFFICERS AND REPRESENTATIVES

Candidates for Medical Staff representation on the Boards shall be selected by a process determined by the collective Summa medical staff. A Summa physician will serve on the committee providing formal evaluation of potential physician representatives to the Boards.
ARTICLE VIII
CLINICAL DEPARTMENTS

8.1 ORGANIZATION OF CLINICAL DEPARTMENTS

a. 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 § 8.4-5.

b. A Department may be further divided, as delineated within the Department's rules and regulations, in order to carry out its functions.

c. The Medical Executive Committee must approve the creation, elimination, modification, or combination of Departments or their subdivisions.

8.2 ASSIGNMENT TO DEPARTMENTS AND SUBDIVISIONS

a. Each Practitioner shall be assigned membership in one (1) Department for purposes of exercising any rights, responsibilities, Prerogatives, and/or Clinical Privileges granted in accordance with these Bylaws.

b. A Practitioner may be granted Clinical Privileges in other Departments and subdivisions.

c. The exercise of Clinical Privileges or the performance of specified services within any Department, or subdivision shall be subject to the rules and regulations of that Department and the authority of that Department Chair.

8.3 FUNCTIONS OF DEPARTMENTS

The general functions of each department shall include:

a. Conducting patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients. The Department shall routinely collect information about important aspects of patient care provided in the Department; identify indicators to be used to monitor the quality of care and the evaluation of the care provided; and periodically review the care to draw conclusions, formulate recommendations, and initiate action to improve patient care. Patient care reviews shall include all clinical work performed under the jurisdiction of the Department, regardless of whether the Practitioner whose work is subjected to such review is a member of that Department;

b. Recommending to the Medical Executive Committee guidelines for the granting of Clinical Privileges and the performance of specified services within the Department.

c. Evaluating and making appropriate recommendations regarding the qualification of applicants seeking appointment or reappointment and Clinical Privileges or a modification of existing clinical privileges within the Department.
d. Conducting and making recommendations regarding continuing education programs pertinent to Departmental clinical practice.

e. Reviewing and evaluating departmental adherence to:

   (1) Medical Staff Bylaws, Manuals, policies and procedures.

   (2) Hospital policies and procedures.

   (3) Sound principles of clinical practice.

   (4) Department rules and regulations.

f. Coordinating patient care provided by the Department's members with nursing, ancillary patient care services and administration.

g. Submitting written reports to the Medical Executive Committee concerning:

   (1) The Department's review and evaluation activities, actions taken thereon, and the results of such action.

   (2) Recommendations for maintaining and improving the quality of care provided in the Department and the Hospital.

   (3) Such other matters as may be requested from time to time by the Medical Executive Committee.

h. In accordance with accreditation standards, meeting for the purpose of considering patient care review findings and the results of the Department's other review and evaluation activities, as well as reports on other Department and Medical Staff functions.

i. Establishing and appointing such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including protocols for proctoring.

j. Taking appropriate action when deficiencies and/or problems in patient care and/or clinical performance or opportunities to improve care are identified.

k. Accounting to the Medical Executive Committee for all professional and Medical Staff administrative activities within the department;

l. Formulating recommendations for Departmental procedures reasonably necessary for the proper discharge of its responsibilities subject to approval by the Medical Executive Committee and the Board.

8.4 DEPARTMENT CHAIR

8.4-1 QUALIFICATIONS

Each Department shall have a Chair who shall be an active Appointee and shall be qualified by training, experience, and demonstrated ability in at least one (1) of the clinical areas within the Department.
8.4-2 SELECTION

a. Permanent Department Chairs shall be selected by a search committee appointed by the Board.

b. Interim Department Chairs shall be selected jointly by the Medical Staff President, Vice President of Medical Affairs, and the Hospitals 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.

8.4-3 REMOVAL OF DEPARTMENT CHAIRS

a. Except as otherwise provided, removal of a Department Chair may be initiated by any of the following:

   (1) The Medical Executive Committee.

   (2) By a petition signed by twenty-five percent (25%) of the Department members eligible to vote.

   (3) By a recommendation of the Board.

b. Removal may be accomplished:

   (1) By a two-thirds (2/3) written vote of the Department members eligible to vote at any regular or special Department meeting at which a majority is present.

   (2) A two-thirds (2/3) written vote of the Medical Executive Committee at any regular or special meeting at which a quorum is present.

   (3) In accordance with the code of regulations of the System.

c. Removal of a Department Chair shall only be based upon his/her failure to perform the duties of the office as described in these Bylaws or on the imposition of corrective action as described in these Bylaws.

d. Removal from the Chair position shall not entitle the removed Appointee to any hearing or appeal rights regarding the issue of removal.

e. Removal of a Department Chair shall not be effective until ratified by the Board.

8.4-4 VACANCIES IN THE CHAIR OFFICE

Any permanent vacancy that occurs in a Department Chair position shall be filled in the same manner provided in these Bylaws for the selection of a chair.
8.4-5 DUTIES OF DEPARTMENT CHAIR

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

a. All clinically related activities of the Department.

b. 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. The integration of the Department into the primary functions of the Hospital.

d. The coordination and integration of interdepartmental and intradepartmental services.

e. The development and implementation of rules and regulations 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 Allied Health Professionals who work within the respective Department.

j. The 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 hospital departments as necessary.

k. The maintenance of quality control programs, as appropriate.

l. The 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.

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 and/or service.

r. Enforcing:

(1) The Medical Staff Bylaws, Manuals, policies and procedures.

(2) Hospital policies and procedures.

(3) Applicable Department rules and regulations.

s. Monitor research activities within the Department.

t. In concert with the Vice President of Medical Education and Research, assisting in the development, implementation, and monitoring of graduate medical education.
ARTICLE IX

MEDICAL STAFF COMMITTEES

9.1 DESIGNATION

The committees described in the Medical Staff Policies and Procedures shall be the standing committees of the Medical Staff. Special or ad hoc committees may be created by the Medical Executive Committee to perform specified tasks. Unless otherwise specified, the chair and members of all standing Medical Staff committees shall be appointed by the Medical Staff President, subject to consultation with the Medical Executive Committee, with the exception of the Medical Executive Committee and the Medical Education Committees. Department committees shall be appointed by the Department Chair. All Medical Staff committees shall be responsible to the Medical Executive Committee. The System and Hospital Presidents shall be entitled to attend all Medical Staff, Department and Medical Staff committee meetings.

9.2 GENERAL PROVISIONS

9.2-1 TERMS OF COMMITTEE MEMBERS

Unless otherwise specified, committee members shall be appointed for a term of one (1) year and shall serve until the end of this period or until the member's successor is appointed, unless the member resigns or is removed from the committee. No limitation shall be imposed on the number of consecutive terms a committee member may serve.

9.2-2 REMOVAL

Any committee member who is appointed by the Medical Staff President may be removed by the Medical Staff President subject to a majority vote of the Medical Executive Committee at any meeting at which a quorum is present. Any committee member appointed by a Department Chair may be removed by the Department Chair or a majority vote of the Department committee at any meeting at which a quorum is present subject to approval by the Medical Executive Committee. The removal of any committee member who is a member Ex Officio shall be governed by the provisions pertaining to removal of such officer or official from his/her office. Any committee member so removed shall not be entitled to a hearing or appeal on the subject of removal.

9.2-3 VACANCIES

Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made.

9.3 REPORTS AND RECOMMENDATIONS

Whenever these Bylaws or Manuals require that a function be performed by, or a report or recommendation be submitted to a named Medical Staff committee, but no such committee exists, the Medical Executive Committee shall perform such function or receive such report or recommendation or shall assign the function to a new or existing committee of the Medical Staff or to the Medical Staff as a whole.

9.3-1 TERMINATION OF A COMMITTEE

A committee may be terminated upon a majority vote of the Medical Executive Committee so long as the delegated responsibility for monitoring the Medical Staffs
and the quality of patient care is not in any way impaired. This section shall not apply to any committees required by any accrediting or licensing agency of the Hospital or Medical Staff.

9.3-2 CONFIDENTIALITY

All attendees at any committee meetings shall be subject to the confidentiality requirements identified in these Bylaws regardless of whether they are Appointees.

9.4 MEDICAL EXECUTIVE COMMITTEE

9.4-1 COMPOSITION

The Medical Executive Committee shall consist of the following voting persons, and at all times, a majority of the voting members shall be Physicians:

a. The Medical Staff President.

b. The Vice Medical Staff President.

c. Chairs of the Departments.

d. Four (4) At-Large Representatives to the Medical Staff.

e. One (1) young Physician At-Large Representative to the Medical Staff. (See § 9.4-2(E)).

f. The immediate past Medical Staff President.

g. The Vice President of Medical Affairs.

h. The Vice President of Medical Education and Research

i. The Board chair, if a licensed Physician, or physician designee of any physician hospital organization.

j. The individuals by position from the Summa Barberton Citizens Hospital Executive Medical Counsel as of the date immediately preceding the merger of Summa Barberton Citizens Hospital into Summa Health System:

(1) The Chief of Surgery.

(2) The Chief of Medicine.

(3) The Chief of Obstetrics and Gynecology.

(4) The Chief of Family Medicine.


(6) The Chief of Radiology.

(7) The Chief of Pathology.


(9) The Chief of Staff of Summa Barberton Citizens Hospital.

(10) The Vice Chief of Staff of Summa Barberton Citizens Hospital.

(11) The immediate Past Chief of Staff of Summa Barberton Citizens Hospital.

(12) Three (3) Members-at-Large.
The above-referenced persons shall hold Medical Executive Committee positions from the date of the merger of Summa Barberton Citizens Hospital into Summa Health System until December 31, 2016.

The Medical Executive Committee shall consist of the following *Ex Officio* non-voting persons:

a. The Hospital President

b. A Member of the Board.

c. Other representatives may be appointed at the discretion of the chair of the Medical Executive Committee.

### 9.4-2 SELECTION OF MEDICAL EXECUTIVE COMMITTEE MEMBERS

a. The officers of the Medical Staff shall be selected in accordance with § 7.1.

b. The Department Chairs shall be selected in accordance with § 8.4.

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 President and Vice President may not be from the same department.

d. At Large Representatives

   (1) The four (4) At-Large Representatives shall be nominated in the same manner as described in these Bylaws for the nomination and election of officers at the annual Medical Staff meeting. At-Large Representatives shall serve overlapping two (2) year appointments to the Medical Executive Committee.

   (2) No more than one (1) At-Large Representative elected by the Medical Staff serving on the Medical Executive Committee at any one (1) time shall be from the same Department.

e. Young Physician At-Large Representative

   The young Physician At-Large Representative shall be nominated in the same manner as described in these Bylaws for nomination and election of officers. To be qualified to run for this position, a candidate shall have completed his/her training within the preceding five (5) years and shall be an Appointee to the Medical Staff for less than five (5) years at the time of election. The young Physician At-Large Representative shall serve a one (1) year appointment to the Medical Executive Committee.

### 9.4-3 QUORUM

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

c. Reviewing Bylaws, Manuals, policies, and recommending amendments to same.

d. Requesting evaluations of Practitioners and Allied Health Professionals when there is doubt about the individual’s ability to 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 including the initiation of and participation in Medical Staff corrective 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 approving 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 health from Medical Staff corrective action functions. The policies and procedures shall be designed to provide (either through internal process or by referral to a Practitioner wellness program approved by the Medical Executive Committee) education about Practitioner health; address prevention of physical, psychiatric, or emotional illness; and facilitate confidential diagnosis, treatment, and rehabilitation of Practitioners who suffer from a potentially impairing condition. If at any time a Practitioner’s health renders him/her unable to safely exercise his/her Privileges, the matter shall be forwarded to the Medical Executive Committee for appropriate corrective action under the Impaired Practitioner Policy.

s. Advising the Board as to the Medical Executive Committee’s opinion 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.

9.4-5 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 Vice President 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 for 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 two (2) calendar 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.
ARTICLE X
MEETINGS

10.1 GENERAL STAFF MEETINGS

10.1-1 GENERAL MEDICAL STAFF MEETINGS

In addition to the annual Medical Staff meeting, other general Medical Staff meetings shall be convened as needed through the request of either:

a. The Medical Staff President, or

b. The chair of the Board, or

c. A majority of the Medical Executive Committee, or

d. A petition of five percent (5%) or more of the active Medical Staff.

10.2 COMMITTEE AND DEPARTMENT MEETINGS

10.2-1 REGULAR MEETINGS

Committees and Departments may provide the time and place for holding regular meetings with appropriate notice. The frequency of such meetings shall be as required by these Bylaws.

10.2-2 SPECIAL MEETINGS

A special meeting of any committee or any Department may be called by, or at the request of: the chair thereof, the Medical Executive Committee, the Medical Staff President or by a one-third (1/3) vote of the committee or Department's current members. No business shall be transacted at any special meeting except that stated in the meeting notice.

10.3 NOTICE OF MEETINGS

Written notice stating the place, date, and time of any general Medical Staff meeting, or any special meetings, or of any regular committee or Department meetings not held pursuant to resolution shall be delivered either personally or by electronic or postal mail to each person entitled to be present thereat not less than two (2) days before the date of such meeting. Notice of Department or committee meetings may be given orally. Notice of general or special Medical Staff meetings shall be mailed. If mailed, the notice of the meeting shall be deemed delivered seventy-two (72) hours after e-mailing or deposited, postage prepaid, in the United States mail addressed to each person entitled to such notice at his/her address as it appears on the records of the Hospital. Personal attendance at a meeting shall constitute a waiver of notice of such meeting, and notice may also be waived in writing without attendance.
10.4 QUORUM

10.4-1 MEETINGS

Unless otherwise provided in these Bylaws, the quorum for all meetings of the Medical Staff, Departments, and committees shall be defined as those voting members present but not less than two (2).

10.4-2 ATTENDANCE BY DESIGNEE

Any member of a Medical Staff committee may send a designee in his/her place. A designee shall be eligible to vote and shall be counted for purposes of a quorum except as may be specified in the Bylaws.

10.5 MANNER OF ACTION

Except as otherwise specified, the actions of a majority of the members present, and voting, at a meeting at which a quorum is present shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater numbers as may be specifically required by these Bylaws. Committee action may be conducted by electronic conference, which shall be deemed to constitute a meeting for the matters discussed in that electronic conference. Valid action may be taken without a meeting by a committee if it is acknowledged by a writing setting forth the action so taken which is signed by at least two-thirds (2/3) of the members entitled to vote.

10.6 MINUTES

Minutes of all meetings shall be prepared and shall include a record of attendance and the vote taken on each matter presented. Copies of such minutes shall be signed by the presiding officer, forwarded to the Medical Executive Committee, and made available to the Medical Staff in the Medical Staff Office. A permanent file of the minutes of each meeting shall be maintained in the Medical Staff Office and are made available to Medical Staff members as appropriate at the discretion of the Medical Staff President.

10.7 ATTENDANCE REQUIREMENTS

Attendance at all Medical Staff meetings, Department meetings, and committees is encouraged, but optional, unless otherwise required in the Bylaws, Manuals, or the Departmental rules and regulations.

10.8 CONDUCT OF MEETINGS

Common sense, as determined by the Medical Staff President, chair of a committee, or Department Chair, as applicable, shall be applied in the conduct of meetings.
ARTICLE XI
CONFIDENTIALITY, IMMUNITY AND RELEASES

11.1 SPECIAL DEFINITIONS

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 §11.6.

b. Practitioner: For purposes of this Article alone, a Practitioner includes a Medical Staff Appointee or applicant.

c. Representative: The Board and any director or committee or delegated representative thereof; the Hospital President or his/her designee; the Medical Staff organization and any member, officer, department or committee hereof; and any individual authorized by any of the foregoing to perform specific information gathering or disseminating functions.

d. Third Parties: Any and all individuals and organizations providing information to any representative identified in §11.1(c).

11.2 AUTHORIZATIONS AND CONDITIONS

By applying for or exercising, Clinical Privileges or providing specified patient care services within this Hospital, a Practitioner:

a. Authorizes Representatives of the Hospital and the Medical Staff to solicit, provide, and act in accordance with other provisions of these Bylaws 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, or acceptance of, Medical Staff appointment and the continuation of such appointment or to his/her exercise of Clinical Privileges or provision of specified patient services at this Hospital.

11.3 CONFIDENTIALITY OF INFORMATION

Information with respect to any Practitioner submitted, collected, or prepared by any Representative of this or any other health care facility or organization of the Medical Staff for the purpose of achieving and maintaining quality patient care, reducing morbidity and mortality, or contributing to clinical research shall, to the fullest extent permitted by law, be confidential and shall not be disseminated to anyone other than a Representative nor be used in any way except as provided herein or except as otherwise required by law. Such confidentiality shall also extend to Information of like kind that may be provided by any Third Parties. The Information so
provided shall not become part of any particular patient's file or general Hospital records, but will remain in the Practitioner’s Credentialing file.

11.4 BREACH OF CONFIDENTIALITY

Inasmuch as effective peer review and consideration of the qualifications of Practitioners to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of any Departments, divisions, or committees, except in conjunction with other Hospital, professional society, or licensing authority, is outside appropriate standards of conduct for any Practitioner and will be deemed disruptive to the operations of the Hospital. If it is determined that such a breach has occurred, the department, the Medical Executive Committee or the Board may undertake such corrective action as it deems appropriate in accordance with these Bylaws.

11.5 IMMUNITY FROM LIABILITY

11.5-1 FOR ACTION TAKEN

Each Representative of the Medical Staff and/or Hospital 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 of the Medical Staff and/or the Hospital.

11.5-2 FOR PROVIDING INFORMATION

Each Representative of the Medical Staff and/or the Hospital 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 to a Representative of the Medical Staff and/or the Hospital concerning such person who is, or has been, an Appointee to the Medical Staff or who did or does, exercise Clinical Privileges or provide services at this Hospital.

11.6 ACTIVITIES AND INFORMATION COVERED

11.6-1 ACTIVITIES

The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations, disclosures, or other Information performed or made in connection with this or any other health care facilities or organizations activities concerning, but not limited to:

a. Applications for appointment, Clinical Privileges or specified services.

b. Appraisals for reappointment, Clinical Privileges or specified services.

c. Any corrective action.

d. Hearings and appellate review.

e. Quality assurance activity.

f. Utilization review activity.
g. Peer review organizations.

h. Any other hospital, Department, committee, or Medical Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct.

11.6-2 INFORMATION

The acts, communications, reports, recommendations, disclosures and other Information referred to in this Article may relate to a Practitioner's professional qualifications, clinical ability, judgment, character, physical and mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care and Medical Staff or Hospital operations.

11.7 RELEASES

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

11.8 CUMULATIVE EFFECT

Provisions in these Bylaws and in the application forms relating to authorizations, confidentiality of Information and immunities from liability shall be in addition to any other protection provided by law and not in limitation thereof, and in the event of conflict, the superior applicable law shall be controlling.
ARTICLE XII
GENERAL PROVISIONS

12.1 DEPARTMENT RULES AND REGULATIONS

Subject to the approval of the Medical Executive Committee and the Board, each Department shall formulate its own rules and regulations for the conduct of its affairs and the discharge of its responsibilities. Such rules and regulations shall be consistent with these Bylaws, Manuals, or other policies of the Hospital.

12.2 FORMS

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

12.3 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.

12.4 TRANSMITTAL OF REPORTS

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

12.5 INTERESTED PARTY

No Practitioner shall actively participate in the discussions of any committee, or vote on any matter presented to a committee if the Practitioner has a significant conflict of interest that would influence his/her vote, or if the Practitioner has information that would unjustly prejudice his/her vote on the matter concerned. It is up to individual Practitioners to exercise this section, except that the Medical Executive Committee may require adherence to this section if it becomes aware of such a circumstance.

12.6 EFFECT OF BYLAWS

These Bylaws shall not constitute a contract by and between the Hospital, its member hospitals, any individual Appointee to the Medical Staff, or other Practitioner.
ARTICLE XIII
ADOPTION AND AMENDMENT OF BYLAWS

13.1 RESPONSIBILITY

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.

13.2 PROCEDURE

Medical Staff Bylaws may be adopted, amended, or repealed by the action set forth in this Section. The mechanisms described herein shall be the sole methods for the initiation, adoption, amendment, or repeal of the Medical Staff Bylaws.

13.2-1 Action by Medical Staff

Proposed amendments to these bylaws may originate from a petition signed by twenty-five percent (25%) of the active Appointees of the medical staff. When the medical staff proposes bylaws changes and before it votes, it will communicate the proposed amendment to the Medical Executive Committee. If the Medical Executive Committee does not pass the proposed amendment to the bylaws, the active Appointees of the medical staff can ask for a vote of the organized medical staff. Each active Appointee to the medical staff will be eligible to vote on the proposed amendment 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 members eligible to vote, the amendment will be recommended to the Board. An affirmative vote will be counted by returning the ballot marked “yes” or by not returning the ballot.

13.2-2 Action by the Medical Executive Committee

The Medical Executive Committee may propose amendments to the Medical Staff Bylaws but before it votes on the proposed changes, it will communicate its proposed amendment to the medical staff. If five percent (5%) or more of the active Appointees object to the proposed changes, 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. If less than five percent (5%) of the active Appointees object in writing to the proposed within fourteen (14) days of mailing or posting of the proposed amendment, the amendment will be recommended to the Board.

13.2-3 Action by the Board

Amendments to Bylaws shall become effective as of the date of an affirmative majority vote by the Board unless the Board establishes an alternative date.

13.3 TECHNICAL AND EDITORIAL AMENDMENTS
The organized medical staff delegates to the Medical Executive Committee the power to adopt such amendments to the Bylaws, Manuals, and policies as are, in its judgment, technical or legal modifications or clarifications, reorganization, or renumbering, or 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 and in writing to the Medical Staff and to the Board.

13.4 BOARD ACTION

13.4-1 CONFLICT WITH MEDICAL EXECUTIVE COMMITTEE/MEDICAL STAFF RECOMMENDATION

If the Board has determined not to accept a recommendation submitted to it by the Medical Executive Committee or the Medical Staff, the Medical Executive Committee or the Medical Staff may request a meeting for the purpose of further communicating the Board’s rationale for its contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the recommendation. The 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.

13.4-2 BOARD-INITIATED ACTION

The Board may adopt amendments to Bylaws, or Manuals, 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 committee for its recommendation prior to adoption any such amendments.

13.5 CONFLICT WITHIN DOCUMENTS

If a change to the Hospital code of regulations results in a conflict with the Medical Staff Bylaws, then the Hospital code of regulations shall control; provided, however, that such conflict shall then be referred to an ad hoc committee for recommendation to the Board as to how such conflict can be resolved. If there is a conflict between a medical staff rule, regulation or 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.
ARTICLE XIV
ADOPTION AND AMENDMENT OF RULES, REGULATIONS, AND POLICIES

14.1 DELEGATION TO MEDICAL EXECUTIVE COMMITTEE

The active Appointees to the medical staff may adopt rules, regulations and policies as necessary to carry out its functions and meet its responsibilities under these bylaws. The medical staff delegates this responsibility to the Medical Executive Committee. Proposed amendments to the rules, regulations and policies of the medical staff may be originated by the Medical Executive Committee. The Medical Executive Committee will communicate the proposed amendment to the organized medical staff prior to a vote. The Medical Executive Committee shall vote on the proposed language changes at a regular meeting, or at a special meeting called for such purpose. Following an affirmative vote by the Medical Executive Committee, any of these documents may be adopted, amended, or repealed, in whole or in part, and such changes shall be effective when approved by the Board.

14.2 ACTION BY THE MEDICAL STAFF

In addition, the active Appointees of the medical staff may recommend the adoption or amendment to any rule, regulation or policy directly to the Board by submitting a petition signed by twenty-five percent (25%) of the active Appointees of the medical staff. The active Appointees must first communicate the proposal to the Medical Executive Committee. If the Medical Executive Committee approves the proposal, the changes will be forwarded to the Board for final approval. Such changes shall be effective when approved by the Board. If the Medical Executive Committee does not approve the proposal, the active Appointees can request a vote of the organized medical staff. Each active Appointee to the medical staff will be eligible to vote on the proposed amendment 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 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.

14.4 CONFLICTS BETWEEN THE MEDICAL EXECUTIVE COMMITTEE AND THE MEDICAL STAFF

14.4-1 Any active Appointee of the medical staff may challenge any rule, regulation, policy or procedure 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 rule or policy in writing, including any recommended changes to the rule or policy.
b. At the Medical Executive Committee meeting that follows such notification, the Medical Executive Committee shall discuss the challenge and determine whether it will change the rule or policy.
c. If changes are adopted, 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 rule or policy to the President of the Medical Staff.
d. In response to a written challenge to a rule or policy, the Medical Executive Committee may, but is not required to, appoint a task force to review the challenge and recommend potential changes to address concerns raised by the challenge.
e. If a task force is appointed, the Medical Executive Committee will take final action on the rule or 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 medical staff member may submit a petition signed by twenty-five percent (25%) of the active Appointees of the medical staff requesting review and possible change of a rule, regulation, policy or procedure. After receiving a petition, the Medical Executive Committee will follow the adoption procedure outlined in Section 14.2 of these Bylaws.

14.4-2 If the medical staff votes to recommend directly to the board an amendment to the bylaws, rules or regulations, 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 bylaws, rules and regulations, or policies that is agreeable to both the medical staff and the Medical Executive Committee.

b. Regardless of whether the Medical Executive Committee adopts modified language, the medical staff shall have the opportunity to recommend alternative language directly to the Board. If the Board receives differing recommendations for bylaws, rules and regulations, 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. At any point in the process of addressing a disagreement between the medical staff and Medical Executive Committee regarding the bylaws, rules and regulations, or policies, the medical staff, MEC or governing 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.

14.5 URGENT AMENDMENT TO RULES, REGULATIONS, AND POLICIES
In cases of a documented need for an urgent amendment to rules, regulations and policies necessary to comply with law or regulation, the Active Appointees of the medical staff have delegated to the Medical Executive Committee the ability to provisionally adopt and the governing body may provisionally approve an urgent amendment without prior notification of the medical staff. In such cases, the medical staff will be immediately notified by the Medical Executive Committee. The medical staff has the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the organized medical staff and the Medical Executive Committee, the provisional amendment stands. If there is conflict over the provisional amendment, the process for resolving conflict between the active Appointees of the medical staff and the Medical Executive Committee is implemented. If necessary, a revised amendment is then submitted to the governing body for action.
ARTICLE XV
ETHICS AND ETHICAL RELATIONSHIPS

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 the Appointees. The principles of professional ethics adopted by local and/or state professional associations pertaining to Allied Health Professionals 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.

These Bylaws have been adopted by:

Summa Health System Medical Staff

Dale P. Murphy, M.D.
President, Medical Staff

Summa Health Board of Directors:

SIGNED ON PDF VERSION

Robert Gerberry
Secretary, Summa Health Board of Directors

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]
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